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The Medical Home: Better for Whom?

Moderated by **Asaf Bitton, MD, MPH[1,2]**

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ABSTRACT

The discussion focused on: 1) The challenges associated with primary care and the lack of systems and infrastructure that allow better management of patients; 2) understanding a working definition of a patient-centered medical home, and differentiating it from current models of primary care; 3) the importance of fully functioning healthcare teams; 4) how the medical home fits into both integrated delivery systems and academic medical centers; 5) the importance and challenges of incorporating health information technology into primary care; and 6) future trajectories for the patient-centered medical home model over the next 5 years. *Med Roundtable Gen Med Ed.* 2012;1(2):164–171.

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DR. BITTON: Today we are talking about the patient-centered medical home, a model of primary care that has generated significant interest and enthusiasm in the United States over the past 5 to 6 years. It's important as a frame of reference to remember that the patient-centered medical home was actually an idea borne out of the pediatric world as a system for organizing care for chronically ill children who have complex, multisystem diseases. The pediatricians have worked on this model for at least 40 years, but it's only been in the past 10 years or less that the adult medicine and family medicine worlds have really embraced and begun to adopt this model. Currently there are thousands of practices and millions of patients being served by medical homes across the country, and it is incumbent upon us to understand where this model has come from, and where it is going.

So, with that prelude, we have convened today a panel of experts in adult internal medicine who are well versed in the medical home model. I am Asaf Bitton from the Harvard Medical School Center for Primary Care and Brigham and Women's Hospital. With me are Drs. Joseph Frolkis and Stuart Pollack from the Brigham and Women's Hospital in Boston, and Dr. Christine Sinsky from the Medical Associates Clinic and Healthplans in Dubuque Iowa.

We're here to try to understand what the medical home model is, how it's working across the United States, what are its main challenges, and to forecast where we see the field moving in the future. So, to all of our panelists, I want to start by asking each of you for your definition of what a patient-centered medical home is. I'll start with Dr. Sinsky.

DR. SINSKY: I think access and continuity are really the most important pieces of the medical home. Patients need access and continuity with the same provider: to proactively manage chronic conditions, to evaluate acute symptoms in context, and to build trust and a relationship.

DR. BITTON: Dr. Pollack, what is your definition of what a patient-centered medical home is?

DR. POLLACK: I think it comes back to really good primary care. I like the World Health Organization definition of primary care from the 1970s: access and continuity, as Dr. Sinsky just mentioned, as well as comprehensive and coordinated care. So my definition of the medical home is just really good primary care delivered by a team, with an activated patient as a key member of that team—and there's definitely a computer thrown in someplace.

DR. BITTON: Dr. Frolkis?

DR. FROLKIS: I increasingly quote my colleague, Dr. Pollack, and say that the medical home is great medical care delivered by a team. But, I also think it's critical to point out that these

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team members are not what used to be called "physician extenders" whose only real function was to increase the physician's efficiency in order to maximize throughput in a Fee for Service world. In the medical home model that we're discussing today, these are colleagues who have shared responsibility for the care of the entire panel of patients in the practice.

DR. BITTON: As a follow-up question, to all of the panelists, how is your definition of a medical home different from just good primary care? Is there a difference or are they one and the same?

DR. FROLKIS: I think that studies have shown that primary care physicians cannot sustain the demands of acute, chronic, and preventive care in the current model of care delivery. Something has to change if we're going to save this field. Team-based care has the potential to be that "something". I would argue that having fully functional teams, and there's no standardized definition of this yet, which may include social workers, nutritionists, exercise physiologists, advance practice clinicians, licensed practical nurses, nurses' aides, community resource specialists, community health workers, and population managers, can provide both a depth and a breadth of care not possible in our traditional, "doctor-centric" model.

DR. BITTON: Drs. Sinsky or Pollack, do you have any thoughts on what's different or not?

DR. POLLACK: I don't think the theory has changed. It's not like 10 years ago we were walking around saying, "I really think care should be uncoordinated," and then 5 years ago, we said, "Oh, that uncoordinated thing isn't working out, let's try coordinated." What is different is our ability to deliver on the theory. For really good proactive primary care to happen, you actually do not need an electronic health record, but you do need a registry, which is really hard to do without an electronic health record. And reimbursement has to change to pay for the team required to have any chance of getting through the volume of work that needs to be done.

