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The Quiet Health-Care Revolution

WHILE LEGISLATORS TALK *about "bending the cost curve," one company serving Medicare patients has discovered how to provide better care at lower cost—with wireless scales, free transportation, regular toenail trimmings, and doctors who put the patient first.*

By ADRIAN SLYWOTZKY AND TOM MAIN

ELLEN, AN 82-YEAR-OLD widow, lives in Anaheim, California. One Wednesday morning last year, she got on her scale, as she does every morning. One hundred and forty-six pounds—wasn't that a little high? Ellen felt vaguely troubled as she poured herself a bowl of oat bran.

Half an hour later, the phone rang. It was Sandra at the clinic. She too was concerned about Ellen's weight, which had jumped three pounds since the previous day. Sandra knew this because Ellen's scale had transmitted its reading to the clinic over a wireless connection.

Given that Ellen had a history of congestive heart failure, a three-pound weight gain in 24 hours was a potentially dangerous development, a sign of possible fluid buildup in the lungs and increasing pressure on an already stressed heart. Sandra wanted her to come in for an immediate visit: the clinic would provide a car to pick her up and bring her back home. Ellen's treatment began that very morning and continued for two weeks until she was out of danger. Had the warning signs not been noticed and addressed so quickly, she might easily have suffered a long, painful, and expensive hospitalization.

Dan, a retired letter carrier, is a patient at a clinic in the same system. At 87, he is decidedly frail, his once-sturdy legs now weak and unsteady. He is a classic candidate for a fall of the kind that has injured many of his friends, in some cases leading to weeks in the hospital and months of rehab. The elderly are prone to falls for many obvious reasons, including weak limbs, impaired vision, and medication side effects. But Dan's doctors knew that some less obvious causes included shag carpets and long, untrimmed toenails. Because of this, they'd sent someone from the clinic to visit Dan's apartment and make sure that his daughter replaced the 1980s-vintage carpets with low-pile rugs. Dan also visits the clinic regularly for light muscle-training sessions and periodic toenail clipping. Due to these preventive measures, Dan and his fellow clinic patients are one-fifth as likely as comparable patients elsewhere to suffer falls.

Joe, a 79-year-old diabetic, cut his foot when he banged it against a door. When it didn't heal after a couple of days, he limped into the office of his family physician. After glancing at the cut, his doctor immediately sent Joe to a clinic in the same system as those that treated Ellen and Dan. For diabetics, even small cuts can be a

serious matter: untended, they can become infected and contribute to an alarmingly high rate of amputation.

At the clinic, a nurse practitioner cleaned and dressed the wound, and told Joe she wanted to see him there in two days so she could inspect and treat it again—and two days after that, and two days after that, until it was fully healed. The clinic would arrange for transportation if needed. Thanks to the steady, regular care, Joe's foot healed without any infection or threat of amputation.

Ellen, Dan, and Joe are all real people, though their names have been changed. The clinics that serve them are all affiliated with CareMore, a company based in Cerritos, California, that operates 26 care centers across the Southwest, serving more than 50,000 Medicare Advantage patients. Those numbers are likely to grow, perhaps dramatically, in the next few years: in August, CareMore was acquired by the insurer and health-services provider WellPoint, which serves 70 million people nationwide directly or through subsidiaries, and has plans to expand the CareMore model.

CareMore, through its unique approach to caring for the elderly, is routinely achieving patient outcomes that other providers can only dream about: a hospitalization rate 24 percent below average; hospital stays 38 percent shorter; an amputation rate among diabetics 60 percent lower than average. Perhaps most remarkable of all, these improved outcomes have come without increased total cost. Though they may seem expensive, CareMore's "upstream" interventions—the wireless scales, the free rides to medical appointments, etc.—save money in the long run by preventing vastly more costly "downstream" outcomes such as hospitalizations and surgeries. As a result, CareMore's overall member costs are actually 18 percent below the industry average.

In addition to policies designed to extend health-care benefits to more than 30 million previously uninsured Americans, the Affordable Care Act, which President Obama signed into law in 2010, contains a host of provisions aimed at lowering overall health-care costs and improving quality of care at the same time. These provisions include the adoption of electronic medical records, programs to increase at-home care and preventive care, the development of evidence-based protocols to improve quality, disincentives for unnecessary rehospitalizations, and other measures, many of them focused on Medicare, which is a primary driver of increasing costs.

The central idea that quality can be improved while costs are being reduced has been met with varying degrees of hope and skepticism. Yet many of the provisions called for have been standard operating practice at CareMore for years. And the company's success to date suggests that such efforts to "bend the curve," achieving better outcomes at a lower cost, may be more plausible than they sound. The implications for the future of Medicare—and the nation's fiscal health—may be substantial.

