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

Margaret Flinter: And I am Margaret Flinter.

Mark Masselli: Margaret, there is a lot going on with health care, a lot of bending and shaping that spending bill, they are still working it out. They need to find a short two-week spending bill that doesn't de-fund cuts with health care reform and that hopefully will pass the President's muster. We are also waiting for Judge Vincent on a request from the justice department to clarify his ruling that struck down the law as unconstitutional. But what's really different is President Obama is coming out in favor of a significant change to the health care reform bill for the first time.

Margaret Flinter: Mark, I have to admit I did not see this one coming. It really took me somewhat by surprise. The president is supporting a plan known as the Empowering States to Innovate Act. It's a bipartisan bill supported by Democratic Senator Ron Wyden from Oregon, Republican Senator Scott Brown from Massachusetts and Democratic Senator Mary Landrieu from Louisiana. And what this legislation would do is create an innovation waiver that allows individual states to opt out of the individual mandate in 2014 instead of 2017 full three years ahead. And as you know, that's been the most controversial part of the law, at least some would say, the one that requires everybody to purchase health insurance.

Mark Masselli: Well, we will watch that. Certainly, the President is trying to engage the other side of the aisle in conversations, he really wants to save the overall architecture of the bill and we will see how this conversation precedes the President that was sticking to his State of the Union theme to innovate. Basically, he told the room full of state governors that if any of them have a better idea, they are welcome to propose them and see what might work. There were a lot of demonstration projects that could fit in here; they would have to convince the President in Washington that their approach covers at least as many state residents, provides equally affordable and comprehensive benefits, and would not increase the federal deficit, a high bar to reach.

Margaret Flinter: A high bar and therein lies the conundrum because many experts, and we have had quite a few of them on this show, say that without the individual mandate you can't get to that affordable comprehensive coverage that protects everybody so we will certainly see how this goes forward. But there are projects underway all across the country led by some very innovative thinkers and practitioners that are showing signs of success in improving quality and reining in the cost and I think they can give us a base on how to approach a challenge like this.

Mark Masselli: I think you are right and one of those innovative ideas is hot-spotting them. Sure, many of our listeners read Dr. Atul Gawande's latest New Yorker article about this. He argues that health care savings will not be found by cutting back on primary care but providing more intensive care to the chronically ill. The sickest 15% of Medicare patients account for 75% of health care cost. Dr. Gawande gives us a concrete example of people in programs around the country that are actually doing this targeting the sickest with better care and in turn seeing lower readmission rates to hospitals and savings to Medicare.

Margaret Flinter: Dr. Gawande has become quite a prolific writer on subjects of interest in health care and in this one, he profiled the Primary Care Physician Jeff Brenner who has been a pioneer in treating the chronically ill in Camden, New Jersey for a few years now and doing it a little bit differently identifying where are those hotspots in neighborhoods where patients with the most admissions to the hospital and the higher costs are coming from. And he mentions our guest today, Dr. Timothy Ferris and his care management program at Massachusetts General Hospital in Boston that he designed. Dr. Gawande says this program offers hope that you can lower cost by providing better care to the chronically ill and that that can succeed on a larger scale. We are Dr. Ferris is here with us today. He is going to talk about his Medicare Demonstration Project that he's been operating since 2006 and I am sure he will have a lot to share with us Mark about both the outcomes they have achieved and how replicable this is for the rest of the country.

Mark Masselli: I am looking forward to the conversation. But no matter what the story, you can hear all of our shows on our website www.chcradio.com. You can subscribe to iTunes to get our show regularly downloaded or if you like to hang on to our every word and read a transcript of one of our shows, come visit us at www.chcradio.com. You can become a fan of Conversations on Health Care on Facebook and also follow us on Twitter.

Margaret Flinter: And as always, if you have feedback, email us at www.chcradio.com, we love to hear from you. Now before we speak with Dr. Ferris, let's check in with our producer Loren Bonner for the Headline News.

