

# Patient-Centered Care and the Health Care Reform Agenda

## A Roundtable Discussion

Kaiser Permanente Institute for Health Policy

### Background

With health care spending at 16% of gross domestic product and still one-quarter of all Americans having their personal health at risk due to inadequate or no health insurance, cost, coverage, and access to health care will continue to dominate the health care reform debate. We see the potential for the concept of patient-centered care—characterized by engaged patients and family caregivers, shared decision-making, information therapy, patient self-management, and a team approach to comprehensive primary care—to be an important organizing principle and goal for health care reform. Patient-centered care—arguably the most personal aspect of the Institute of Medicine (IOM) aims to improve quality—is gaining political attention, though not yet enough widespread support. To dig deeper into these important issues, the Kaiser Permanente Institute for Health Policy sponsored an invitational roundtable discussion on “*Patient-Centered Care and the Health Care Reform Agenda*” on Sept. 16, 2008. The following is an edited transcript of the roundtable discussion.



#### Moderator

#### Paul Wallace, MD

Medical Director for Health and Productivity Management Programs, The Permanente Federation; Fellow, Kaiser Permanente Institute for Health Policy



#### Thomas Lorentzen

Regional Director (Region IX)  
U.S. Department of Health & Human Services



#### Participants

#### Cindy Ehnes, JD

Director  
California Department of Managed Health Care



#### Tom Rundall, PhD

Executive Associate Dean  
UC Berkeley School of Public Health



#### David Lansky, PhD

President and Chief Executive Officer  
Pacific Business Group on Health



#### Josh Seidman, PhD

President  
Center for Information Therapy



#### Ruth Liu

Senior Director  
of Health Policy & Health Reform  
Kaiser Permanente



#### Wells Shoemaker, MD

Medical Director  
California Association of Physician Groups

To focus the group's thinking and clarify areas of existing agreement from which to move forward, the Institute of Medicine's definition of patient-centered care was presented to roundtable participants. The Institute of Medicine's (IOM) *Crossing the Quality Chasm* report described six dimensions of performance (care that is safe, timely, effective, efficient, equitable, and patient centered) for a 21st century health care system. In *Crossing the Quality Chasm*, the IOM defines patient-centeredness as:

*"Providing care that is respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions."*

**Paul Wallace:** We laid the Institute of Medicine definition of patient-centered care on the table because it's probably as close to an old testament that we have for scripture reading, if you will. Do you agree with this definition as a basis to advance patient-centered care on the health care reform agenda?

**Wells Shoemaker:** I think the definition is sound and useful, but it would be stronger if it specifically addressed the need for cultural engagement. This is especially relevant in California, with our changing demographics. Cultural engagement is something that requires the same sort of learning discipline as other things that we do in clinical medicine, and I would like to see more emphasis on that, incorporated with what we look at in terms of structural aspects of the delivery system.

**David Lansky:** My reservation about the definition is that it feels unidirectional. It feels like a system defining how it will direct its energies toward a person, not how the person chooses, selects, engages, and exercises their own sense of control. There's a tension that we have to resolve or at least explore, between how much of patient-centered care is about redirecting the behavior of the health system and its professionals and institutions and how much is about creating the environment in which people experience their health and their care. People need a way to express themselves, their values, their needs, in the health care system, which I think is almost completely lacking today. I mean that they can express themselves not only in the market sense, but in the policy sense as well.

**Tom Rundall:** I think that every complex idea needs a concise elevator speech that explains the concept simply to an audience. And I think the IOM definition does that. Its advantage is that people can walk away remembering most of it and be motivated by it. I think the IOM message has stimulated a lot of innovation and change. But for policy purposes, a definition like this is simply inadequate and lacking in important ways. It doesn't provide enough dimensionality. What is it that we're asking the health care provider and the systems that they work in to do? There isn't enough specificity to guide us in articulating and formulating policy proposals—incentives, penalties, or regulatory requirements.

**Cindy Ehnes:** What we're trying to accomplish with patient-centered care is make a provider of services either do something or not do something. But we end up creating mixed messages to the physicians. We need to align the system—through health IT, care coordination—things that help physicians make good decisions. The IOM definition of patient-centered care sounds like motherhood and apple pie—they are "feel good" words. My concern is that as a policymaker, I wouldn't have any idea of what to actually focus on with that definition. I'm more nuts and bolts. I need to know how to operationalize the IOM's definition.