THE CAREMORE STORY begins almost two decades ago, with a man named Sheldon Zinberg, a gastroenterologist who was deeply concerned about the changing economics of health care in Southern California. There, as in other U.S. markets, health-maintenance organizations, or HMOs, had come to dominate the landscape. The theory behind HMOs was attractive: "managed care" was supposed to coordinate and guide treatments in order to maximize both patient wellbeing and economic sustainability. But under pressure from corporate health-insurance sponsors and government agencies (as well as investors seeking profits), HMOs increasingly focused on reducing costs by any means necessary—including short-term fixes that often led to worse patient outcomes and, in the long run, even higher medical expenses. Patients were suffering, doctors were getting squeezed, and costs, after falling for a time, were soon spiraling upward again.

Zinberg was alarmed. Back in the 1960s, he'd founded a large internal-medicine practice that had grown to include some 20 physicians in a range of specialties, from cardiology and oncology to rheumatology and nephrology. But by the late 1980s, with a small number of HMOs growing more dominant, referrals were dwindling and restrictions on services were multiplying. Zinberg and his colleagues were forced to spend ever more time on the phone with "benefits coordinators," whose main job seemed to be finding reasons to deny coverage.

Already in his late 50s, Zinberg could have simply retired and walked away from the problem, as many of his colleagues were doing. Instead, he made a different decision. Zinberg had long been mulling the elements of a coordinated-care system that would be centered on reducing hassles and improving outcomes for patients rather than simply cutting costs. He began to envision a health-care organization in which teams of doctors, nurses, therapists, trainers, and other professionals worked together, continually sharing information and insights about their mutual clients and providing whatever services were needed to keep those clients in the best possible physical and mental health.

Zinberg spent almost two years struggling to recruit physicians to launch his program. "During 1991 and '92 my wife barely saw me," he recalls. "I was having dinner four nights a week with groups of doctors, explaining my concept. I was begging them, literally begging them, to help me create a new health-care-delivery system."

Fortunately, a few of the doctors Zinberg approached were moved to join by their personal connections with him or by the depth and sincerity of his commitment to the cause. By 1993, physicians and teams of physicians operating 28 separate medical offices had agreed to become affiliates of Zinberg's new system, CareMore Medical Group.

Zinberg had always seen his vision of coordinated care as especially well suited to the needs of the elderly. As a gastroenterologist, he naturally saw a high percentage of older patients in his practice, and as he himself grew older, his interest in the physiology of aging deepened. (His ideas on the subjects of exercise, nutrition, genetics, and memory retention would lead to his 2003 book, *Win in the Second Half*.) And Zinberg recognized that elderly patients covered by Medicare—the people normally regarded as the greatest drain on the health-care system—could benefit the most from special attention. Because the existing system failed to connect the dots, they experienced a variety of unnecessary complications: avoidable hospitalizations, duplication of treatment, misdiagnoses, needless suffering, and sheer neglect.

At first, CareMore accepted patients of all ages, but in 1997 Zinberg and his team restructured the company around his original concept, focusing on the elderly and eventually accepting payment exclusively from the Medicare Advantage program. Rather than paying for services rendered (the traditional fee-for-service model), Medicare Advantage pays CareMore an annual per-patient fee, adjusted according to each client's risk profile. This system, by replacing the distorted incentives of the fee-for-service economic model, allows CareMore to be rewarded for innovative, results-oriented care. In particular, it enables the company to build specialized programs for its highest-risk patients, who generally suffer more—and run up astronomical costs—under traditional fee-for-service plans.

One of CareMore's critical insights was the application of an old systems-management principle first developed at Bell Labs in the

1930s and refined by the management guru W. Edwards Deming in the 1950s: you can fix a problem at step one for $1, or fix it at step 10 for $30. The American health-care system is repair-centric, not prevention-centric. We wait for train wrecks and then clean up the damage. What would happen if we prevented the train wrecks in the first place? The doctors at CareMore decided to find out.

An early discovery was that CareMore's elderly patients failed to show up for as many as one-third of their doctor appointments. As Charles Holzner, one of Zinberg's initial partners at CareMore and now a senior physician with the company, explains, "About one in three of the elderly people we were taking care of were home by themselves. They'd outlived their family resources, they couldn't drive, and their kids lived out of town. So when they got sick, they ended up calling 911. And when it came to routine doctor visits, they sometimes just couldn't make it at all."

Offering patients free transportation to medical visits may seem expensive, but CareMore found it saved money in the long run.

CareMore's unconventional solution to the problem was to provide transportation, at no charge, to get patients to their medical appointments. Local car-service companies were happy to have the business, and while the transportation cost money, it ultimately saved a lot more. Increased regularity and consistency of medical care meant that many simple problems were recognized and treated in their early stages: complications were avoided, and rates of hospitalization and nursing-home admittance began to fall.

