HealthBlawg :: David Harlow's Health Care Law Blog

Interview of

Dr. Gene Lindsey, President and CEO of Atrius Health and Harvard Vanguard Medical Associates

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David Harlow: Hello, this is David Harlow on HealthBlawg and I have with me today Dr. Gene Lindsey, President and CEO of Atrius Health, an alliance of 6 medical group practices in Eastern and Central Massachusetts with over 1000 physicians at 50 locations. Dr. Lindsey also serves as President and CEO of Harvard Vanguard Medical Associates, the largest of the groups. He started practicing at Harvard Vanguard's predecessor, Harvard Community Health Plan, over 35 years ago and has held a variety of leadership positions in these and related entities through the years. Gene, thank you for joining us today.

Gene Lindsey: I'm glad to be here David, thank you very much for inviting me.

David Harlow: My pleasure. So you've had some firsthand experience practicing in the early days at one of the country's leading HMOs - in fact, working with our soon-to-be-former CMS administrator Don Berwick. How are those days and that experience similar to the current environment where so many folks are focused on accountable care organizations and new payment systems? Many have said these look a lot like capitation - though we're not allowed to say capitation these days, and of course we have some new bells and whistles. I wonder if you could speak to some of the similarities and differences and, since we didn't fix the healthcare system for good back in the '70s, what's different this time around?

Gene Lindsey: Well, that's one of my favorite questions, David. It is déjà vu all over again for me in many ways, in that there is certainly a sort of a pioneer spirit that's associated with our organization now that feels very reminiscent of the spirit that existed when I joined the organization in 1975. In fact, the term "capitation" was not a term that we used back then. Dr. Robert Ebert, who was the dean of the Harvard Medical School and through whose vision Harvard Community Health Plan evolved, used the phrase "prepayment" and it was his concept which we still share today: that fee-for-service medicine led to a fragmentation of care that was deleterious to the concept of wellness and to the preservation of health. And so some of the terms that were popular at that time really focused more on health maintenance and so we call them HMOs, Health Maintenance Organizations - it's too bad that these three-letter acronyms became four-letter words. But I think that that was because of the fact that the larger market that wasn't driven by Dr. Ebert's vision of wellness but was more economically focused on institutional bottom lines sort of took the spirit of the process and diverted it in a different direction; but the early days of Harvard Community Health Plan included not only Don Berwick, but other people who have gone on and made huge contributions like Glenn Steele who was a surgeon here - he is now the CEO of Geisinger. Glenn was a surgeon at Harvard Community Health Plan from the mid 70s through the late 80s. There was Glenn Hackbarth, who is the current chair of MedPAC, who was one of my predecessors as the CEO of Harvard Vanguard.

So our organization has always been focused on the future and always been focused on what we can do in the moment to improve the health of the individuals who come to us for care.

David Harlow: So you said the word "pioneer," so I wanted to ask you about what you're doing in the pioneer arena as we're moving towards ACO development, and my understanding is that you're moving in that direction on behalf of the organization. I'd like to get your thoughts on the Pioneer ACO structure and how that relates to your present activities, or activities over the past year or so under the alternative quality contract with Blue Cross Blue Shield of Massachusetts.

Gene Lindsey: Well I certainly am in support of the Affordable Care Act, in particular the part of the Affordable Care Act that's looking at the development of new practice models through CMMI, and on various occasions we have had conversations with people at CMMI and CMS - they've asked us for our input in how to create programs that will be potentially successful. Their goal is obviously to simultaneously reduce the healthcare spend while improving the quality of the care that's provided, and our organization literally has adopted as a major portion of its reason for existence the success of what the IHI has called the triple aim: better care for individuals and better care for communities at an affordable cost.

The ACO movement, I believe, is the national extension of Dr. Ebert's ideals. We've been looking for an economic model that actually supports the fact that care that's going to be most effective will probably be care that's delivered in a variety of environments that are difficult to harness in a fee-for-service way. I think that we have sort of gotten as far as we can get in terms of health improvement and efficiency paying for care only in a hospital or in an office, and the advantage that Dr. Ebert saw 42 years ago was prepayment, was that many programs that utilize time and energy of clinicians outside the office and hospital environment were going to be the fulcrum of what we could accomplish with patients. Now in this moment that means trying to take care out of the office into the space where the patient lives, and our organization does that through things like a patient portal on our website that allows them to have direct communication with their physician or with other caregivers in our system. We'd like to have programs of wellness, behavior modification, things of that sort, that go beyond the scope of the 15-minute appointment, and actually often take our clinicians into the home for the homebound elderly in ways that are very difficult to support – again, if there's a turnstile in front of the office that a patient has to walk through to economically support the system.