For one thing, patients have to be able to communicate what they need from the system. And there has to be some sensitivity to them in the cultural context that Wells described. An example is the California Department of Managed Health Care's language assistance

regulation that will be implemented on January 1—it requires the plans and medical groups to hit the ground running to provide services to patients in whatever language they speak, with an overlay of culturally appropriate care. This is fundamental to patient-centered care.

**Josh Seidman:** I basically agree with the comments made so far, but I also want to point out that I feel that the Quality Chasm report and the ten recommendations have been incredibly valuable as a way of organizing thinking around systems, systemness, and system-wide improvements.

**Ruth Liu:** I see a conflict between some of the points that IOM makes on patient-centered care and actual consumer preferences. For instance, the rule about evidence-based decision-making may not meet the needs and preferences of every patient. The patient might say, "What are you talking about? You say it's not evidence based, but that's really what I need, and what I desire." As policymakers consider delivery system changes in health reform, they'll probably run up against similar concerns.

**Paul Wallace:** *So how do we begin to frame the key messages about patient-centered care in a policy context?*

**Josh Seidman:** When we start boiling down patient-centered care into a sound bite that tries to resonate with people, we lose a lot. I see this happening over and over again in many of the conversations in Washington. patient-centered care gets pushed down to the realm of health information technology when policymakers start talking about engaging consumers. patient-centered care is really about listening to patients and consumers, and understanding what their needs are. The Center for Information Therapy has done quite a bit of that over the last year, really spending time in the exam room, in the clinical delivery setting, listening to patients and clinicians talk with each other, and then also thinking about how do we build information systems? How do we build care delivery systems to meet the needs of people?

**Thomas Lorentzen:** It's important to have a simple symbol, such as the Department of Agriculture's food pyramid, to illustrate where we want to go and what it's about. We don't have that for patient-centered care. Dr. Gerberding, Director, Centers for Disease Control and Prevention, recently spoke at the Commonwealth Club about concerns that there's too little health in health care. That's where I think the language is important in how we frame it and phrase it. I think as we try and figure out what we're really trying to accomplish, if we're really trying to accomplish health, as opposed to health care, per se—which may be a more limiting term—then we change perceptions of thinking among people, among entities, among decision-makers.

**Cindy Ehnes:** The term "patient-centered" is frequently used in the context of "consumer directed" health care, which has acquired almost a political context that is off-putting because it represents a policy that is about an ownership

---

*The IOM definition of patient-centered care sounds like motherhood and apple pie—they are "feel good" words. My concern is that as a policymaker, I wouldn't have any idea of what to actually focus on with that definition. I'm more nuts and bolts. I need to know how to operationalize the IOM's definition.*

– Cindy Ehnes –

---

society. It basically says to the consumer, "You're on your own." Patients must take charge of saving for and directing their own health care, which often causes them to be underinsured. They are empowered to decide whether they can afford a lifesaving treatment or not.

**Ruth Liu:** I agree that the term consumer-directed health care tends to have negative connotations. But when we talk about consumer responsibility for health, there are positive aspects that we can move forward on, that we tried to move forward on—

somewhat in California, around the idea of the consumer taking more responsibility for their health and thinking about what they can do personally to improve their health. How can we, through incentives to a delivery system, come up with benefit designs that help the consumer to do the right thing? In California we discussed a Healthy Actions benefit design where every insurer was mandated to offer to an employer a benefit that would give an incentive to the consumer for doing the right thing, for taking care of their health. So if they were a smoker and they enrolled in and completed a smoking cessation class, then they would see some benefit. It's a way to move the financial incentives to engage the consumer, have them take some more responsibility for their health, and drive the system in a more efficient way.

