In a panel discussion at Business First’s summit on the federal Patient’s Protection and Affordable Care Act, program sponsors shared their thoughts on questions about the landmark reform rules. What follows is an edited transcript that highlights points raised in the October 3 question-and-answer session.

JEFF WRIGHT: Welcome to our third annual Health Care Reform Summit. I want to acknowledge our sponsors, Independent Health, Catholic Medical Partners and Catholic Health Partners and recognize our panelists. Moderating our discussion today is someone that many of you know. Tom McNulty is president of Success Stories, an Orchard Park consulting firm.

Tom will be asking the questions, but he’s going to want you to be involved, too. Partway through our program, he’s going to ask you to submit your questions. Tom, take it away.

MCNULTY: Thank you, Jeff. Today, we’re going to be talking about several items and words that you’ve heard before: Affordable, cost, disease management, employers, health care, bending the curve, Affordable Health Care Act. But to get us started, I want you to be thinking in terms of framework of where we have come.

All of you are here obviously because you follow trends in health care. They impact you as a consumer. They impact you in the workplace and they impact you as a provider. So, I want you to kind of set your mind on your framework of what you’ve witnessed over the years in our community.

I’ve asked our speakers today to keep their comments to the impact in Western New York. We’ll leave the impact for the debates that are going to be going on later this weekend into November, but we really want to get a sense of what’s going on here in your community and what it means to you. To get us started, I’m going to ask each of the panel members to give an opening comment. So, we’ll start with Dr. Mike Edbauer.

EDBAUER: Well, I think one of the things that we’ve recognized is in order to really be able to make an impact on cost of health care, it really has to start on how it’s fundamentally delivered and this really works at Catholic Health and their focus is not only on the primary care physician offices, specialists, but also acute care facilities, long-term care and home care and really developing a program that will be most efficient in that manner.

The other piece that I wanted to touch on today is also the relationship with the business community, those who are paying for health insurance and we’ve seen as many folks as a consumer. They impact you in the workplace and they impact you as a provider. So, I want you to kind of set your mind on your framework of what you’ve witnessed over the years in our community.

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The other part is the reason why there’s emphasis on the IT is so important is to have the information we need available in front of the provider at the time of care to reduce the likelihood of waste. You can imagine if the patient is not there when you come in to see the doctor, the likelihood of ordering unnecessary tests, repeat tests, etcetera.

And then lastly, is that this also requires that we work as a team approach to the health care, which is quite different than how we were operating 10, 15 years ago. You have to change the terminology whether you’re going to see your health care office or your medical home and this really incorporates using our individuals in multiple areas of skill and training such as pharmacists, nurses, dietitians, physical therapists and the list goes on.

In fact, this care, if all these individuals are utilized properly, you’ll actually receive higher quality than individuals with greater training and expertise in those particular areas and still coordinated through your doctor, but ultimately at a lower cost.

MCNULTY: Next, I would like Joe McDonald to make a few comments, but I think what the audience needs to know in terms of the sincerity of our presentation today is the average CEO in health care usually stuck around for about three years and if you’ve been in this community, we all witnessed that.

Come in, play the role of troubleshooter, fixer and move on and I think it’s a tribute and I want to personally thank Joe for what many of you have already read, is that he has extended his time in this community for another 10 years.

MCDONALD: Thanks, Tom. I’ve been here for ten years and what you don’t realize is I was on probation for ten years. We always have to have a probationary period but as an employer, we’ve got about 8,000 associates that work with Catholic Health.

I’ve got 5,000 of those associates taking our health insurance and we’ve seen as many folks
We have problems, taking better offers from one health insurance plan or another and more and more of our associates are opting for our health insurance. I am working with the financial folks at our company, I do want to approach this as a CEO coach a little bit for other CEO's, too. It was pretty clear to me early on that we had a significant gap within our own system of understanding the implication of health care.

We're in the business of taking care of patients, focusing on that, try to respond to our associates. 45 percent of our workforce is represented by organized labor so again, that's another dynamic. So, it's pretty clear that what I had to do is recruit into our system individuals that have a unique core competency and interest in understanding the complexity of health care and complexity of health care physician.

How I manage that and how I'm successful with that really dictates how successful I am with the financial folks and that, we see if we get to the HR folk and finance folk to come together and really understand the reality of our existence.