So those ideas all feel to me like they're exploratory and in that regard the concept of it being a pioneer effort seems very appropriate. I think in the commercial area - you referred to the AQC, I believe - we've learned a lot over the last 3 years because what the AQC contract had as a very laudable direction was moving from volume-based reimbursement to value-based reimbursement. And when it started for us we didn't know for sure how to begin that journey but what we did quickly learn was – and I know that you have a prior relationship with Marc Bard – Marc preaches that the whole success will be on the basis of moving from a concept of individual effort to group effort. He talks about moving from I to WE and that's exactly what was necessary to be successful within the AQC - to begin to assemble groups of clinicians and healthcare professionals to look at rosters of patients, to look at results in a collective fashion, to put together programs that would allow outreach to people whose health needed particular attention in one area or another - congestive heart failure and diabetes have been certainly big

areas of focus, we're beginning to try to put together programs that help with mental health issues and also with the new epidemic of obesity. So all of these programmatic approaches to problems that are shared by patients is what we refer to as population medicine and you can do more, and do more effectively, if you approach it in terms of programs - and those are all not possible to support very effectively in a fee-for-service system. But if you can group the budgets from many patients together as a resource then in fact you can very efficiently fund programs that do promote wellness which, over a series of years, will reduce the total spend on healthcare because it'll be avoiding a lot of long term complicated problems that are otherwise going to be an individual drain on the collective healthcare spend. So we're learning a lot - it's a fun time - my only regret in this is that I'm old as I am and I don't have that many more years left to go because I think the next 20 years of healthcare is going to be a really fantastic place to be.

David Harlow: Yes, we are certainly in interesting times. You said a couple of things I wanted to follow up on. One is on the question of seeing results and system savings from the approach that you describe. There was a recent piece in The New England Journal of Medicine looking at initial experience under the AQC which basically said, if I remember correctly, looks good, looks like we're moving in the right direction, but further study is needed. Is there any information that you could bring to bear on that observation from prior experience with Atrius, with Harvard Vanguard, with Harvard Community Health Plan, that would tend to support the idea that this is actually going to work?

Gene Lindsey: Yes, in fact that article was based on just the very earliest results from the first year and I'm aware of the results of the next year already and almost two years' more data, and the data has continued to improve. We've learned a lot, our initial efforts for instance in the quality areas led to what I would say is the reproduction of a typical dose-response curve. You had a sharp improvement that then began to plateau off, and that's not a surprise because I think that each time you do something new it has an effect, and the effect will carry you so far towards the goal, but then you have to come up with what's next that'll get you a little further so it's a very interesting concept of continuous improvement. And in fact much of the results that we've achieved have been through the adoption of continuous improvement in the form of Lean process management so that the results that we've achieved so far are the results of a very fledgling organization with Lean and I'm very excited that as our process improvement skills increase, our ability to yield results within the AQC-type payment mechanisms will improve as well.

What we're really driving for is improved health. We talk about outcomes, and ultimately, to get the sort of outcomes we need and want, we have to go through a process of creating professionals who know how to affect behavior. And then we have to have those skills connect with patients in such a fashion that the patients begin to be involved in improving their health. And that is a series of adaptive changes that takes time and so I think that it's a long climb, but we're well on our way, and it is a good example of the phrase that you sometimes hear, which is "act your way into learning." We really, every time we do something, whether it works or not, it clarifies to us what will lead to more success - and that's really the adventure of it. I think physicians by nature are heuristic, they like to solve problems, the people who work with us - our other healthcare professionals - have found that this adds a new meaning to their work; they all went into healthcare because they have strong empathetic tendencies, they want to see improvement, it's been frustrating for them to be embedded in systems that don't deliver results,

and the hope of being involved in something that actually approaches what they dreamed of when they went into healthcare - I think it's been a personally regenerative sort of process for a lot of folks. It's sort of exciting to be around.

David Harlow: It sounds like it. I'm wondering as you're talking a lot about retraining and redirecting and refocusing folks who have been practicing clinicians for a while, and earlier this year or last year the Lucian Leape Institute issued a recommendation to blow up medical education and start again, basically saying – look, we haven't really addressed the issues of medical errors and cost and to do so we really need to reinvent medical education. Do you see that as a reasonable approach? An organization like yours is of a size that can afford, in the scheme of things, to engage in this sort of reinvention, but most medicine is still practiced in smaller settings and folks can't really do that.