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Loren Bonner: I am Loren Bonner with this week's Headline News. President Obama gestured a willingness to give states some leeway with health care reform. During an event with the nation's governors, the President said he supported amending the measure in the law to allow states to opt out three years earlier from a range of requirements, one of those being the most controversial part of the law the Individual Mandate that requires everyone to purchase health insurance. Instead of waiting until 2017 under the current law, states would obtain waivers to create their own design for expanding insurance coverage as

soon as the law took effect in 2014. But the President said states that don't like the Federal Healthcare Plan and want to draft their own must consider some stipulations.

Barack Obama: If your state can create a plan that covers as many people as affordably and comprehensively as the Affordable Care Act does, without increasing the deficit, you can implement that plan and we will work with you to do it.

Loren Bonner: While some Republican governors praised President Obama for reaching out, others like House Majority Leader Eric Cantor said the proposal wasn't enough and that Republicans will continue to fight to repeal the law. The amendment will go before Congress for approval. Regardless of how states will choose to implement health care reform many governors are worried about how much it will cost to carry out the law. The federal government understands this concern and has offered several rounds of grant money to implement certain parts of the law like funding to expand home and community based health care in state Medicaid programs as well as grant money to encourage Medicaid beneficiaries to adopt healthier lifestyles. The latest round of funding from the federal government could help states evaluate health insurance rates. Starting in August, states can apply for 3 year grants worth $3 million to develop programs to fight insurance premium hikes.

Mark Masselli: This is Conversations on Health Care. Today, we are speaking with Dr. Timothy Ferris, Medical Director of the Massachusetts General Physicians Organization at Mass General Hospital and an Associate Professor at Harvard Medical School. Dr. Ferris designed the Care Management Program at Mass General, a Medicare demonstration project jointly run by the Centers for Medicare and Medicaid. There has been reducing cost for high risk chronically ill patients with better care since 2006. Welcome Dr. Ferris.

Dr. Timothy Ferris: Thank you very much.

Mark Masselli: Demonstration projects like yours targets the sickest 15% of Medicare patients who account for about 75% of health care costs. Could you start out by giving us a clear picture of the different types of people enrolled in your program?

Dr. Timothy Ferris: The program enrolls patients who are living with generally multiple chronic conditions so we like to say that we don't have patients with diabetes or heart failure or depression in our program, we have patients who have all three. And as you can imagine, managing one chronic condition presents certain challenges, managing 3, 4, or 5 present really large challenges. Particularly as technology evolves and the number of medications that they are on increases, the ability to sort of keep track of all that stuff the doctor's visits, the medication, really goes up exponentially and I think exceeds the capacity of most

people to manage effectively and so that's where the care management program comes in.

Margaret Flinter: So Dr. Ferris, I think yours was one of only six hospitals who took on this challenge from CMS in 2006 and I don't think anybody would be shy about saying certainly a goal was to save money to reduce expense. But this time it really was not in any way about cutting back on care but probably addressing more care to this population you are describing, people with three or more chronic illnesses by essentially providing them with better care and better coordinated care. Tell us really about the design of the program. How did you approach that kind of intensive care, intensive care coordination to make a difference?

Dr. Timothy Ferris: Well the idea is an old one. There have been papers written back in '60s and '70s about the idea that care coordination as an investment so spending money on increased nursing and support for patients could actually give a return on investment. But it turns out that the systems necessary for that to work in practice are relatively recent phenomenon and what I mean by that is the statistical and data approach is necessary to predict who is going to be high risk and then applying those care coordination techniques to them are really a fairly recent development over the past 10 years. I had developed a number of programs prior to this one which quite frankly were failures, they were either inaccurate in their targeting and then others where the intervention itself was too weak so phone-based interventions rather than the practice-base interventions that this demo used. So the design was really based on essential modern technology and data that we use now in our system as well as experience with predicting who is going to be high cost and therefore benefit the most from this and then finally getting the nurses to know the patients, getting them in the practices, making them a trusted member of the care team between the doctor and the patient, those really were the essential elements to the design which led in this case to the success.

Mark Masselli: Predictive modeling is a real science and we will probably talk about that in a little while but what sort of outcomes have you achieved both in terms of your overall savings as well as in terms of better health and what areas were you just sort of disappointed in or surprised with the results and what are you trying out now?