One of our other things we just came to the conclusion is we did not have enough control over these resources and their time. So, we moved forward with a community plan and took on more responsibility and accepted more responsibility being self insured.

A lot of board members were very angry at the time but it was really clear we weren't able to get our hands around the base, the specific utilization.

The next issue is preparing our organization, our 8,000 associates, our 5,000 folks that use our health insurance, prepare them to understand the dynamic that health care financing was about to go through and not only for them to understand as a provider, what does that mean for a nurse, what does that mean for the surgeon, but understand as an employee, your health insurance pack.

So, I'm gardener. I said, we have to do a lot of work preparing the soil, a lot of information, a lot of education, a lot of question and answers, a lot of special work with our folks that were represented by a labor union because we cannot unilaterally change structures or strategies without getting our organized labor folks with us. So, that was part of the ground, nothing is going to happen with the snap of the fingers.

We're pretty proud of the care we give and we saw almost no reason for our associates to leave our system.

We don't provide a lot of health care services. We don't have a burnout service, but we've got great relationships with people who can leave our system and seek good care where they needed to. So, it is a — we are completely at risk for the efficient and efficient care that our patients and our clients are getting and we are completely at risk for the clinical outcomes, early intervention and those types of issues.

We can't mess up and then be in a position where we're going to be working in a system where we are progressing in our community with affordability and cost effectiveness.

Fourth, we need to have a greater alignment in the health care system. We've got to break down the walls and silos that existed, creating synergies, not just between the disciplines and collaborations going forward. It's got to extend beyond the wall as Dr. Edbauer indicated and out into the greater community as well.

And then we have to have the knowledge of the use of health information technology and we are blessed in Western New York with HealthyLink which the envy of most communities in terms of a information highway that is a community asset that patients control the flow of their information available on the highway. When you talk about HealthLink, whether it's in Albany, the State Health Department or in Washington, people say, I wish we did it that way, I wish we did it that way. This is an amazing resource that's going to help us move forward at a faster rate and now, I'd like to go to the next slide which is, I think, the good news which gives us that realistic optimism to shoot for.

This slide depicts communities around the country that are working in this area with the Commonwealth Fund. The Commonwealth Fund is one of the two biggest entities of some policy makers and other research in health care and in March, they released data based upon a court order that they created to determine of the 30 NSAs around the country, how do they rank in the composite score of providing quality care, access to care and affordability.

Now, what was interesting is there is a strong correlation between poverty and a bad score. So, the NSAs that ranked at the bottom were areas that wouldn't surprise you Louisiana, Mississippi, Texas. The areas that ranks at the top, St. Paul, Minnesota, number one. But the Midwest did quite well. They have more resources. And what struck people was that Buffalo came out 5,4 in the top quintile when we're the third poorest large city in the country. People couldn't understand that.

And so, I got a call from the Commonwealth Fund. They want to ask me what's going on? And I told them about some of the work that's going on with Catholic Medical Partners with HealthLink. They got back to me in April and said, we want to talk to a few more people. They circled back to me and they said there's something interesting going on in Buffalo.

We decided we want to do an in-depth study of four communities to really profile excellence and opportunities and you're one of the four communities in the country that we want to do this on. We've got a starting point and a platform to go forward to really make a difference and it's going to take the kind of creative thinking and the language to engage the entire community, take us from 54 to the top 10 where we belong.

MCNULTY: This would be a good time to start to jot down some questions.

Dr. Mike Edbauer, I hear from my colleagues in primary care about the — the community's ill

esses and the high rate of emotional and epidemic versus long-term and those coming into the primary care setting initially and then moving on. What is the new role of the physician groups that you've worked with and specific to people who we go to the most, our primary care doctors, in that whole process of affordability and care effectiveness.
A Closer Look at Healthcare Quality and Patient Safety

For most patients, quality and safety are their primary concerns when they need medical care – and rightfully so. From drawing blood, to preparing food, to performing lifesaving surgery, patients expect and deserve high-quality care and service with each medical encounter. At Catholic Health, our commitment to quality and patient safety is at the heart of everything we do. The quality of our care improves the patient care and our patients’ perception of their care – what we call the “patient experience.” Our goal is to make every patient experience the best it can be.

The first step is to provide great care and exceptional customer service. Second, and equally important, we must document the great care we provide.