The problem of "noncompliance" isn't limited to missed appointments, either. Patients, especially elderly ones, also leave prescriptions unfilled, medicines untaken, exercise-and-diet regimens unfollowed, and symptoms unnoticed and unreported. Health-care professionals often grumble about noncompliance, but given the myriad demands on their time, they generally can do very little about it. At CareMore, by contrast, Zinberg decided, "noncompliance is *our* problem, not the patient's." So the company began adding more nonmedical services to its routine care in order to improve compliance rates—for example, sending health-care professionals to its patients' homes to make sure they had scales to keep tabs on their weight, to look for loose throw rugs that might cause falls, and to provide "talking pill boxes" that remind patients to take their medicine with preset alarms. Each of these innovations led to a small improvement in patient wellness and a corresponding improvement in the economics of providing care.

Next, CareMore began experimenting with an aggressive treatment of diabetes, one of the most widespread and debilitating illnesses suffered by elderly patients. The primary treatment for diabetes, insulin injection, had long been considered inappropriate for the elderly—too intrusive, too difficult, and too costly for patients whose life expectancy was already short. But CareMore doctors made insulin-injection treatment available to their patients. They also set about investigating exactly how the worst complications associated with diabetes occurred.

Take amputations, for example. The typical chain of events begins with a small cut on the foot suffered by a diabetic patient and self-treated using an ordinary home remedy such as a Band-Aid. If the cut resists healing for a week or more, the patient visits her primary-care physician. The doctor cleans the wound, changes the dressing, and advises the patient on further care, but with no way of knowing whether the advice will be followed. A week later, with the wound getting worse, the patient visits her doctor again and is referred to a surgeon. After the typical two-week wait for an appointment, the patient learns from the surgeon that gangrene is now beginning to develop, and she is referred to a specialized vascular surgeon. After yet another two-week delay, the vascular surgeon sees a wound so serious that a hospital stay and amputation are now inevitable—at a cost of many thousands of dollars and an untold degree of suffering. All beginning with a single, scarcely noticeable cut.

CareMore responded by creating a wound clinic, staffed by nurses whose primary job was to care for diabetic patients with small cuts. The wound-clinic nurses would change the dressing every other day and spend a few minutes talking with the patient, making sure the wound was healing on schedule. Over time, amputation rates for CareMore's diabetic patients fell to 60 percent below the Medicare average.

Another recent CareMore innovation is wireless monitoring for patients with congestive heart failure or hypertension: the former, such as Ellen, receive wireless scales on which to weigh themselves every day; the latter, wireless blood-pressure cuffs. After six months of using the wireless-scale system, CareMore found that hospital readmissions for congestive heart failure had fallen by 56 percent. Now the company is testing similar systems for diabetes monitoring, as well as the use of camera phones for daily conversations with a nurse practitioner.

Not all of these innovations are unique to CareMore—wound clinics for diabetics, for example, are becoming more common. But the company's focus on integrated care is exceptional, and at the center of it all is a care manager called an "extensivist." The term originated to describe a physician who served as a bridge, or "extension," connecting hospital care with outpatient follow-up treatments. At CareMore, it refers to a doctor who coordinates multiple kinds of care for an individual patient. The underlying philosophy is simple: a patient is one unified human being, not a collection of disconnected symptoms. One *New England Journal of Medicine* study looking at the care received by Medicare beneficiaries found that those with chronic conditions such as diabetes, heart disease, and lung cancer were typically visiting several different primary-care doctors and specialists. These doctors only rarely speak to one another, coordinate their plans, or consult on the possible interactions among their treatments. In such cases, it generally falls to the patients to keep track of their various treatments—a role that very few laypeople have the time, energy, and expertise to play effectively. "When we started CareMore, we found … a sizable fraction of our patients would inevitably get readmitted over and over again, if you treated them like routine patients," explains Charles Holzner. "So to keep our patients out of the hospital, I began seeing them myself every week or two. I basically became their personal doctor, making sure they understood their postoperative regimen and were following it correctly. But very rapidly, I became overloaded. So I told Dr. Zinberg, 'We need more people like me.' "

An extensivist must be a knowledgeable physician, of course, and must have the proper tools available. (One such tool is QuickView, a system of unified electronic health-care records of the kind that the Affordable Care Act aims to promote on an experimental basis around the country, but which is already up and running at CareMore.) But people skills and a talent for clear, effective communication are even more important. "I saw that when I got involved in a patient's care, if I gained his trust, he

would do anything I told him to do," Holzner emphasizes. "So showing patients that we have their best interests at heart—unlike some of the HMOs and other providers out there—is key to a strong and healthy relationship."