Dr. Timothy Ferris: We have achieved remarkable cost savings so by saving 12% of the cost on the patients enrolled we saved 4% of cost to Medicare largely through reducing hospitalizations and emergency room visits. On the quality side what we were not expecting to see was we actually had a 4% mortality difference between the patients in our intervention and a control group selected from the Boston area and therefore demonstrated that in addition to being able to successfully keep patients out of the hospital when they didn't need a hospital, the patients in this program actually lived longer than patients in the control

group. And those are the big findings. I think the things we are still working on include the fact that we did not significantly improve our re-admission rate and getting into that in a little bit of detail a lot of our patients, these frail elderly patients who are discharged from the hospital go to rehab facilities or nursing homes for a short period before being transitioned back to their house. And the speed with which and the frequency with which they get re-admitted to our hospital didn't change at all and so we are now partnering, developing partnerships with what are called post-acute facilities, the rehab and nursing home facilities in our region, to better understand how we can support these patients, these frail elderly patients, when they are in the rehab or nursing home so that they don't need to come back to the acute care hospital.

Margaret Flinter: Well reducing cost by that margin and saving lives by that margin, reducing mortality are very impressive outcomes. And we were very intrigued by Dr. Gawande's recent New Yorker Article titled Hot Spotters where he makes the case that deploying the most resources to the hotspots, the areas where health care costs are the highest, can certainly save a lot of money to the system and again, we think reduce misery and suffering. And he cites you in the care management program as one of the science that medical hot-spotting can succeed on a scale that would help a larger population maybe be part of our national approach to health care. So maybe you could talk just a little bit about how you are working to translate this approach nationally and what are the challenges. It certainly seems from our perspective that one of the big challenges is having the data to know where those hotspots are. We say in primary care we can tell you without too much sophistication in predictive data modeling programs who our sickest patients are but if we are not even seeing that patient, that patient that's described in the New Yorker article as going to emergency room dozens of times a year but not associated with primary care how do we in primary care find that person and bring this person under our care. So maybe you could talk just a little bit about that.

Dr. Timothy Ferris: So those are great questions and we are working hard on trying to develop some answers to those questions. To be successful really requires a partnership between the people who are paying the billing claims and the providers of health care. And for our program to be successful, we had to work very closely and we continue to work very closely with CMS, Medicare around these issues of data which you have just highlighted which is how do we know if the patient is seeking care outside of our system. Well we don't unless Medicare tells us and in the demonstration program we get data frequently from Medicare about what's going on with our patients. Of course there are rules about sharing data, we have to abide by all those rules but we have managed to come to a place where we get data frequently and often it's accurate enough that we can then turn around and use that data for exactly the purposes that you are pointing out which is letting us know about issues that we would not be aware of where the patient's just using our system. And I think going forward to the national scene you are going to see that, that that's an essential ingredient with

these accountable care organizations of which I would say we are one even though it's not exactly clear what the formal definition will be. Whatever it is, this activity that we are conducting with Medicare in the demonstration projects makes us an accountable care organization and for that organization to be successful we will need this partnership with the payers.

Mark Masselli: Today, we are speaking with Dr. Timothy Ferris, architect of the Care Management Program at Mass General Hospital. Dr. Ferris, an important part of the health care reform is based on funding demonstration projects similar to yours that improve care and reduce costs. $10 billion will go toward funding innovative demonstration projects in communities around the country. How effective is this approach and what needs to be done so that it could be translated into policy down the road?

Dr. Timothy Ferris: You know I am a big fan of this approach. I think the diversity of provider types and organization types that provide medical care makes it very difficult for policy makers to create a set of rules that will always apply and be successful. So I think the complexity that we are facing in the delivery of health care it is a wise choice on the policymakers' part to use a demonstration or pilot model essentially priming the pump for the organizations to coalesce, to figure out what their governance and payment structures are going to be and then learn what it will take to be successful. I think a heavy-handed legislative approach would be fraught with difficulty in this situation.

Margaret Flinter: I would like to explore with you a little bit the team and your approach. And the people who are on the team certainly you have primary care providers, physicians, I don't know if you have nurse practitioners or PAs as primary care providers, you have nurses who seem to have all but disappeared from most private primary care practices although they play a critical role in our community health center model, certainly we have pharmacists and behaviorists on our team. Tell us about the team you have at Mass General and if you could is Mass General a model of primary care? People tend to think of that as the big house of specialty; do you feel like you are able to really model a primary care team that will be able to be replicated in practices around the country?