Within our system, we track hundreds of quality measures each day. This pinpointing work helps us improve our quality from month to month and year to year to keep up with the latest advancements in medicine and continually improve the safe quality and patient safety. We compare these measures against our own benchmarks and with providers across the county, and we are seeing results.

Our quality ratings are among the best in the region and the state, and we have reduced significant “harm events” by 75% from 2008-2011. For our patients and their families, that means we have reduced the number of incidences that can cause harm or have the potential to cause harm from 24 in 2008 to just six in 2011. And we won’t be satisfied until that number is zero.

These quality measures are reports to doctors and agencies that provide their own quality ratings for Catholic Health. These ratings are an important qualitative improvement tool and provide consumers with useful information to make more informed healthcare decisions. The Joint Commission, HealthGrades® and the Centers for Medicare & Medicaid Services (CMS), are just a few of the agencies that rate Catholic Health.

Evidenced-based Medicine and Core Measures - Better Quality, Better Outcomes

For our work focused on changing and improving the way health care is delivered through the use of systematic processes and information technology to enhance the quality of patient care. The Patient Centered Medical Home (PCMH) is one example. PCMHs emphasize the use of systematic, patient-centered, coordinated care that supports access, communication and patient involvement. In addition Catholic Medical Partners is accredited by NCQA and is following best practices in office-based disease management.

“"Our work focuses on changing and improving the way health care is delivered through the use of clinical teams, technology, clinical integration and patient engagement, which come together under the Patient Centered Medical Home program," said Dr. Michael Edbauer, Chief Medical Officer, Catholic Medical Partners. "Catholic Medical Partners and our members have taken the lead in implementing these important innovations in our Western New York community.”

Believing that true reform begins at the practice level, Catholic Medical Partners has helped its members implement a series of reforms and measures to help them work collaboratively with patients and with each other in a more patient-centered, coordinated care that supports access, communication and patient involvement. In addition Catholic Medical Partners is accredited by NCQA and is following best practices in office-based disease management.

“The ACO designation was a milestone in the effort to reform and improve the way health care is delivered through the use of systematic processes and information technology to enhance the quality of patient care,” said Thomas DeGrave, DO, Chairman of the Board, Catholic Medical Partners. “The commitment of our physician partners and our strategic relationship with Catholic Health and Mount St. Mary’s is enabling this transformation and we are excited to have the opportunity to serve our Medicare and Medicaid patient populations as an accountable care organization and to move our community one step closer to realizing the goals of true healthcare reform – improved quality, improved patient experience and lower cost.”

For Catholic Medical Partners, the inclusion in the ACO program is the culmination of several years’ work.

The organization’s efforts to improve the healthcare delivery system and reverse the unsustainable cost trend recently took another step forward, when Catholic Health, Catholic Medical Partners and Independent Health announced that they are joining forces to offer both large- and small-group employers two new products designed to help achieve the Triple Aim of better health, better care and lower costs.

The first of these products – “First Choice” – a self-funded, tiered-network product targeted to large-group employers, with approximately 200 employers will be available through Independent Health starting Jan. 1, 2013. It offers a coordinated delivery model that provides employers with the ability to customize their health care coverage based on individual employee needs and the health status of their workforce. The fully insured product targeted to the small-group employer market is expected to be made available in mid-2013.

“This program is unique because in our conversation with employers, the key drivers behind their interest in our product are the quality and value of the care we deliver to their employees,” said Dennis R. Horgan, President & CEO Catholic Medical Partners.

Partnersing for Better Healthcare

In Western New York

Healthcare remains a primary national and local concern. Aside from campaign rhetoric and political inighting, true focus must be given to finding practical solutions for improving the quality and delivery of care and, in turn, reversing the unsustainable growth in costs.

The quality for changing the way healthcare works in our community has been taking shape in many local physician-driven initiatives over the last several years. As an organization, Catholic Medical Partners, a network of more than 900 independent physicians, Catholic Health and Mount St. Mary’s Hospital, has committed itself to a system of clinical integration, physician and patient engagement and evidence-based medicine to help improve access, quality and cost. This strategy was adopted in 2005 and the Catholic Medical Partners network has made unprecedented investments in technology and establishing an infrastructure that enables the physicians to provide patients with the right care at the right time in the right setting.