---

*Patient-centered care is really about listening to patients and consumers, and understanding what their needs are.*

– Josh Seidman –

---

**Paul Wallace:** *The “it” of patient-centered is characterized by engaged patients and family caregivers, shared decision-making, information therapy, patient self-management, and a team approach to comprehensive primary care. Let’s talk a little bit more about the “it.”*

**David Lansky:** The undercurrent for this conversation is the segmentation of the patient/consumer population, whether it's around diversity issues, or health status issues, or psychological needs and approaches. There's not “a consumer” or “the consumer.” We have to think more than we have about an adaptive system, a flexible system, a system that accommodates a wide variety of human needs, even in the same age-sex band. It doesn't presume some central authority or politburo. We have to think about a more dynamic model—including a set of incentives and structures that

address safety and public interest. Don't make it difficult for a person to find their way to care relationships that work for them. It's about creating an environment which stimulates that kind of ferment in the delivery system. And that means setting up a set of rules or funding streams which don't reward incumbency, but instead reward an adaptive quality.

**Cindy Ehnes:** But when individuals come into the health care system sick, vulnerable and scared, their ability to drive decisions from that part of who they are as a patient is, I think, far more difficult. Systemness at that time has a very important value. What they want is to be able to trust that their caregivers have the knowledge and experience to make the best decisions about their health. They need a trusted guide by their side through the system.

**Josh Seidman:** There's a whole field around user centered design. I agree with the framing that patient-centered care equals user centered design. This is especially important to remember when you're talking about health information technology. We need to start by asking the question: What is it that consumers want to do with their health, and what are the things that technology can help us do to accomplish that? But the technologies are just tools—and tools should be designed around the needs of the patients and their concerns.

**Wells Shoemaker:** Without patient-centered care, ambulatory care actually is doomed to work poorly, regardless of the skills and decision support systems of the professionals. I think people are beginning to realize this, especially now, as our primary care workforce shrinks. But in order to solve that, it won't help to more aggressively whip the 18 remaining family practitioners in California and confront them with their shortcomings. I think we have to look at ways of integrating other community resources with our traditional offices and clinics, so that our systems can perform with a bigger footprint... with greater success and satisfaction for all of the people involved. True, some of our professionals will need some change in attitude

---

*I think we have to look at ways of integrating other community resources with our traditional offices and clinics, so that our systems can perform with a bigger footprint...with greater success and satisfaction for all of the people involved.*

– Wells Shoemaker –

---

towards welcoming patient-centered care, and it will take some patience to modify our existing systems to use these broader partnerships. We have already used “new thinking” approaches within our delivery systems for health information technology, well ahead of the pace of the rest of the country. Likewise, we have been continuously working to bring in chronic care programs that are working decidedly better than they were five years ago. I think we can do the same thing with patient-centered care, but we do have to use both our technical systems and community resources to get there.

**Paul Wallace:** *Is there any guidance about how to organize delivery systems that emphasize patient-centered care?*

**Cindy Ehnes:** I think the term Josh used, “user centered design,” really captures the notion of what we should mean by patient-centered care. And I think that includes systemness. Patient centeredness involves the ability to have teams, as opposed to a fragmented system where I carry my records if I want them to get there. I think users designing a system that responds to their needs would include systemness as an attribute. Systemness includes health IT, care coordination, alignment of financial incentives, and expectations about quality and performance—things that we think help physicians make good decisions.

**Wells Shoemaker:** Chronic illnesses appear to be our biggest looming threat, not just for the well documented cost factor, but for sheer volume of people. We’re severely undermanned for the

projected caseload of diabetes alone in 2015. Without some changes in the way we conduct our “business,” we’ll be swamped. I’ve done a lot of community wide work with diabetes, and in the old “doctor-centered” way of “managing” diabetes, a patient would spend maybe 15 minutes with a doctor every 3 to 6 months. However, virtually all of the decisions that affect people’s health are made outside of the exam room. Family, culture, and community often play a role much greater than the doctor’s goodwill and good instructions. The “big ellipse” of the Chronic Care model illustrates the importance of the bigger picture, and we need to connect them.

**Tom Rundall:** Sheer size of the practice setting is one of the factors that drive the implementation of the Chronic Care Model. Practice size is important because larger organizations have more resources than smaller organizations, and they can bring those resources to bear on the implementation of the Chronic Care Model. For example, having an electronic medical record facilitates a lot of what we want to have happen in the chronic care delivery setting. It’s not absolutely necessary, but most people seem to think that it’s extremely helpful. Small practice settings have an enormous amount of trouble coming up with resources to buy an EMR, maintain it over time and extract from those electronic databases and the capabilities of their electronic medical records the information they need in order to provide better care. All of that is expensive, and typically, clinicians are not reimbursed for doing those things.