DR. SINSKY: I would also add that the medical home framework has given a language and a legitimacy for strengthening primary care and it provides a roadmap for how to do so. As Dr. Pollack said, no one started out intent on providing uncoordinated care; the medical home now gives us direction as to how to deliver truly comprehensive and coordinated care.

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DR. BITTON: Dr. Sinsky, could you tell us a little bit about how you got involved in these efforts at your clinic and in the model that you've built?

DR. SINSKY: Sure, I'm happy to. We formally went through the process of medical home recognition in 2008 when we were recognized as a level III clinic by the National Committee on Quality Assurance (NCQA). In fact, we were the sixteenth clinic in the nation to have medical home recognition. But, it was really during the previous 20 years that we gradually built systems so we could manage the three domains of primary care Dr. Frolkis identified: acute care, prevention, and chronic illness care, with planned care appointments, with pre-visit laboratories, and with an after-hours nurse call line for our patients. We built stable care teams, initially with a 2 to 1 ratio of nurses to physicians. Now, we're piloting three nurses per physician. So, our medical home model has been gradually evolving over a 20-year period.

DR. BITTON: What are the biggest changes that you've seen in your day-to-day work of primary care, Dr. Sinsky?

DR. SINSKY: Over time patient care has become more complex. Fifteen years ago a patient with a blood pressure of 146/85, cholesterol 235, fingerstick blood sugar of 134 and a creatinine of 1.5 may have been considered to be doing fine and might have been advised to come back in a year. Now, that very same patient may be diagnosed with four chronic diseases and in need of more intense management. We now need better systems and infrastructures that'll allow us to manage this increased complexity in our patient population.

DR. BITTON: Dr. Pollack, can you tell us a little bit about your journey into the world of medical homes and how it arose in your context?

DR. POLLACK: I spent most of my career practicing in what we would now call an accountable care organization, a multispecialty group integrated with

a hospital and a single payer. I ended up as Chair of Medicine about 10 years ago. About 3 months after I started, the group decided to change to a fee-for-service multi-payer group, which now sort of sounds crazy, but 10 years ago it was what people were doing.

So, I actually got to help transform a group of physicians into a fee-for-service model. On paper, we did very well. Relative value units (RVUs) per physician went up by 50% in 2 years, the budget looked good, and people were productive. But when you sat back and talked to the patients and to the nurses and to the doctors, people really weren't happy. In addition, it got to the point where we literally could not recruit young primary care physicians. And when you love what you do, it's depressing to realize that young docs don't want to do it anymore.

I think we did a really good job of optimizing a model that was fundamentally flawed. I woke up one morning and realized that it was just not working. It wasn't the people in the model; it was the model itself that was broken. I wanted to get way outside the box and create a primary care innovation site. That was just when medical home was really hitting peoples' consciousness. I discovered that if I talked about medical home, organizations would respond to me. It's been a wonderful journey ever since.

DR. BITTON: Dr. Frolkis, tell us about your network's effort to promote the model, and especially why or how it might fit into an academic medical center context.

DR. FROLKIS: I think it's important to remember that academic medical centers are still fundamentally just "hospitals," but with the added complexity and incremental missions of teaching and research. So, the critical importance of a strong primary care base is every bit as relevant to the fiscal health of the academic medical center, to their market share, and to their community mission, as it is in a community hospital. In fact, whether we remain in a fee-for-service world or end up in a fully accountable care world or in what is our current quite uncomfortable transitional space, primary care physicians still generate the referrals that "feed the beast" of subspecialty care, which is where the margins are for hospitals now. By doing so, they drive the clinical enterprise, but also, by definition, the educational enterprise and the teaching mission. We supply the cases that become the great teaching opportunities that medical students and residents in all the specialties learn from.

I would add that in this new world toward which we're heading, however uncertainly, academic medical centers will be wise to invest in patient-centered medical home growth to deliver on the metrics that are going to become very important to them, such as population management, quality, access, and cost outcomes. Finally, for this point, I would say that it's also a wise investment for academic medical centers because the transformation of primary care and the creation and spread of patients in medical homes is an increasingly potent draw for medical students and residents who are interested in being part of this movement of care redesign and health system reform.

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>
> **Joseph Frolkis**

DR. BITTON: The next question I'd like each of you to answer in sequence starting with Dr. Sinsky. What are your thoughts about the trajectory of the medical home movement or transformation across primary care in the United States? Specifically, is this a panacea for primary care, a temporary flash in the pan, or something in between?