One of the principal tenets to which Catholic Medical Partners subscribes is creating a stronger foundation at the primary care level. More than 30 of Catholic Medical Partners’ affiliated primary care practices have achieved the highest level of recognition under the national Physician Practice Connections®- Patient Centered Medical HomeSM program. Administered by the National Committee for Quality Assurance (NCQA), a private, non-profit organization dedicated to improving health care quality, the Patient Centered Medical Home program recognizes medical practices that use systematic processes and information technology to enhance the quality of patient care. The Patient Centered Medical Home program was adopted in 2005 and the Catholic Medical Partners network has made consistent investments in technology and establishing an infrastructure that enables the physicians to provide patients with the right care at the right time in the right setting.

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To our patients, their families, area businesses, and the community at large, with the safest, highest quality care experience possible.

Catholic Health - A Leader in Quality

- Joint Commission - Numerous Accreditations
- HealthGrades® - Numerous Five-Star Excellence Awards
- Three New York State Designated Stroke Centers
- Society of Thoracic Surgeons - Three-Star Quality Rating for Catholic Health Heart Center
- UDSMR Top 10% in the Country for Medical Rehabilitation
- Kenmore Mercy Medical Rehabilitation Unit
- American Heart/Stroke Association - Get With the Guidelines Stroke and Heart Failure Quality
- AIMIS Academic Center of Excellence in Women’s Health Surgery - Sisters of Charity Hospital
- IMS 2012 Top 100 Integrated Healthcare Networks
- Clevery & Associates - Community Value Five-Star Hospitals

with providers across our state and country to improve the overall quality of care in our community, eliminate preventable medical errors and reduce unnecessary hospital readmissions. Together, these efforts are helping us provide our patients, their families, area businesses, and the community at large, with the safest, highest quality care experience possible.

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We just don’t say “quality,” we define it. And, we know what it takes to become a high-performing healthcare network – providing the right care, at the right time, in the right place.

Our network continues to be recognized for providing the highest quality care in Western New York by national healthcare ratings agencies that represent the gold standard in hospital performance, including HealthGrades, IMS Health, the Society of Thoracic Surgeons, the Centers for Medicare and Medicaid Services, and the NYS Department of Health (for a full list of our accomplishments, visit us online at www.chsbuffalo.org/AboutUs/Quality).

Long before healthcare reform hit the national stage, we made a commitment to transform the way healthcare is delivered by investing in electronic medical records technology, creating patient-centered medical homes, and developing new ways to bend the cost curve that enhance the quality of care while providing a seamless network of services.

We are leading the way and are gaining national recognition for our efforts. New models of delivery piloted by the Centers for Medicare and Medicaid Services were developed right here at home by Catholic Health and Catholic Medical Partners. The federal government also chose us to be one of only 27 health systems in the nation to serve as an accountable care organization.

When you’re as committed as we are to working with top physicians, utilizing advanced medical treatments and state-of-the-art technology, and offering a broad range of high-quality services, only one thing is acceptable. Striving to be the best.

To experience this highly-acclaimed care for yourself, or for a physician referral in your area, call (716) 447-6205 and learn first-hand why quality is a word we never take lightly.
Better quality, coordination, access can lead to a sustainable health care system

The biggest challenge facing our health care system today is finding new and innovative ways to control spending. There are numerous reports underscoring this fact, but one of the most eye-opening is the recent Milliman Medical Index, which says health care costs for American families doubled from 2002 to 2011, and if it continues at this pace, will represent nearly 70 percent of the median household income by 2021. This unsustainable trend can be attributed to three key factors:

- An estimated 75 percent of medical costs are due to chronic disease, largely driven by unhealthy lifestyles.
- Approximately 30 percent of medical services in the U.S. don’t add value.
- Only 50 percent of the necessary preventive health services are provided when needed.

Reversing the high cost of health care cannot be done by one entity alone. It is up to us as a community to collaborate and seek sustainable solutions that improve quality and make our health care system more efficient.

Western New York is fortunate to have some of the best medical care in the country. Independent Health is actively working on collaborative initiatives with our many stakeholders within the health care system to transform our area into a high-value, high-performing health care community.

Independent Health has recently announced two such initiatives that will help to impact the health care system landscape in Western New York for years to come. The first is The Primary Connection, which launched in July 2012. It enables the primary care physician to be a vital part of improving the health care system by achieving seamless coordination of care with specialists and other providers to improve health outcomes, which will lead to lower costs over time.

