Mark Masselli: This is Conversations on Health Care. I am Mark Masselli.

Margaret Flinter: I am Margaret Flinter.

Mark Masselli: You know Margaret, it's interesting to watch how health care is playing such a prominent role in political races around the country and the Massachusetts governor's race incumbent Deval Patrick is being challenge by a former health insurance executive and the current state treasurer who's been very outspoken about Massachusetts' budget woes over health care. Even though the latest polls show that voters are mixed over Governor Patrick's performance, polls do show that a majority in the state will support their health care system.

Margaret Flinter: Well, the biggest unknown in many ways at the state and the national level is whether cost will go up and how much and when if ever will they start come to down as we read the benefits of some of the reform efforts. But beyond the dollars for premiums, there are some good news stories I think that have came out of Massachusetts' experience with Health Reform in particular and one of them is what we have seen there in terms of tobacco cessation. When they implemented Health Reform, one of the changes they made was to mandate coverage for smoking cessation counseling and prescription drugs, including for Medicaid recipients. And the result there has been the sharpest drop anyone seeing in the population of people who smoke particularly among Medicaid enrollees, it went from 38% to 28% and that's just good news in terms of both health care cost and building healthy communities.

Mark Masselli: It really is and it's spreading nationally as the Health Care Reform Bill will provide broader Medicaid coverage for smoking cessation. We all want to see more programs like this when it comes to health care.

Margaret Flinter: And there is a lot we can learn from all of the states, but I think we also can narrow it down even more to what individual communities can do when they come together to improve the health. So here in Connecticut, it was quite a pleasure last week. We had our Fifth Annual Weitzman Symposium. Mark, you did a great job by introducing some physical activity in the form of dance into the middle of it. We got people up and dancing. But the focus was obesity and I particularly enjoyed Mayor Joseph Curtatone of the City of Somerville, Massachusetts talk about a community that came together to improve health and leader they have become across the country through their shape Up Somerville program in preventing and reversing childhood obesity.

Mark Masselli: They are certainly in shape in Somerville, and speaking about our minds agile, the Department of Health and Human Services has launched their Community Health Data Initiative. It brings together the best minds in technology and data and information, and it's trying to attempt to liberate the data that's been locked up in the recesses of Washington far too long, help all of our communities figure out better ways to innovate and improve our own health care.

Margaret Flinter: A new liberation movement, Mark. I think that's when we can get the odd. And turning to today's guest, Dr. Paul Grundy is here with us to talk about what corporations are doing to get better value for their health care dollar for their employees and for their employees' dependence. Dr. Grundy is the IBM Global Director for Health Care and the Founder of the Patient-Centered Primary Care Collaborative.

Mark Masselli: Speaking of innovative ideas, I noticed in the Op-Ed in the New York Times that we might want to start paying people to stay healthy and response to a story they ran about paying people to take their medication, it seems like there are a lot of employees and employers who like the idea and we might see it further developing areas of weight loss and smoking cessation.

Margaret Flinter: I am sure it won't sit well with everybody but money is the motivator and if it works, I am not sure that that's the bad thing. And no matter what the story, you can hear all of our shows on our website Chcradio.com. You can subscribe to iTunes to get our show regularly downloaded. Or if you want to hang on to our every word and read a transcript of one of our shows, come visit us at Chcradio.com.

Mark Masselli: And as always, if you have feedback, email us at Chcradio.com, we would love to hear from you. Before we speak with Dr. Grundy, let's check in with our producer Loren Bonner with Headline News.

Loren Bonner: I am Loren Bonner with this week's Headline News. Doctors treating Medicare patients won't see a reduction in reimbursement fees that were supposed to take effects Tuesday. Medicare won't begin processing claims under a reduced payment formula for doctors until June 18th, anticipating that Congress will intervene this week. The delay is the latest in the string of efforts to prevent doctors who see Medicare patients from receiving a 21% reduction in the payment formula that's used to reimburse these

providers. Over the weekend, President Obama called on lawmakers to avert the pay cuts faulting Republicans for the delay. He also pledged to work on a permanent solution to fix the way Medicare doctors get paid.

Barack Obama: After years of voting to defer these cuts, the other party is now willing to walk away from the needs of our doctors and our seniors. Now, I realize that simply kicking these cuts down the road another year is not a long-term solution to this problem. For years, I have said that a system where doctors are left to wonder if they'll get fairly reimbursed makes absolutely no sense. And I am committed to permanently reforming this Medicare formula in a way that balances fiscal responsibility with the responsibility we have to doctors and seniors.