DR. SINSKY: I'm really optimistic about the trajectory that the patient-centered medical home might take primary care on, if you will. While it is not yet certain that patient-centered medical home will strengthen primary care, I think it's very plausible.

I'm concerned that we're at a tipping point and that we now have to pay attention not only to the patient in the patient-centered medical home, but also to what it is like to live in the medical home as a physician, a nurse, a medical assistant. Can we make this work joyful, manageable and rewarding? Some practices found that when they first implemented the patient-centered medical home they did it on the backs of the providers and actually decreased work-life satisfaction. So, we have to make sure that we pay attention to joy in practice.

DR. BITTON: I know that you've been studying some of those practices, Dr. Sinsky. Are there themes or predictors of maintaining that joyfulness during the transformation?

DR. SINSKY: Having intentionality about the transformation—creating time and space to step aside and analyze and improve your work—is a way to create adaptive reserve within a care team. So, I would say intentionality and time for team meetings and planning are predictors of survival and thriving.

DR. BITTON: Dr. Pollack, your thoughts on the trajectory?

DR. POLLACK: I've been practicing over 20 years and I think primary care has been in crisis since the day I started. I really believe things are different this time, and that we will finally get the resources to deliver on the promise of primary care. I believe that the fundamental problem with health care in the United States is that we are too good at what we do. The number of interventions that now work is so huge that it if we don't redesign the system to deliver those interventions, we will drown. Both primary care and health care in the United States are at a tipping point. I'm optimistic that we are going to tip in the right direction and end up with a much better system. Medical home is just the beginning of the change.

DR. BITTON: Dr. Frolkis—your view of the trajectory?

DR. FROLKIS: One of the great things about going last is that everyone else has contributed, so I only have to say I agree! But, I do in fact agree and would saying in addition that we really have no choice. This primary care crisis really is a crisis. I am reminded daily of the urgency of coming up with a way to save our field. I've been practicing for 30 years, scary to say, and would agree with Dr. Pollack that primary care as a profession has been going downhill not because it isn't a wonderful occupation. I think it's the best job in medicine. But we have not done a good job of fighting back for primary care interests effectively enough during that period.

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>
> **Christine Sinsky**

When survey results of primary care physicians indicate that only 2% of medical students are indicating an interest in primary care internal medicine, when the differential of reimbursement is so great between primary care physicians and specialists, when job satisfaction is plummeting, when people are burned out and say that they would not become physicians again, it is a particularly telling, and, to me, disturbing sign.[1] I think we have to find something that works to revitalize our field, because as I'm sure everyone on the panel agrees and as Barbara Starfield and others have long demonstrated, societies where there are more primary care physicians are healthier and less costly societies.[2]

So, I am enthusiastic about the patient-centered medical home. I don't know whether its current definition will be the final definition. But, its "viral" spread is reassuring. As I said earlier, it's attracting young people who want to be a part of this thing that we're all creating in many ways from whole cloth. I also would echo what Dr. Pollack said that I think it's just the beginning. At Brigham and Women's Hospital, for instance, and we're starting to develop the "Medical Neighborhood", an effort to more effectively and explicitly coordinate care with our specialty colleagues in order to maximize the medical home's ability to deliver on its promise of improving access, quality, and value.

DR. BITTON: Dr. Frolkis, if you are a specialist, how do you see the rise of the medical home impacting your work? Some skeptics argue that this is a play by primary care to rebalance reimbursement. Others see it in a more positive light. What are your thoughts or messages for the specialist community?

DR. FROLKIS: I think the answer depends on where we are in the uncomfortable transition zone that I referenced earlier. I think that in the current reimbursement system it is in many ways a zero-sum conflict. Of course it's not as if income redistribution goes into the pockets or paychecks of primary care physicians. But there is a necessary upfront investment in infrastructure to allow team-based care to succeed, and specialists are likely to see that investment as a loss to them. A number of sites around the country have shown a remarkably quick return on investment for downstream savings. It is clear that those savings are linked to the model of care in which

they occur, so that Geisinger in Pennsylvania and Group Health in Seattle, for instance, could argue that by being in integrated systems it is easier to demonstrate "proof of concept" for the medical home.