The Primary Connection, which includes more than 140 internal medicine, family practice and pediatric physicians, empowers primary care physicians to expand their influence and provide more patient-centered care. This innovative approach has led to improved coordination between primary care and specialist physicians in managing chronic conditions and the use of alternative sites of care when an acute care hospital stay isn’t necessary.

The other initiative Independent Health recently announced in early October is our partnership with Catholic Health and Catholic Medical Partners, which focuses on offering both large- and small-group employers new products designed to help achieve the goal of better health, better care and lower costs.

The cutting-edge collaboration with Catholic Health and Catholic Medical Partners will help bend the medical cost trend through product offerings, as well as the coordination of patient care, prevention and wellness initiatives. The partnership will benefit employers and their employees, and help to create a “culture of health” in Western New York.

The ability to control health care costs will not be the single most important determinant of the economic success of our community – or any community – in the near future. Communities that get it right will be the most desirable places to locate business, so the vitality of our health care improvements will not only be essential for health care reform, but it will play an essential role in local economic reform as well.

We are excited to bring the community these innovative initiatives that are promoting disease prevention and wellness, revitalizing primary care, reforming the payment model to reward quality instead of volume, achieving alignment of the diverse sectors of the health care system and enhancing access to health information technology.

However, Independent Health’s continued innovation in the community would not be possible without the partnership of local physicians, providers and employers who are making sustainable health care reform their focus as well.

To learn more about the promising initiatives that Independent Health is leading through innovative partnerships, please visit Independent Health’s 2012 Community Report, “Taking action to reshape the care of our community,” at independenthealth.com/2012report.

Taking Action.

“In order to transform our area into a high-value, high-performing health care community, we have to create a culture of health where people are motivated and able to make better choices to lead healthier lives.”

Michael W. Cropp, M.D.
President and Chief Executive Officer

Learn about the promising initiatives that Independent Health is leading through innovative partnerships at independenthealth.com/2012report.
I can imagine a time in the middle of February with two or three feet of snow how that some of these home devices might be continued the conversation of health promotion and health stability with the right provider could end up being life-saving technology.

So it’s nice to see we’re moving in the right direction. A few questions I’d like to share with our panel from the audience. What is being done to create a true care culture in the Buffalo community?

EDBAUER: I’m actually a board manager for the PC collaborating with a holistic Health and what there is, is there is an increase in awareness of the need for improvement of the health of the community that Dr. Cropp talked about before and this is actually a great opportunity for P2 to help lead that way.

P2 by definition already has a great number of connections and relationships with the community we’re involved with and others so, what we think about is that we look at further opportunities to bring resources to the community.

The other area because of our climate is are there adequate places for people to continue to exercise during our longer winter months. And then, the other question is can we work together and bring resources to the community.

Part of it is through education and they’ve got to work with the school districts and make sure that the education is occurring at the level of the children, but also to make sure that we look at further opportunities to bring resources to the community.

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MCDONALD: I’m going to ask you each to comment on that but I want to share with you the theme of some of the questions that are coming from the audience.

What can we do to increase the opportunity for primary care physicians coming out of graduate school to work in the suburbs? How do you build an incentive package? Are physicians really behind payment reform and then the other themes are around that whole idea of creating an ongoing conversation with the patients who have been identified as having behavioral health issues as well as linking the patients who have been identified as having behavioral health issues with the community as well as what’s available to the suburbs.

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Another opportunity for us to engage in this beyond just simply health care.

MCDONALD: A balanced scorecard that would tell the community and the every community in the state how are we doing with respect to the cost of care, quality of the care in terms of the community and creating a culture of health. Without a scorecard, it’s going to be hard to know are we making the right kind of decision.

MCDONALD: What do you say, Dr. Cropp to our audience today from an employer perspective? How do they influence creating this culture of health?

CROPP: So, not to sound like I’m pitching books here, there’s another book that I found really helpful in thinking about this and it’s called “Influencer” and what they describe is six different situations where what was called for is massive social change and they went through and depicted how this change came about, was affected and sustained and the framework that we have articulated is that if you want to create the kind of change on a scale they’re talking about, the culture of health, where ultimately we’ve got to is a share of everybody’s mind thinking about health of themselves or their loved ones or their work colleagues all the time, then you’ve got to recognize that get that kind of change, you have to impact peoples’ motivation and their abilities and you have got to go to three levels for motivation and ability.