It’s more than just practice size. It has to do, of course, with recognizing how important continuity of care and coordination of care is to the outcome of patients with chronic illness, more so than patients who have acute disorders and investing heavily in systems that enable you to do that. That can include nurse coordinators. It can include being able to have your computer talk with other computers; some kind of a network. And it also involves linking up with community based resources that you know enough about so that you meaningfully refer patients to community resources.

---

*Virtually all of the decisions that affect people's health are made outside of the exam room. Family, culture, and community often play a role much greater than the doctor's goodwill and good instructions.*

– Wells Shoemaker –

---

**Paul Wallace:** *So does the employer have a stake in this?*

**David Lansky:** I'm not sure the employers understand the pathway to patient-centered care at this point. Employers are thinking about rationalizing the system and enabling the consumer/patient to be an informed participant in their care, without putting too much burden on them—either economic burden or intellectual burden—especially at a time of vulnerability. Employers have a sense they can intervene with wellness and related programs at the worksite and they can lean on the health plans and the medical groups to try to improve chronic care. Employers haven't focused on shared decision making as a tool in this paradigm.

There's a lot of “organized systems of care” fatigue among the employers, in the sense that for 20 years now, we've been preached at about a model for cost-effective and high quality care. These are exactly the same discussions we had 16 years ago. And where are we today? Why are still having this discussion about serious safety and quality failings? I don't think there's a sense that the models we've developed so far are satisfying employers' concerns.

**Paul Wallace:** *What are the potential levers to bring patient-centered care to bear in transforming the current health care environment?*

**Josh Seidman:** Most attempts at pay-for-performance have not been very focused on patient-centered care. It's not that the goals

aren't right or people aren't trying or there's a lack of concern. It's just that people haven't figured out how to do it. I think the NCQA's Physician Practice Connections—Patient Centered Medical Home accreditation standards are a good first step. But it's sort of like saying that just because my doctor is licensed that he or she is a high quality care physician. It's a minimum threshold. And I think that in order to drive truly patient-centered care, we have to focus much more on the kinds of things that we're all talking about, if we want those kinds of accreditation systems to really drive that.

**Tom Rundall:** Patients/consumers can spend an enormous amount of time becoming health services researchers in order to make informed decisions about whether Kaiser is better than Sutter, or better than John Muir Health. But I don't think they're going to do that. I think that there has to be another way of creating a market that enables consumers to make these choices more easily. I think the NCQA is on to something with the certification of physician practices that have met minimal standards of what they call patient-centered care. It's like what the federal government did with their quasi-private/quasi-public commissions that dealt with the electronic medical record and health information technology world. They created a certification for electronic medical records that met specific criteria. And so a doctor felt more confident in buying one of those systems because they were unlikely to make a big mistake. Well I think patients/consumers need the same kind of assistance. We need to create a market where people can at least know which groups of providers have been certified to have these characteristics that encourage the physicians within them, and me as a consumer, to act in a more patient-centered care way.

**David Lansky:** The way to get at this issue is to say that for any high-risk, high-cost, and high-variability procedure—like breast cancer, for example—we should allow a patient to go through a shared-decision making experience. Whether it's using a computer or a person who

guides them through the decision making, these are people who need someone who is a health services researcher with a small “r” who can walk them through trade-offs. We can’t expect every single person to be their own guide. But we need to provide guidance, whether they’re technology tools or people.

**Wells Shoemaker:** One of my objections to NCOA’s medical home criteria is that they’re not all evidence-based and they’re very rigid. They are oriented to granular office structures and do not necessarily fit with the coordinated care infrastructure we have built widely in California. The tremendous variability in local circumstances requires ingenuity and adaptability, not rote compliance. And they create the potential for practices to play to the test and say what they have to say to get in. We’ve got a lot of strong minds out there that are aware of patient-centered care and our flaws at a visceral personal level. And they’re in positions to change systems. We need the same kinds of resourcefulness that drove the computer industry, not a rigid template which may, in fact, prove to be the wrong model.

**Tom Rundall:** For a lot of reasons, it’s going to take something dramatic to see change in this decade or the next. I’m thinking of something like a major CMS initiative to provide incentives for physician organizations to move in this direction—in addition to local incentives like pay-for-performance programs. Like it or not, money is the source of the energy behind a lot of the innovations that have been successful in medical care and I think that will be the case for patient-centered care as well.