There are some other demonstration projects that I think are showing a fairly impressive return on investment as well,[3] not only on the cost side, but in terms of patient, physician, and staff satisfaction. So, I think that to the extent that reducing emergency department visits and ambulatory care sensitive admissions and unnecessary utilization is relevant to the reimbursement model extant at the site, the more cost effective the patients in a medical home are going to be to the system. Part of our job is messaging because our specialty colleagues are going to be in the same bundled or capitated world that we're in.

DR. BITTON: Drs. Pollack and Sinsky, any thoughts about specialty interactions or thinking from their perspective on this model?

DR. POLLACK: I'm finding more and more that the trailblazing work primary care is doing around integrated team and population management and patient activation is being adopted by our specialist colleagues. We've always been a little more under-resourced and hence we drowned a little bit earlier. Specialists are running up against the same problem primary care faces: the sheer volume of care that works exceeds our ability to deliver it.

DR. SINSKY: I have a vision of how the medical neighborhood could be, and I think it would be very good for our subspecialty colleagues. In this vision the subspecialist may spend a third of their time on direct patient care, a third of their time on academic detailing—providing updates about changes in your specialty—to the primary care physicians in their network, and a third of their time on population management and community facing activities. An example of these activities would be an endocrinologist who works with the local school district to improve the healthy food choices offered in schools to reduce childhood obesity/diabetes. Just as primary care transformation has the potential to improve work-life satisfaction for primary care physicians, the medical home neighborhood has the potential to transform specialty care into a more satisfying professional life as well.

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>
> **Stuart Pollack**

DR. BITTON: Let's run with that thought about improving the work conditions for primary care and hopefully for the rest of ambulatory medicine. Daniel Pink, in his book *Drive*, defines elements of satisfying work as the following: "work which contains of high levels of autonomy, mastery and sense of purpose."[4] I would like for you to reflect on how the medical home model approaches those three domains: autonomy, mastery, and purpose. Does it get us there in any meaningful ways in your experience so far?

DR. POLLACK: My experience is that working in a medical home is highly satisfying for everyone on the team, probably because it hits all three domains. We are enabling pharmacists, nutritionists, social workers, nurses and medical assistants to work at the top of their license, which gives them both autonomy and mastery. Sending a message that their job is to provide care directly to the patient (not just to support a physician) is huge. Even the administrative assistants I've worked with chose primary care, instead of working in a lawyer's office, because they want to be able to help the sick and comfort the ill.

All of the above also applies to physicians. Let us work at the top of our licenses and give us the resources to take really good care of patients. It even applies to specialists. If we (primary care) effectively treat the primary care aspects of their specialty, then they (the specialists) will get to see a more complex population that allows them to work at the top of their licenses, doing what they presumably love to do and why they became a specialist in the first place.

DR. BITTON: Other thoughts?

DR. FROLKIS: I would echo Dr. Pollack's comments. As we develop our medical neighborhood outreach effort, these are potential advantages that we stress with our specialist colleagues. Early work in the medical neighborhood has shown, for instance, that the percentage of referrals deemed inappropriate drops precipitously when you actually work out medical neighborhood collaborative care agreements or other ar-

rangements. It allows the specialist to practice at the top of his/her license and see the clinical issues that are intriguing to them.

It also empowers the primary care physician because there is an embedded educational component there if you are reestablishing the kind of collegiality that made us all love residency. Then the primary care physician is learning in real time in a case-based model how to become more competent at things so that his or her autonomy, mastery, and purpose increases. I can't reiterate enough how important it is to team members to be empowered to do things that they are fully capable of doing but had never been given the opportunity to do, and how liberating it is for physicians not to have to do stuff that we didn't go to medical school to do and are not particularly interested or adept at doing.

DR. BITTON: Dr. Sinsky, you were going to add in?

DR. SINSKY: It's hard to add to such well-spoken comments. I want to say that we did use the autonomy, mastery, and purpose framework for our site visit guides as we visited 23 high-functioning practices looking for joy in practice. It parallels the control, order, and meaning framework that Dunn has put together to promote physicians' well-being and satisfaction in work.[5]

DR. BITTON: Dr. Sinsky, what do your patients think about this model? Do they know they're in it and has their perception changed over time?

DR. SINSKY: Sure, that's a great question. I'm not certain our patients would know what a medical home was if you asked by name. But, if you ask by function, I think they would. The critical part of our practice model is pro-active planned care. For example, we arrange for our patients to have their laboratory reports completed ahead of their appointments.