MCDONALD: Isn’t that what the whole health promotion and education piece comes in, about really helping people understand how to do that?

CROPP: Your right, but many health promotion programs as wellness programs are well-intended, but poorly designed but that has been structured around this framework. So you’ve got to impact individuals’ motivation and they do that by creating a program out there and you deal with the motivation, you forget about the fact that they’re not able.

MCDONALD: Next level?

CROPP: Next level is a social level. How do you enable the right kind of peer-positive work to help support one another? What do you do to structure teams to help people deal with their weight issues or other challenges at work? How do you build an incentive for teams? How do you help one another to not isolate or to get by themselves? So, the third level is structure. What kind of policy changes go into effect? So, as Mike was talking, about having more access to fresh fruits and vegetables in the city, you know, it’s going
HEALTH CARE REFORM SUMMIT

CROPP: Well, I think that there has to be a policy change at CMS to deal with this issue because right now for seniors and let's focus on them because they are the poorest of the poor and the sickest of the sick in our communities and the basic benefit for Medicare if you have people on Medicare and basically defines the playing field, is you have a 20 percent co-insurance for these expensive injectable medications. This whole reimbursement is a shift from the expense and the use of an oral medication which is now—many of them have generics available to more highly-specialized injectable drugs which, at the low end, cost about $1,000 a month and at the high end can cost upwards of $100,000 a month and asking people to put a 20 percent co-insurance on that government policy is absolutely just wrong.

MCNULTY: They (CMS) set the standard.

CROPP: They set the standard, but the other thing that's going to happen is we're going to see through advancements in science and genetic testing, the ability to target medication. So we're going to see a narrowing of the use of some of these medications.

MCNULTY: Dr. Edbauer, most physician practices are currently constructed to succeed in the traditional fee-for-service model. How do we shift the weight from that in a way that allows doctors to take more of a fundamental role without a complete reimbursement system. What we have seen in the marketplace, how the practice is not at risk in this scenario is a shift from the expense and the use of an oral medication which is now—many of them have generics available to more highly-specialized injectable drugs which, at the low end, cost about $1,000 a month and at the high end can cost upwards of $100,000 a month. So what are we going to do to put a 20 percent co-insurance on that government policy is absolutely just wrong.

MCNULTY: We have a major initiative to improve the next generation of young clinicians and it's not just specific to advanced practice. What we have seen in the market is that we have a significant number of small practices where you see a one- or two-physician group and to ask them to be successful in recruiting one more new associate is a pretty big lift. It's their private practice. They know how to have the procedure of a corporation. So, organizations like ours working with our partners have aggressively gone out and done a couple things, help recruit, help our existing practices understand their situation and determine whether their groups, if their private group would be a good place for several new physicians to begin their practice after their fellowship training. I think the private practice, a specialist, is a great opportunity for us. I think we put that and look at the additional strength of advanced practice nurses, doctors or nursing practice that can practice higher levels and then you create a phenomenal team that can take an existing 3,000 patients and they can take care of 6,000 patients.

MCNULTY: Couple of questions here and I'll ask Joe, to address. Although large businesses have access and experience with claim reporting, the small business does not and then are stuck in community rating systems. Is there a way this can be changed moving forward and part two of that question, the second question, how will this help the small business owner of 20 people or less improve the availability and affordability of affecting health insurance to our employees who tend to live paycheck to paycheck.

MCDONALD: Good point. A couple things. First is I believe if you talk to them, you'll see a series of new products that are specifically targeted towards the small employers and I think that's the way I think the exchange is another option smaller businesses can look at. In the insurance exchange that will be up and running in 2014, Dr. Cropp and I both were advisors on the practice for that will create one more avenue, too.

The other thing is that a lot of small businesses have not done is be willing to come together in associations, contractors or builders or tire distributors, too, and see is there a way to create a coalition to improve purchasing for health care and some trade associations do that. That needs to happen, but I go back to something I said a few moments ago.

Go back and look at your own management needs and look at the agenda and the top three or four things that are important to you are usually at the top of the agenda and if health care is not there, that tells you about where your own focus is, too.