Dr. Timothy Ferris: I am very hopeful that we have and I wouldn't say we have nailed it certainly, we have ways to go on creating better teams. But I think there are enough examples across the country that have sprung up and been described all over the country that have really effectively turned primary care practice into a real team-based activity as you describe. So we use pharmacists, social workers and nurses in conjunction with our primary care doctors to manage patients in this demo. And there really is a team in a way that I didn't previously experience, I am a primary care physician here and the nurse in my office generally was refilling prescriptions and seeing minor ailments rather than what my nurse in the program is doing now working with social workers and our pharmacist to make sure that each patient is being looked after. In fact I got a

call this morning from my care management nurse about one of my patients who was hospitalized at an outside hospital and she is arranging for a transfer to a post-acute facility even though his patient isn't even being cared for within a Mass General affiliated institution. So that's the extent to which the whole delivery of care is being thought about differently when you are on a team like this. I as a primary care doctor it would have been very unlikely that I would have been involved in the care of that patient hospitalized outside my institution but under this new model I am involved and I am involved through this team. And the team really provides resources that I could never have brought to bear for the patient before the social worker's knowledge of available community resources is much greater than mine and really provides the patients in the program with a terrific service.

Mark Masselli: Dr. Ferris, you just talked about looking around the country. Tell us what you see in terms of innovations and what other projects our listeners at Conversations should be keeping an eye on.

Dr. Timothy Ferris: Well I think you will see a lot more electronic interface with physicians, it's springing up allover as it is here at Mass General where you can conduct e-visits and phone visits between patients and doctors. It's usually for more minor issues but certainly more convenient for patients. I think you will see a lot more outreach from doctor's offices encouraging the delivery of preventive services like colonoscopy and mammograms making sure that those are getting done, reminders and so forth. All of those are sort of systems-based practices that exist now but are not as common as they should be. I would also say that in order for this to happen one, there is a fundamental issue that needs to change around payment in primary care and that is that primary care physicians are only paid generally for face-to-face visits and these kinds of efficiencies like phone visits and email visits will be very important to unclog the system in primary care and allow the doctors to spend more their time with their teams taking care of the sickest patients. But for that to happen, the payment system needs to change, we need to find a way to pay for primary care that doesn't revolve completely around face-to-face visits, that's really the piece of this that needs to move in order to generalize what are now lots of great experiments to make it really widespread, the payment system has to change.

Margaret Flinter: Lots of room for innovation in payment as well as clinical care. Today, we have been speaking with Dr. Timothy Ferris, Medical Director of the Mass General Physicians Organization of the Massachusetts General Hospital, Associate Professor at Harvard Medical School and architect of the Care Management Program at Mass General. Thank you so much Dr. Ferris for joining us today on Conversations.

Dr. Timothy Ferris: My pleasure, thank you.

Mark Masselli: Each week Conversations highlights a bright idea about how to make wellness a part of our communities and everyday lives. This week's bright idea focuses on a student-led effort that takes primary care training to whole new level. The Crimson Care Collaborative based at Massachusetts General Hospital was designed by Harvard Medical students to enhance their clinical experience in primary care while at the same time bringing critical primary care services to those in need. Although primary care providers are in short numbers all across the country, Massachusetts has experienced a greater demand ever since the state began in 2006 mandated that all residents carry health insurance. That's created an influx of newly insured residents who were in need of primary care providers. Harvard Medical students were eager to step up and address the shortage of practitioners. With the help of the internal medicine associates, a flagship practice at Massachusetts General, the seven-week student pilot program began officially in operation as an extended hour of practice in the fall of 2010. Patients are initially seen by first or second year students who take their vital signs, third or fourth year students complete the patient history and conduct a physical exam. The senior students then present each patient's case to the supervising doctor. Other students fill in as patient coordinators, social workers, and lab directors while a team of research and quality tracks data on patient health needs and wait times. Medical student-run clinics aren't new but if this experience encourages more Harvard Medical students to choose primary care as their specialty, that's a bright idea.

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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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