Loren Bonner: Until a permanent solution to this sustainable growth rate formula for Medicare is agreed upon, the temporary fixes by Congress will do more harm than good to control the cost of Medicare. As new regulations roll out under Health Care Reform, the Department of Health is trying to balance market stability with flexibilities for families and businesses when it comes to their health plans. With the Department's announcement of the new grandfather rule, businesses can keep their current plan while providing important consumer protections they give Americans rather than insurance companies control over their health care. Department of Health Secretary Kathleen Sebelius said, "These new rules are carefully written to make sure the grandfather plans still have the flexibility they need to make reasonable changes."

Kathleen Sebelius: So if health plans significantly raise co-payments or deductibles or significantly reduce benefits, for example just stop covering treatments like HIV/AIDS or cystic fibrosis, they lose their grandfather status and their customers then have the full set of consumer protections as new plans.

Loren Bonner: Critics are saying the changes could end up causing millions to lose their coverage, but the White House says the flexibility and the regulation means that routine plan changes under Health Care Reform wouldn't affect grandfather status. On a more conciliatory note, the Department of Health has awarded $23 million in grants to states and health systems to test medical malpractice reforms. Three-year grants will be issued to implement pilot programs and one-year grants will be issued to plan future programs, all in response to calls for an overhaul of the medical malpractice system.

Today on Conversations on Health Care, we are exploring transforming care in the workplace toward a model that's more focused on primary care and preventative services. Workplace medical clinics adopt the principles of the traditional medical home that put the patient at the center of the delivery process. The services are also tailored to the company-specific health care needs. Take Care Health Employer Solutions Group, a division of Walgreens Health and Wellness, operates over 400 onsite medical clinics around the country that can range from a small as a single nurse onsite all the way up to a 24-hour, seven-day-a-week clinic with a staff of as many as 60 physicians. In all cases, the patient receives continuous and comprehensive care from one person who serves not only as a direct provider but also as the coordinator of care. Peter Hotz, Chief Operating Officer for Walgreens Health and Wellness division says, "There is a need today for a more robust primary care system when it comes to a company's health care needs."

Peter Hotz: Some of the biggest things we can do are to promote engagement with the health care system, to help people take care of issues before they become chronic and, for those that are chronic, to make sure that they are adhering and complying with medication regimens and treatment regimens so that we prevent this chronic issues from escalating into a situation that requires hospitalization.

Loren Bonner: Focusing on prevention and management translates into health care savings over time, something else employees are seeking. According to Take Care Health, companies save as much as $4 for every $1 invested in onsite clinics. Although some companies worry about the need for a significant marketing to encourage employees to use the facility, Hotz says it's more simple than that, the biggest driver has been the traditional word of mouth. Let's turn now to our interview with Dr. Paul Grundy who has been transforming the way IBM purchases its employee health care for the Patient-Centered Medical Home model of care.

Mark Masselli: This is Conversations on Health Care. Today, we are speaking with Dr. Paul Grundy, IBM's Global Director of Health Care and President of the Patient-Centered Primary Care Collaborative, a coalition that advocates for the use of Patient-Centered Medical Homes. Welcome, Dr. Grundy. Now, your focus at IBM has been to transform the way IBM purchases health care for its employees around the world. You've served as the Director of Healthcare, Technology and Strategic Initiatives for IBM, what were seeing at IBM that convinced you that there was something fundamentally wrong about the care you were buying? How did you

diagnose, if you will, the problem as a lack of Patient-Center Primary Care and begin that transformation to a new model?

Paul Grundy: So what we are seeing was an intense focus on rescue care. We found a huge variation in price and in quality across the United States and because that's where the money flowed, we saw a real intense focus on "high-end procedures."

Mark Masselli: You are very focused on outcomes and evaluation studies, and there have been a lot of the impact of implementing the Patient-Centered Medical Home model. But they all seem to come from systems with the fine patient enrollment Intermountain, Geisinger, Group Health to name a few. But IBM's millions of employees are all over the globe in communities large and small getting care in big systems and in small practices, how much impact has IBM itself seen on improvements in care in higher value at lower cost for its employee base in recent years due to your efforts?

Paul Grundy: Even around the mid-Hudson where we had, I don't know, 100,000 lives or something, a significant employer, we have the large concentration now of NCQA Medical Home certified practices in the country. I think the last time I looked, it was about 11% of the whole nation's. That's a community that's not integrated, it's not a Kaiser, it's not a Geisinger, it's not an Intermountain. It's "real America" as I call it. I mean how do you change those places where we buy 96% of our care, that's a very interesting question and it's the question that our nation is trying to answer right now. And certainly, the rollout, the announcement on June the 2nd of the Medical Home pilots, Advanced Primary Care Medical Home pilots by HHS at the state level, is beginning to address that as well.