In general, I'm going to give you more resources out there and if I was running a smaller organization with 50 people, I would take one of my senior folks or if it's a family business, my smartest child, who is probably the daughter and ask them to become the content expert. Invest in that person. Give them the opportunity and the time to really deeply dive and understand what the local market is like and make the conscious decision about where can they get the best value for your people but because it's so big an issue, sometimes it’s overwhelming, and you sort of put it off. You need to make it the center of an agenda.

MCNULTY: When Joe and I were talking on the phone about this event, I said, you know, you have a role along with the other panel members of making yourself available as a coach to people who are hungry for the information that you can provide for them to guide some of these tough questions that are coming up to the podium.

Dr. Cropp, a question has come up now that three separate ones and I'll phrase it by saying it's a sensitive issue, but apparently an issue of concern that has to do with the exorbitant cost associated with late-in-life care. How do we address that?
those decisions.

MCNULTY: Dr. Cropp, you wanted to add?

CROPP: Yes. I want to add to that, too. The issue on the focus on the payment reform, when I was practicing, I had a severely injured patient who came to me with severe heart failure and he transferred to my care from a cardiologist and I couldn't figure out why. He said, well, the cardiologist really wasn't listening to my wishes. And I said, well, what are your wishes? He said, I want to live to see my 50th wedding anniversary which was 13 months from now.

So, we sat down and had a conversation about how sick he was and what it was going to take and had multiple conversations with him, his wife, his daughters and my partner. We all knew what the care was and whatever it was going to take to get him 13 months to achieve what he wanted to achieve and we worked tirelessly.

We had a couple of bumps in the road with hospitalizations but ultimately, he celebrated his 50th wedding anniversary. He achieved what he wanted to achieve and now, he wanted to give back.

It's what his wife wanted, what his daugh-
ters wanted and unfortunately, his son who lived in Philadelphia hadn't been part of the conversation and he tried to swoop in and change the dynamic but because we had the relationship and the ability to get everything done, the family basically said, dad's comfortable.

EDBAUER: One piece of the pay-
ment model and also having the resources available and again, it isn't all the doctor who is the best one to do that. Sometimes, these people who are also homebound and so, we have to reach out and go to them to make sure we're having conversations with practitioners as well. So, it's really a whole new mentality to be able to know that I can make this work from an economic point of view.

MCNULTY: A lot of what we have been talking about this morning is changing lifestyles by being informed consumers in doing so but also not feeling obliged to be scholars in this area.

Again, by a show of hands, how many of you have invited outside providers to come in and talk to you, as Joe McDonald said, put on your agenda, maybe have a guest come in to your meeting and talk about some of these issues? A lot of coaching out there, Joe. Good time to be a consultant.

MCDONALD: Definitely.

MCNULTY: I think that you'll see the opportunity where the question was asked about creating a culture in Buffalo of health care. I would ask you to comment on models you've seen in other parts of the country that cannot afford to have any critical segment of that partnership left out and still expect it to occur to create that culture.

You thought on the role of the provider community in this partnership that you're creating or the employer community.

MR. MCDONALD: Well, I'm going to answer the first question, too. The provider community and I see a more and more sig-
ificant commitment to be open to explore new partnerships, all regions of the state to not be shackled by the way care was delivered in 1990, 1995 and 2000 and that they're willing to talk about how can we make some changes, how can we help move the pathway across the provider community, the health system community, the managed care community. This community – and I come to you from – this is not a South Buffalo accent. I'm from a different part of the country. This is a pretty amazing community and when I first got here, all these people were pretty much down on yourselves.

I was really impressed how much energy and resources you have around being able to get better wherever you were. There's bright spark plugs of innovation that's going on and I think the provider communities are open to being on investment in models. To me, it depends on where health care and health is in their agenda. How they do or do not connect with the idea that their economic enterprise being successful.

Some employers, not all employers, think there really is a correlation or two. It is in my world, but it may not be in other people's worlds, too. So, your own trade associations can be great places, the chambers are looking at trying to figure out are there other models and sometimes, it's hard for competitors from one industry to talk to other competitors in the same market but you've got people that do the same type of job but other markets that you can reach out and say what are they doing and you can transport or translate in some of their progress, too.

MCNULTY: Any other comments from the panel on that? Talk a little bit if you would from your perspective of where you think electronic medical records, electronic health records, EMR/EHR is interchange-
able, is going from your perspective and behind the scenes perhaps what the audi-
ence doesn't see each of you are doing to take advantage of getting more done with technology but really gathering the electronic health data that will help forecast the need of the future in our communities.