---

*Like it or not, money is the source of the energy behind a lot of the innovations that have been successful in medical care and I think that will be the case for patient-centered care as well.*

– Tom Rundall –

---

**Ruth Liu:** As one of my former colleagues in California health reform used to say, “it’s all about the money.” He said that in the context of financing coverage for care. But when we think about changing the delivery system and focusing on different care delivery systems and promoting systemness, you have to be pretty bold about putting strong financial incentives or financial disincentives in place to get people to really change their behavior. Patient safety is one area where that has proven very successful in a short period of time. For example, by CMS and Medicare saying, “We’re not going to pay for this list of ‘never events,’” the hospitals moved really fast. So it may take policies like that to really move the system forward at a faster pace, so that we’re not here 20 years from now still talking about the same problems.

**Thomas Lorentzen:** I agree with Ruth, money drives most everything. I think the difficulty we’re dealing with in terms of making the type of changes that need to be made, to reach the outcomes we need to have, is that the money is so deep in its impact and cautious by nature, that it inhibits change rather than encourage it.

**Paul Wallace:** *Many uninsured Americans experience problems getting access to needed health care. How do the uninsured fit into a patient-centric approach to reform efforts?*

**Cindy Ehnes:** Benefit design for the uninsured always is a trade-off between how comprehensive the benefit is and how affordable it is, both for the state or federal government who’s paying for the subsidized care, and for the individual if they are not being subsidized. The notion that patient-centered care is a system swaddling itself around an individual is just ludicrous. Many people essentially have no coverage for the services that they are seeking. And so the idea that they’re now in charge and driving this train is like somebody saying, “This new cancer drug would really be of assistance to you, and I’m sorry, but it’s going to be \$500 or \$1,000 a month. And I’m empowering you to make that decision as to whether you can afford it.”

**Ruth Liu:** Policymakers will face challenges around the trade-off between how comprehensive the benefit is going to be and how affordable it is—both for the state or the federal government who's paying for the subsidized care, and for the individual, if they are not being subsidized. One of the major challenges for patient-centered care in health reform hinges on the covered benefits that will be provided for people who are uninsured. One plan design may meet the needs of a large percentage of people. It won't meet the needs of every person out there.

**Thomas Lorentzen:** Sometimes we talk about insurance as the panacea. Obviously, we should and we need to expand access to coverage. But insurance alone may not bring the people in to get the attention that they need. One of the health care success stories in recent years has been the expansion of the community health center concept. There is a comfort zone for many of the people who access community health centers and may not feel comfortable accessing other delivery systems. They're often the uninsured, the underinsured, and they're comfortable going to community health centers. I believe the community based concept is an important concept for education, for information, for health care, and the individuals benefit from that type of environment.

---

*One of the major challenges for patient-centered care in health reform hinges on the covered benefits that will be provided for people who are uninsured. One plan design may meet the needs of a large percentage of people. It won't meet the needs of every person out there.*

— Ruth Liu —

---

**Paul Wallace:** *Where are consumers today in driving change?*

**David Lansky:** I think there are different opportunities for different groups of people. Studies indicate that a quarter to a third of the population is ready to be active, informed health care consumers. These individuals already have high expectations that push the system and they're role models for their neighbors, friends, and peers. They're the ones who say, "What? Your doctor doesn't give you online access to test results?" Enabling them to become visible spokespeople and advocates for changes that are responsive to consumers is an important thing to do. I think the public policy stance should be to create the environment in which those kinds of situations are exposed, and the progressives, if you will, are enabled to be successful.

**Josh Seidman:** Some progressive delivery systems—Kaiser Permanente, Group Health Cooperative and so forth—are rolling out very, very robust health IT tools for consumers. What does that do in terms of changing the starting point? If I'm someone who has been using a fully functional personal health record and has accessed all of my health information that is linked to content that I can use to message my clinician, get information when I need it, where I need it, and then I switch to some other provider that doesn't offer that. Well, I'm not going to tolerate it, because I've become accustomed to another level of service. But we're still very far from that point in terms of consumer expectations.