Margaret Flinter: Dr. Grundy, let me ask you about the Patient-Centered Primary Care Collaborative for a moment. Since its inception, you've brought together this prominent group of stakeholders representing employers of I think some 50 million people across the U.S., 200,000 physicians, leading consumer groups and now some of the top health insurance companies. So the question is this, how is that collaborative viewing the Federal Health Reform Law in terms of its potential impact on furthering your objectives, on furthering the Patient-Centered Medical Home concept? And do you think the administration has seen this as a fundamental strategy to reduce cost while we are advancing universal coverage in the United States?

Paul Grundy: Yes, I would say that not only this administration but the last administration, Secretary Leavitt got it and we have been working on it bipartisan, we have Newt Gingrich say, "The single most important thing that you should/can/need to/have to do is Medical Home" from the Republican side and we have the President on June the 8th for the 27th time. So it's widely brought bipartisan and I think it's understood universally that there is no health care system in the world that works without having a robust base of primary care community medicine and prevention.

Mark Masselli: Dr. Grundy, you are known as a critical thinker both in the areas of practice redesign and payment reform, and I want to focus a little on the payment reform side because there is no single best payment structure for Medical Homes that have been established in some pilots that primary care provider or practice gets an additional per-member per-month payment in other systems like the VA, it's a close system with no fee for service payments. What are the most promising strategies going forward and do you anticipate there will be any one best payment methodology? And as the primary care medical home changes get fully incorporated and really become the norm, what's the likelihood that payers, whether public or private, will be willing to continue to pay a bonus and want this ultimately getting incorporated into the cost savings that the country needs to find?

Paul Grundy: I think that's a great question and the answer is you have four or five knobs, you have dials that you can turn to get the outcomes you want. And when you take one dial, let's say fee for service, and after all you use and you turn it on, what are you going to get, too many services, I mean it makes sense. If you pay for high-end procedures, you will get high-end procedures. The system responds to the money. If you pay capitation, so if you pay a single capitated fee, I mean what you get, the outcome that you get is that the docs who would want to see as many people as they can and deliver as few services because why not, I mean that's where the money is. And another dial that you could use would be to pay for outcomes, to pay for value, to pay for either the whole community and how well they do or your individual patient and how well they do, I mean you take those dials and you start somewhere, and you dial them up or dial them down.

Margaret Flinter: So when we look at the evaluation studies then going back to those, Dr. Grundy, we do see some dramatic gains being reported, significant drops in inappropriate emergency room use, decreases in readmission to hospital, preventive admissions, cost in

treating certain chronic conditions. It seems that the outcomes and data, that's hard to get on a large scale unless you have electronic health records and health information exchanges. Certainly, there is a huge push to do that in the United States, but what's the collaborative in IBM's take on the need to mandate the practices to go to electronic health records within a very short period of time? Are you saying that you really can't achieve these goals without that kind of electronic health record or are you still at the encouragement phase versus the mandate phase for your providers?

Paul Grundy: With HIT, with data becoming executable information at the point of care, we are really going to have docs that are smart, I mean we are going to have a registry in which they can see exactly what's going on with their patient, with their population, reminders that you now get from your bank. I mean it's really a phenomenal transformation and there is billions of dollars coming down on the docs right now through ARRA and other mechanisms to begin that transformation. But it's early, it's a journey and it's early.

Mark Masselli: Today, we are speaking with Dr. Paul Grundy, IBM's Global Director of Healthcare transformation and President of the Patient-Centered Primary Collaborative. You really have a global perspective on health care, both by the _____ 17:01, son of a Quaker missionary, and you spent your earlier years in West Africa. And really, by your work, you worked as a senior diplomat in the United States State Department facilitating health and diplomacy. More than most, you are no doubt aware that the developing worlds don't have the kind of health care manpower to implement this model built on personal relationships with the physician yet. They aren't very focused in on building strong primary care infrastructures. In fact, there seems to be a much more of a trend towards the use of remote technology, community health workers, and primary care workers of all kinds. What do you see for the future of primary care in the developing world and are there lessons for us in their work?

Paul Grundy: It isn't about face-to-face time necessarily, it's about relationships and some of those can be asynchronous and some of those can be distant. So, I mean in some places, even here in the United States, our patients now are up to 25% to 30% of their visits being portal based or e-mail based visits and not face-to-face. And I think those kinds of enablements will really help in a developed world. But we did a solution for Tristan da Cunha, the most remote island on the face of the earth, that's seven days boat ride from Cape Town, 300 people linking them to

University of Pittsburgh Medical Center where they get the appointments online. And we now have some of the docs that are delivering this kind of care in United States. We have one Chuck Carlo in Portland who I think, something like 70% of his visits are asynchronous. We have one employee, he moved from Portland to New York and continues to have him as his doctor. Now, we can deliver services literally anywhere in the world, including the most remote inhabited island on the face of the earth.