When I tell my patients that I'm going away next week to speak about a new way of giving care and that pre-appointment lab is one feature, they're quite surprised that other practices don't do that. I've had patients move away and then when they move back to the area, they'll contact our office and ask to have their labs and their mammogram ahead of the appointment. They know the results can then be incorporated into face-to-face shared medical decision making at their appointment. They don't know the term shared medical decision making, but they know the act.

DR. BITTON: Dr. Pollack, what do the staff and trainees at your clinic think about this model?

DR. POLLACK: The staff has really enjoyed this. The practice manager and I meet with every member of our staff to assist them with their professional development, which gives us an opportunity to ask how they think we are doing. We hear things like "I've never worked anywhere like this. I can't imagine working anywhere else." I think it comes back to autonomy and mastery and sense of purpose. I would point out that evidence to support the idea that medical home will improve staff morale and decrease burnout in safety net clinics was published in the *Archives of Internal Medicine*.[6]

From the point of view of trainees, all I know is that we are a very requested site for continuity clinic. I believe it's because they can come here and imagine doing this for a living. One of my personal metrics for the success of this model is by the time our trainees leave they will say, "Hey, maybe I don't have to be a hospitalist. Maybe being a primary care physician is doable, something I can enjoy and be successful at."

DR. BITTON: Dr. Frolkis, what does the conversation in the executive suite sound like around this model?

DR. FROLKIS: I've been pleased and encouraged at the support that primary care, and the urgency of the need to transform primary care towards the team based model has enjoyed in the executive suite. I think that there has been an inevitable learning curve for all of us, but there seems to be a growing understanding that this is something we have to do for the good of the institution and the security of its future.

DR. BITTON: That gets into the next question for anybody in the group. How do you pay for this model and will it eventually pay for itself?

DR. FROLKIS: I would reiterate that to the extent that we are in an accountable world, the upstream investment in medical home infrastructure will pay for itself downstream in reduced, unnecessary utilization, emergency room visits, and admissions. I think that there is early but reassuringly consistent data that this is the case.

DR. BITTON: Dr. Sinsky, the community medicine world is a little bit away from quaternary academic medical centers. What are your impressions on how this model pays for itself in the community environment?

DR. SINSKY: I would agree with Dr. Frolkis. My own clinic practice has been a rudimentary Accountable Care Organization for about 35 years. The investment in a strong primary care base has had downstream savings for us over time. I think that in any integrated delivery system if you double the investment in primary care, you will gain that all back and more in downstream savings.

DR. BITTON: Dr. Pollack, if a private practitioner in a small group, primary care practice comes to you and asks if this is a feasible model in the current state of affairs, what do you say to him or her?

DR. POLLACK: I would say that you need to find someone to partner with, be it an insurer, a local business, or your hospital, because this really does require new resources. But, even in a fee-for-service system, given that hospitals are going to be penalized by Medicare for readmissions, medical home makes sense, because just the savings to the hospital should cover the costs of some rudimentary transformation.

DR. BITTON: A final question before we summarize our discussion is around health information technology. Is it up to par right now for this model? If not, what areas really need to be improved or built out? I know all of you have thoughts on this. So, let's start with Dr. Sinsky.

DR. SINSKY: Thank you. Actually, one of my goals for the next five years is to help in some way to bring our technological tools, and some of the regulations around those tools, into alignment with the goals and needs of the medical homes. There's a lot of potential power is in the Electronic Health Record and depending on your particular vendor and your institution's implementation policies, you may have more or less realization of that power. But, right now, many physicians and their teams are actually finding their technology is getting in the way of a team-based model of care; that often the electronic health record is based on the presumption that it's a physician and a computer, and not a team of people who will be interacting with the computer and interacting with the patient.

DR. POLLACK: I agree with Dr. Sinsky. The medical assistant is on my team, and the social worker is on my team, and the patient is on my team, and a bunch of specialists are on my team, but for some reason the computer doesn't want to join. It's not very flexible. There are many things that the computer can do much better than people, especially involving databases and population management. But, it just doesn't do that. All it wants to do is document my notes, frequently not in the way that's efficient for me and the other staff I'm on a team with. It doesn't make it easy to get data into structured fields where it can feed directly into registries or be used for predictive modeling, and it's not nearly as good as it could be in serving as a communication tool, and helping us distribute work among team members and reminding us to get it done.