EDBAUER: I'm very happy to say by the end of this calendar year, we'll be to the point where virtually our entire network will be online. So, this is something we've been working on since 2006. So, it hasn't neces-
sarily happened easily or quickly but we're finally there. That's good news. The bad news is despite having electronic health records in the office doesn't mean we're taking full advantage of what electronic health records ultimately can provide.

So, what some of the things we recognize is that we need to provide to our practices that one of those resources that I mentioned in the past is to have a group of people go out and actually help them to make sure they're utilizing the electronic health records and also having the requirement of more importantly to help them on a day-to-day basis to get the most out of their health information in the population. The next big challenge is going to be imbib-
ability. So, we have everyone using electronic health records, but there are 12 or 15 vendors out in the community.

So, people have different electronic health records and ultimately all have to have the requirement to be able to talk to each other. That's not where we are today at the end of 2012. There's some innovative work going on with the commercial sector and co-exchange information so you actually can send basic information electronically from one practice to another and that's very help-
ful but that's right now going to take a little move along and I think we'll see a continued consolidation in the market.

Also, there are new software products that are being developed that you can actually overlay on the electronic health record. So, almost like an enterprise management soft-
ware for the enterprise being successful.

In the ER, every primary care physician has an electronic medical record which is great for the physician and great for that patient if they stay in that practice. None of them are connected so that the information doesn't flow to the specialist, to the hospital and the ability to manage the population by region is severely limited. So, they've got to go back and retool the whole information infras-
tructure now and we run the risk of overinvesting in that interoperability piece.

If you think about the information that's useful in the medical record, most of the infor-
mation is around any procedures, medi-
cations, allergies, lab tests, imaging results, all that is codifiable uniform standards.

To move that information that's already codifiable and uniform standards is a lot simpler than trying to take everything in the medical record and move it over. So, we focus our efforts on getting that to the extent that we can standardize the information that's already codifiable and not wait for the last 15 percent because we're going to spend millions and millions of dol-
ars for that last 15 percent when the first 85 percent is actually good enough and we run the risk of falling into that trap and most com-
unities have fallen into that trap.

MCNULTY: Which is changing as we speak, but in terms of our discussion today, gentle-
man, the opportunity to create affordable, cost-efficient care, are there opportu-
nities for there to be continued discussions with the employers? That's the question you're collecting, the data that you're compiling on history in the communities with the employer group in that kind of partnership, again, just go back to the question somebody raised about cre-
ating that culture of health in the commu-
nity. That sharing of data is what we found, here's what we need to know, there's more cost-effective and affordable care. Joe said, designating someone in the organization as a health promotion champion is important.

Are those opportunities emerging as well?

MCNULTY: Yes. I think that if something comes into an office and inadvertently looked at my record, nobody is going to know who looked at my record. You contrast that with what happened with Octomom case out in Los Angeles where a dozen poor lost their jobs because they accessed her record with out rights to do it and there was a footprint that led back to those 12 people.

You know, somebody embarks in a motor vehicle accident in Jamestown, severe acci-
dent, they go to WCA Hospital and they need a major trauma center, you know what? If they sign their consent, their X-rays, their labs, everything about them is going to end up in before they are and the trauma team will help plan their care before they arrive and those seconds may save their life.

MCNULTY: Dr. Cropp, a follow-up ques-
tion for you. With the growing usage of high-deductible health plans, how can you improve the transparency of negoti-
ated rates so that members can make more informed choices?

MCNULTY: I think it's a huge challenge because I think that transpar-
ency doesn't lead to the right level of com-
petition. It can lead to everybody raising the prices in the communities like CNET, but I do think it's important for people to understand what they're looking to receive, are there differences in terms of experience as well as differences there are, there are more difference in the outcome as well as price.

So, putting that all together to help people make informed decisions is going to be really important but let's not forget that at the core, you want the patient and the primary care physician to be talking about this together. You don't want to set up a situation where some-
body goes online and sees that the cheapest procedure might be at this hospital where the physician doesn't have any relationship or any knowledge of what's going on.

So, you know, it's not all it's cracked up to be. I think it helps to facilitate conversation, not to forget to get back to the conversation and the trust.

MCNULTY: I think that's an excellent way to conclude about what we're talking about.