THE CHIEF BENEFICIARIES of CareMore's innovations are, of course, its patients. According to polls conducted by the company, 97 percent are either very satisfied or somewhat satisfied with their CareMore health plan, and more than 80 percent have recommended the company to a friend.

In the long run, though, the company's impact on the economics of health care may be more important still. When he launched CareMore in 1993, Sheldon Zinberg told his partners, "If you put people before profit, everyone profits." During its first four years, operating as a more-or-less conventional health-care provider, CareMore accumulated losses of about $11 million. But as the system of Medicare-financed, coordinated care Zinberg had initially envisioned came into being, the company turned the corner, showing a $24 million profit in 2000. It has remained solidly in the black ever since.

The economic logic behind CareMore is unusual. Every additional service it provides costs money, and the professionals at CareMore have to take on tasks and responsibilities that physicians don't traditionally assume. CareMore employs more staffers per patient than other companies, and they spend more time with patients and their families than is typical. But every dollar CareMore spends saves multiple dollars down the line, resulting in those member costs that are 18 percent below the industry average.

The crucial question is whether the CareMore model—or models like it—can work on a much larger scale. The American health-care marketplace, after all, has had many one-off success stories that have defied replication. The few examples of successful expansion—Kaiser Permanente and the Mayo Clinic, for instance—tend to highlight just how slow and difficult the process can be. And many medical groups have found to their dismay that something peculiar to their culture or leadership does not translate to new clinics or markets.

It was with this challenge in mind that a group of private-equity investors purchased CareMore from Zinberg and his partners in 2006 and made Alan Hoops the CEO. Hoops's experience and mind-set were well suited to the task of expanding and replicating the CareMore model for new regions and patients. As the chairman and CEO of PacifiCare in the 1990s, he'd led the health-care company to achieve exceptional growth, with revenues increasing from $2 billion in 1993 to $11 billion in 2000. Hoops also started PacifiCare's Secure Horizons program, which under his leadership became the country's largest Medicare HMO, serving more than 1 million beneficiaries.

Hoops knew from the beginning that CareMore's operational and clinical processes could be documented, systematized, streamlined, and replicated. But he also knew that the real magic of the company was in the physician-led culture and the top-to-bottom commitment to patients. The growth challenge, as he saw it, involved replicating the model in local communities, not building "scale" in a single location. "*Scale* implies we need huge numbers of patients to make our system work," Hoops explains. "That's not so. We can set up shop in a community, attract 3,000 to 5,000 patients, and begin having an impact in terms of reduced costs and improved patient outcomes right away."

Hoops's focus has been on making this replication strategy work—and so far he appears to have been successful. From 2005 to 2010, CareMore managed to grow its membership by 15 percent each year. And despite differences in population demographics and community environments, CareMore has branched out into Arizona and Nevada, while expanding in its native California. The company hires a leadership team for a new market almost a year in advance and has them work in an existing clinic to learn the specific CareMore patient-care model. When the new center opens, an experienced leadership team works side by side with the new team for the first six months of operation. New employees are integrated into the company culture and encouraged to become active members of the continuous-learning and -improvement environment.

Hoops's efforts to replicate the CareMore model should gain new momentum following the company's August acquisition by WellPoint, which operates Blue Cross and Blue Shield plans across the country. WellPoint serves 34 million members in its affiliated health plans and another 35 million through subsidiaries. "CareMore was a perfect strategic fit with the direction in which we're moving our company," said Angela Braly, the CEO of WellPoint. "We have been focused on delivering greater health-care value, and finding ways to put the patient in the center of the system ... That's the entire focus of the CareMore model."

WellPoint's extensive infrastructure, access to capital, national Health Information Technology capabilities, and existing relationships with patients and physicians could all accelerate the process of replicating the CareMore model. "In our service areas, 1 million Baby Boomers will be joining Medicare from now until 2030," Braly said. "That's an extraordinary level of potential demand."

Moreover, the population that CareMore serves—the elderly, and in particular the frail, high-risk elderly—is crucial when it comes to controlling overall health-care costs. "We talk as if we need to overhaul the entire health-care system," Hoops says. "But that's not quite correct. The biggest problem—and opportunity—lies with the part of the system that serves our high-risk populations. That's the part of the system that's unsustainable."

Braly believes that as CareMore continues to expand, it will help redirect the health-care conversation in Washington. "Many people are skeptical that it is possible to significantly improve quality and reduce costs at the same time," she says. "The CareMore experience shows that if you change the underlying process, you can, in fact, achieve both objectives, and you can do so consistently."

It remains to be seen whether the WellPoint-CareMore partnership will work as planned and replicate CareMore's experience on a mass scale. But whether this endeavor succeeds or not, the integrated, early-intervention model pioneered by Sheldon Zinberg in the mid-1990s is likely to offer lessons for American health-care reform, now and in the future. *A*

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