DR. BITTON: So, you're saying that the electronic health record really exists right now around a billing template as opposed to a shared information transfer template for a team.

DR. POLLACK: Electronic health records were built for the fee-for-service systems they were sold to. Medical home and accountable care really is a fundamentally different model and the electronic health records need to catch up with that.

DR. FROLKIS: Information technology has to provide four key functions in this new world: attribution, severity adjustment, registry functionality, and utilization data. No system that I've worked with so far has done all four of those in a way that facilitates what we're trying build.

DR. BITTON: Sounds like there's shared agreement there. So, in summary, we have one last set of questions for each of the panelists. We'll start with Dr. Frolkis. What are your goals for this model in the next five years? What worries you, and also what excites you?

Clinical Implications

- **Primary care providers across the United States are increasingly turning to the patient centered medical home model to improve and reorganize the delivery of care around the aims of improved access, quality, and value.**
- **Medical homes are entities that provide team-based care in a patient-centered environment, utilizing health information technology and a renewed focus on improved patient access and care coordination to improve outcomes.**
- **Early evidence suggests that medical homes can improve quality of care, patient and provider satisfaction, and may reduce costs, but further work needs to be done to evaluate and refine the model.**
- **Medical homes form a natural building block for wider health care transformation efforts such as accountable care organizations to improve the value and efficiency of the health care system.**

DR. FROLKIS: What worries me is the zero-sum conflict that I referenced earlier in our current model, and the ability of the folks who are excited about this, not just in the primary care workforce, but in the executive suite to sustain the political will to see this change through. That's what worries me. What excites me are all the things we've talked about in the last 35 or 40 minutes: the regenerative energy around this model, the enthusiasm of young people, the promise of revitalizing our profession.

In terms of goals, I think that if we're going to make this change stick we need to make it scalable. We need to figure out what's critical and what's optional about the models we're building. We need to figure out who really needs to be on the team. Then, finally, I would say that the goal for the next five years should be to continue the momentum on research and evaluation of this model so that we can say we've proved the concept. There's a lot to look at and a lot to report on. That's very exciting.

DR. BITTON: Dr. Sinsky, your thoughts on this summative question?

DR. SINSKY: What excites me is the possibility of more closely aligning physician and team member training with a population's need for medical care, rather than restricting training along traditional specialty boundaries. If we do this in physician training, for example, patients will have less fragmented care and more points of contact, and thus continuity, with their primary care physician. And primary care physicians will have a better work experience. Without realignment of training to practice there is a risk that primary care will be reduced to simply the triage station of the medical neighborhood. This would be a mistake in my view.

I believe primary care physicians can be trained to manage chronic conditions further along the spectrum of complexity, and also to perform a wide variety of commonly required procedures, such as joint injections, Intrauterine Device placements and wound treatments. Possessing these skills will enable primary care physicians to provide truly comprehensive, longitudinal, coordinated and personalized care to our patients; and thus also to achieve greater joy in work.

DR. BITTON: Finally, Dr. Pollack, your thoughts?

DR. POLLACK: I think what worries me is the word "panacea." I worry that businesses, governments, insurers, and health care organizations have too short of an attention span. When I left medical school, angioplasties were just starting to be routinely performed. Maybe they worked two thirds of the time, which is not great for something that only treats symptoms and has some fairly significant risks. In 2012 a drug-eluting stent works 95% of the time. That was a 25-year journey. If somebody had said, "two thirds of the time isn't good enough, we're not going to pay for this," then cardiologists and device manufacturers and pharmaceutical companies wouldn't have done the amazing work that got interventional cardiology to where it is today.

Medical home clearly improves quality. They save money. But, the expectation is that we will save huge amounts of money and create huge improvements in quality and solve all disparities in health care while providing the patient with a wonderful experience. Do I think we can do all of that? Yes. Do I think we know how to do all of that today? No. There's a learning curve.

The odd thing is that if the medical home were a new drug it could barely improve results and significantly drive up costs and it would still be paid for. On the other hand, we are expected to both improve results and lower costs simultaneously. I worry that the standard we're going to be held to is very high and that if we don't succeed immediately people will move on to the next panacea that doesn't exist.

DR. BITTON: Thank you all for these really thoughtful words on where we are with medical homes and where we could be in the future.

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