The semantics around patients and consumers made me think of "patient" as an adjective. I think that consumers are too patient in health care, that expectations are very low, and that we need more "impatient" consumers in order to drive changes in the delivery system. Why are expectations so low? I think people just don't feel entitled to having care that's organized around them.

**David Lansky:** For a lot of people, patient centeredness is about their money, their job,

and their difficulties getting health care. If they want to shop at LensCrafters, or go to a retail clinic, they are not seeking a continuous healing relationship. Those services may not offer the warm and fuzzy characteristics, but they are centered on that patient's needs. We haven't grappled with the reality of the patronizing view that says "we know how health care should look and feel; we're going to build it and embrace you with it." The person in the real world has to take time off work to see the doctor and manage the complexity of the system we've created. There's not a mechanism right now to respond to that, because insurance benefits don't really support patient-centered behavior. It supports conforming to the rules of the system.

**Paul Wallace: Are there key opportunities for consumer engagement?**

**David Lansky:** Who is a good doctor for my kid's asthma? We should make it a national priority to be able to answer that kind of question. It would solve a huge proportion of the patient-centered care needs. People could seek out providers who met their criteria.

**Thomas Lorentzen:** What the family concerned about their child's asthma and finding the right doctor is really looking for is somebody who can produce an outcome that is beneficial for the child. And it strikes me, from the public policy standpoint, policymakers are being pressured to find a way to produce outcomes in the areas of cost, access and some measurement of who the good doctor is, and who the good hospitals are. Of course, that's a very difficult area.

**Tom Rundall:** The question of who is the right doctor for my child's asthma is intriguing. And of course there are variations on it. I'm an organizations researcher and I think a related and equally important question is which doctors work in systems that allow them to be outstanding doctors? And I just wonder if you took a doctor who is functioning at a very high level as a primary care physician in an integrated delivery system and put them in a solo practice, without an electronic medical record and without feedback on their performance, and without a payment system that

---

*I think that consumers are too patient in health care, that expectations are very low, and that we need more "impatient" consumers in order to drive changes in the delivery system. Why are expectations so low? I think people just don't feel entitled to having care that's organized around them.*

– Josh Seidman –

---

encourages them to provide prevention and health promotion and to be more personal with their patients—is that same doctor going to function as well in that environment? I hazard to guess the answer is no. So there are two questions. Not only, who's the best doctor for my kid's asthma, but is that doctor capable of functioning at a high level in the delivery system in which they're working? It's not necessarily the doctor that's the issue, but rather the capabilities that they have available to enable them to fulfill their promise as a physician.

**Paul Wallace: What about physician engagement?**

**Wells Shoemaker:** When the Quality Chasm report was released in 2001 the decline of the primary care workforce was not a major concern. There were assumptions that the workforce would look pretty much like it did in the '90s. Now we really have to make sure that patient-centered care is linked to maximize the capabilities, as well as the satisfaction, of the primary care physicians that remain in the workforce. Several things need to be done to improve the capacity of primary care physicians as team leaders and team members to care for more people than they currently do—and to do a better job. There's a need to deal with the widening reimbursement gap. And there's the whole issue of satisfaction, which is more than making money, or having somebody say thank you. It has to do with getting rid of a lot of the junk and

clutter in their professional lives and having happy patients that are pleased with the care they've received. And that can overcome a lot of financial grudges.

**Paul Wallace:** *How does patient-centered care fit into a health care reform framework where we're not just focused on how much we pay, but what we pay for?*

**Cindy Ehnes:** The notion of systemness is a fundamental precept that we keep coming back to—creating systemness from a fragmented system. I've never, ever heard anyone say, "What we need are more solo practice docs." What I hear is the desire to create something that resembles a system through various mechanisms, whether it's pay-for-performance or the medical home concept. I think we need to end the debate on systemness and just put our stake down and say, you know what? We don't have it perfect, we don't know every attribute of it, but we know that systemness is fundamental, not just to saving money, but for creating some of the dynamics that we think are essential to take place in medicine.