Gene Lindsey: I think you've thrown me enough to talk about for maybe 3 hours right there, in that last little soliloquy. Let me just begin with a first thought. The core of the reason for the formation of Harvard Community Health Plan was to do just that - to change medical education. Dr. Ebert envisioned it as a teaching practice. I'm a student of history, in a way, and I've gone to the Countway library archives, with permission of his wife, and gone down into the bowels of the building where all of his papers are stored and actually read what he wrote back in the '60s. And he imagined then that much of the problem lay in medical education, in the fragmentation of the education that residents and interns and medical students received, where they learned about the kidney and then they learned about the heart and then they learned about the lungs, but they never learned about the whole person. And he didn't believe it that was possible in a hospital environment, which is very artificial in a way and he felt that the education needed to move into the ambulatory environment where people could actually see their patients closer to where they lived and closer to where the behaviors that created disease actually occurred. So that's not a new thought, and I think it is true that we need to be continuously redesigning medical education - in fact I read recently that some of our medical schools across the country, the one that I remember reading about, Jefferson Medical School for instance in Philadelphia, I think, has a program where they actually admit medical students to the hospital overnight so they can have the experience of being in the hospital to understand what it's like from the point of view of the patient. And I think that there's been a lot of activity towards trying to introduce into the lives of medical students how to assess readiness for behavioral change and things of that sort. So the progress is slow but it's not non-existent - I do believe that it needs to continue. I can tell you that every medical student who graduates from Harvard Medical School now has some sort of experience within Harvard Vanguard. So it's not as if we're at zero; we may not be up to full speed but there is progress towards the issue of retraining, and revamping medical education, and I think Dr. Leape's Institute is correct that process needs to - I assume that they're using a lot of hyperbole in their statement and trying to --.

David Harlow: I don't think they said they're going to blow it up - that was me -

Gene Lindsey: That was you, okay -

David Harlow: That was me -

Gene Lindsey: Okay, so you're the anarchist, okay - but it does need to continuously improve, that's for sure, in this direction. So I think that's also a part of what's encouraging in the moment. The term that I've really come back to again and again and again are the issues of adaptive change both for patients and also for healthcare professionals. The ways in which we have worked have created a lot of understanding scientifically and yet, as Atul Gawande says, the issue is that we're not without knowledge, we're just inept in applying that knowledge. So I see this period of time, over the next 20 years, as the way in which we develop the systems that actually bring the fruits of the bench science and the medical technology that's developed over the last 30 years to the benefit of more and more people in a more and more efficient fashion. And that's about organization and that's about teamwork and that's about redeployment. It's certainly true that as in many other industries we're still shackled by the fixed investments that we have and so it's about a process of, as a society, moving away from nonperforming assets and all of that is difficult because there is a sense of loss that's associated with it, and that's got to be balanced by a continuous reminder to ourselves of what it is we're trying to achieve because that's the only way that you can find the emotional energy to do the hard things that are necessary to get to a better level. I don't believe you can do it for money; I think you have to do it because you believe that it will be better for the community - for the same reasons that you plant flowers around your home: because you want it to look better and to be aesthetically something that provides you a gratification that just a focus on finance can't ever bring.

David Harlow: Well, hopefully, it has some of these desired results because otherwise we're going to bankrupt ourselves. I heard an interesting figure last month, or earlier this month, where somebody said that in order to support our expanding healthcare spend at the federal level, by 2050 our marginal tax rate will have to be 93%.

Gene Lindsey: Absolutely.

David Harlow: So we do have to focus on costs.

Gene Lindsey: I was in a conversation recently with Jay Gonzales who is the Secretary of Administration and Finance for our State, Massachusetts. Right now we're spending 41 cents of every dollar that the state collects as taxes on healthcare. You don't have to be an economist to know that that's probably not a good idea; it doesn't leave us much left over for roads, for public safety, for schools, for the cultural things that add meaning to our lives. It pretty much just makes it about supporting a hospital-based system and that's really -- I don't think, I can't think of anyone who would prefer to go to the hospital versus the symphony. It's just not right – now, so let me clarify something: all of the stuff that I'm talking about is not in my mind a sense of adding more dollars to the system, I think that I'm a total proponent of the concept that we have allocated enough of our economy to healthcare we're just not spending it effectively and efficiently. If there is any phrase that reverberates through my mind on a daily basis it's efficient, effective, and that's the thing that's appealing to me and if you remember those are two of the six domains of quality. We have constructed our organizational activities around what the IOM called the six domains of quality, the most important of which is patient-centricity. We need to design the system to be a benefit to the people who come to us for care - they are our reason for existence. That's not been true in the past. In the past we've designed it for a lot of other reasons, but not always and specifically to benefit the care of people. Sometimes it's for

the convenience of physicians, sometimes it's for the perpetuation of august institutions - whatever it's been, but it's not always been that the patient's been at the center of it. Lucian Leape, whose name you introduced earlier, focused us on safety. The other issues - just quickly - care needs to be timely if it's going to be safe and patient-centered, it needs to be efficient and effective if we're going to have a society that continues to exist, and the last and most important of the domains is it's got to be equitably delivered -- and probably that has been the biggest conundrum for our country. How do we get the last 15% of our citizens covered in a fashion that doesn't destroy the economics for the rest of us and that in and of itself is the most compelling reason to look hard at why and how we waste resources.

David Harlow: Well thank you Gene. I think I'd like to end it there wrap it up there and you've given us a lot to think about today and again I thank you for joining me on HealthBlawg.

Gene Lindsey: Thank you David. I really appreciate this opportunity.

David Harlow: I've been speaking with Dr. Gene Lindsey, CEO and President of Atrius Health and Harvard Vanguard Medical Associates. Thanks again, Gene.

Gene Lindsey: Thank you David.