Mark Masselli: I think that's true, but it does really require a cultural change. My four children are comfortable using Facebook in communicating with people all over the world. I am not sure we have trained this generation of primary care providers to be asynchronous. There are certainly a few leaders in the industry, but they do seem to be a little behind the times in terms of that. I think the model you are referring might have been out in Washington State where there are a few but they are really the exceptions. Do you see the next generation really being trained to be comfortable in this type of medium?

Paul Grundy: I see a beginning. I had the privilege of visiting a couple of primary care training programs recently down in the Carolinas and in Virginia that are P4, that are Patient-Centered Medical Home, embracing primary care training programs. Those members are really expanding. And when I talk to the young docs coming out of those programs, they get this, they understand this, they are ready to deliver this.

Margaret Flinter: I want to bring you back to this domestic workforce issue again because we clearly have to focus on transformation. And the Federal Health Reform Law made it clear that we have to expand our definition of who is a primary care provider to include not just physicians but also nurse practitioners and physicians' assistants and that they need to be able to lead primary care homes as well. The model relies heavily on our ends as care coordinators. And then, there are so many other people, patient navigators, the health care coaches, health information technology, people all the way down the line. So it seems we need to look at this whole issue of health care workforce training very broadly, much more broadly than we have done in the past and get out of our silos a little bit. Domestically, where do you see the leadership for that transformation coming to get out of the silos between the health professions?

Paul Grundy: What do I see is really the silo change agents driving this. It's really fascinating to watch because the last huge transformation we

have in health care which was really driven by the DOD and the Veterans Administration, went out in World War II and even, in fact, in World War II. They started to specialize, they decided to then create training programs around all of the Veterans Administrations, in academic health centers, by the way, where half of our residents trained. And that was that evolution into what evolved into high-end, high-procedure cost on medicine. So you look at where they are going now, I mean they both are, the DOD and the VA have said every vet, every DOD member will have a Medical Home by 2012 and they are driving towards that big time.

Mark Masselli: I always like to ask our guests, when they look around the country and the world, what do they see in terms of innovations and who should our listeners at Conversations be keeping an eye on?

Dr. Paul Grundy: They have all states that are profoundly changing the way care is delivered. Community care in North Carolina is an example where they are really focused on Medicaid and we saw decreases in asthma hospitalization by 44%. Vermont has really stepped up to Medical Homes in every community. They are growing it out and they have integrated community health wellness and a blueprint for health. There are some great examples of places around in United States that are really already stepping up and making a difference.

Margaret Flinter: Well, you are right and those are all areas that we have been keeping our eye on. Today, we have been speaking with Dr. Paul Grundy, IBM's Global Director of Healthcare Transformation and President of the Patient-Centered Primary Care Collaborative. Dr. Grundy, thank you so much for joining us today.

Dr. Paul Grundy: Only a pleasure.

Mark Masselli: Each week, Conversations highlights a bright idea about how to make wellness a part of our communities into everyday lives. This week's bright idea focuses on new technology that's helping asthma patients and their doctors better monitor the disease day by day. Asthmapolis is a collection of disease-tracking services that helps to determine the triggers of asthma. Although much progress is being made in understanding asthma, morbidity remains high. Every year, asthma accounts for two million ER visits and 27 million missed days of school and work. These high rates are largely due to the fact that doctors and patients still lack crucial information about where and when asthma symptoms develop. That's where Asthmapolis comes in. Here is how it works. Patients attach Asthmapolis tracking device to the top of

their inhalers. It's basically a GPS to pinpoint the time and location of each inhaler use. The device is used in tandem with Asthmapolis's mobile diary which can be accessed on any computer or phone with a web browser. The mobile diary compiles the device's data to map asthma triggers, symptoms, and inhaler use, giving patients a comprehensive look at how their disease affects them day to day, and when and where it affects them. Patients can also program the mobile diary to text their medication reminders. Researches conducted in partnership with the CDC last year showed that these kinds of real-time reports made a big difference in how effectively patients manage their asthma. Asthmapolis was featured in the Department of Health Community Health Data Initiative, launched earlier this month. The presenters had this to say about the trial run.

"Patients reported more awareness of patterns of asthma, a better understanding of their triggers and, also, most importantly, I think better and more regular use of their controller medications."

Mark Masselli: Asthmapolis not only improves individual patient quality of life, it also uses crowd-sourcing technology to map population level data about asthma for public heath research. On both the micro and the macro level, Asthmapolis is helping change the way patients, their physicians, and public health agencies manage asthma. Now, that's a bright idea.

Margaret Flinter: This is Conversations on Health Care. I am Margaret Flinter.

Mark Masselli: And I am Mark Masselli, peace and health.

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