---

*I think we need to end the debate on systemness and just put our stake down and say, you know what? We don't have it perfect, we don't know every attribute of it, but we know that systemness is fundamental, not just to saving money, but for creating some of the dynamics that we think are essential to take place in medicine.*

– Cindy Ehnes –

---

**Ruth Liu:** I think there are three areas where health reform and patient-centered care can move forward together in tandem. One area is convenience of access to care. We've got to think about what is convenient for the consumer, such as retail clinics, when we think about patient-centered care. The second area is health information technology where there's broad consensus irrespective of political party, about the opportunity for improved health outcomes and greater efficiency. The final area is an increased focus on chronic care management—how can I get my care coordinated more smoothly, so that I don't have to go from specialist A here to specialist B there, to all of these different places? And how can clinicians and physicians work together in team-based approaches to improve the management of care?

**Josh Seidman:** There are different approaches that could be considered in advancing patient-centered care. One is to incorporate more of these patient-centered care objectives into performance measures. Another approach is to marry incentives for clinicians with incentives for consumers or patients. In this model (created by MedEncentive), the purchaser gives physicians incentives for following guidelines—or explaining why they didn't follow the guidelines—and for delivering information therapy, prescribing information to their patients. And it's also giving patients incentives for filling an information prescription, for going to the URL, not only to read the information, but also to grade their physicians on whether they have explained the information. That's a way of getting at a more holistic approach to patient-centered care.

**Thomas Lorentzen:** The patient-centered concept is a very nice concept, but I'm wondering, is that going to produce the type of outcomes that the public officials need to produce to satisfy the public. Sometimes we don't know what will produce the right outcome. Sometimes we have to stumble across it and it may not be part of the orthodoxy of what we're trying to achieve. We have to be detectives to find what works out

there. But I think the pressure, politically, in this country is really outcomes oriented. What we have now is good if you're in the systems. But if you're not in the systems, you're really at risk. So I think the question is what can get us to change those outcomes in the most desirable manner?

**David Lansky:** I would try to be practical from a policy point of view and focus on payment and measurement strategies that reward achieving good outcomes rather than trying to prescribe the formulation of the resources that achieve those outcomes. So I think there are going to be opportunities in the next 20 or 30 years for new forms of health improvement delivery. We should allow for that and encourage it, stimulate innovation, and not reward incumbency.

**Paul Wallace:** *Going forward, what strategies will be most effective in accelerating patient-centered care?*

**Joshua Seidman:** One of the things that I struggle with is how to take all the patient-centered concepts that we're talking about and build them into what I'm sure will be a very robust debate around how to reform the delivery system over the next two years. I think that a lot of the things that we've discussed certainly are things that I would like to see, but I'm not convinced that they're going to sort of gel and be incorporated into that public dialogue until we can figure out how to better say them, and better communicate them. This is sort of a challenge of marketing and communication. I think we've got a long way to go.

**David Lansky:** The policy strategy has to calibrate the sharpness of the teeth. We need to pick out a couple channels. For example, comparative effectiveness information being ubiquitously available to consumers who want it and are capable of using it, and providing it in a form they can understand and apply. So if you're choosing between mastectomy and lumpectomy, there's a way to get your hands on the relevant information, whether it's through a health coach or a website or whatever it is. The IT platform has to be ubiquitous and essentially mandatory. As a consumer, my health information has to be available to me. That

should be a regulatory, mandated pathway. We've seen that the market alone will not accomplish that. So I'd pick three or four very discrete policy objectives and calibrate how much can we get done and call that a reform agenda for patient-centered care.

**Thomas Lorentzen:** I think at this moment in time, we're being driven by questions of cost; by questions of access; and uncertainties regarding quality. And those are the driving forces. As long as health care costs continue to outpace inflation and the number of people that are not getting access to the system remains high, those will be the primary driving forces for change. We're captured by the dynamics of the moment because those trends continue to worsen. Policy makers are feeling pressure to come up with answers to these issues.

**Tom Rundall:** It's very easy with this very large and somewhat ambiguous field of play to get lost and not accomplish anything. For starters, I would look at the NCOA medical home criteria: physician directed medical practice—whether there's a physician-led team that meets together and talks about how to improve care for patients and shares responsibility for their care; care coordination and integration that would include the electronic medical record, among other things; focus on quality and safety; and enhanced access. And I think if you at least started with those four, and then also maybe had a category for other innovative and creative ideas that hold promise, you would have a scorecard that could be useful to consumers, as well as to policymakers. We are so low down on the continuum on every one of these, let alone other measures of patient-centeredness that you could come up with, that we have an enormous distance to go.