Mr. Starnes: Today we will talk about expanding medical professional relationships, which can take many forms. In some—oncologist working with a radiologist, for example—there is a well-defined protocol for communication and continuity of patient care. We want to focus more on medical doctors working with medical professionals who are not MDs. Let’s start with a definition. What is a medical professional?

Dr. Hu: It has to do with a degree of specific medical training in some specific field as well as professional interest. It has to involve some aspect of medicine, however broadly you want to define that.

Dr. Sawyer: In our institution, we not only train chiropractic doctors but acupuncturists and massage therapists, and our definition of massage therapy is therapeutic massage. We very much consider them to be medical professionals.

Dr. Desai: When you define a medical professional, you get into a lot of political discussions, and some people get their hackles up. Folks who have gone through medical school or dental school or chiropractic school sometimes show an ingrained defensiveness based on the school they’ve attended and the education they’ve had. I’m part of a multidisciplinary practice, so I work very closely with behavioral health specialists, psychologists, licensed social workers, physical therapists, and others. Oftentimes I work with chiropractors or other medical professionals, as well as with acupuncturists. The value of that is undeniable.

Mr. Hustvet: I like the term “health care professional.” Our current discipline is really pushing to alleviate some of the problems of having a limited number of physicians. Would I take it personally if I were called a “mid-level provider?” I would really look more at what I’m able to do for the patient. Am I able to meet a need in a timely fashion? Am I able to assist and provide care where maybe there would have been a delay?

Mr. Starnes: As science and training expands, many health care professionals have the ability to make frontline diagnoses of conditions that could be shared with physicians. Any examples of the ways in which these individuals could work with physicians?

Dr. Gulon: Dental schools now include the curriculum. Dentists are trained to not only work on prevention, but disease treatment as well—and, like our physician colleagues, to deliver care over the lifetime of our patients. It’s obvious that everything that goes into the mouth pretty much enters all the pathways of all the basic systems of the body. Understanding that and applying disciplines and approaches to care that impact and/or prevent it are going to be useful in at least the teamwork process in health care.

Mr. Starnes: Let’s talk about expanding the relationships between health care professionals and the benefits this can bring. What are some of the existing barriers to this more collaborative approach?

Dr. Sawyer: The biggest barriers really have to do with payment and the incentives in

The new face of health care
Expanding medical professional relationships

payment. When a patient walks in our door we manage that patient in a silo, and we aren’t thinking of other providers that might be able to have a better impact or an additional impact on that patient.

Mr. Wingrove: A lot of us are still getting to know each other, and I think that is one of the keys to having successful interdisciplinary approaches. We’re being forced now to look outside of our own box and collaborate with other people. In the long run, I think that’s going to serve the patients well. It’s probably something we should have done a decade ago.

Dr. Desai: Patient ownership is an area that we tend to ignore. It’s the most uncomfortable of the areas to discuss. The cultural issues surrounding patient ownership are the ones that are the hardest conversations to have.

Dr. Gulon: I see this as an opportunity, not as a barrier. First of all, 40 percent of the population seeks dental care in any given year. Fifteen percent of those people don’t see a physician, and that’s a problem. If we’re presented with conditions in which we could be a source of referral to the physicians through appropriate screening, whether it’s hypertension, which we do routinely, oral cancer screening examinations, diabetes screening, or sleep apnea screening, there are windows and/or opportunities to collaborate at a higher level with our physician colleagues.

Mr. Starnes: Are we going to foster better relations between provider types if the consumers themselves broaden their approach to health?

Mr. Hustvet: Changing a patient’s view on taking ownership of their health isn’t going to happen in a five-minute conversation at a physician’s office. It probably won’t happen even after three or four five-minute conversations at the physician’s office.

Dr. Hu: Say you need to get a CT scan and an MRI. Each costs different amounts at different places, whether it’s inpatient, outpatient, or in hospitals. There’s very little transparency, so even if they want to be involved in making those decisions in a cost-effective manner based on their insurance or deductible, they can’t do it.
Mr. Johnson: We all need to provide education to our patients about preventive care and following up with preventive checkups, because it can’t be a burden for just one profession.

Dr. Hu: I’m a specialist, a vascular surgeon, so my view may be skewed towards specialty care. Again, we’ve been siloed for a long time. We have radiologists who do angiograms and surgeons who do surgery, but those barriers have changed, and everyone wants to protect their turf. I think the financial barriers are the first hurdle and probably the biggest hurdle in order to build a multidisciplinary team with a common goal.

Mr. Starnes: We need to better understand the levels of training of different kinds of providers. How early in one’s health care career should this learning begin?

Mr. Johnson: In the physical therapy program it happens early, and for good reason. Everybody is in learner mode. I think it needs to be a little bit more robust, actually, so training would continue beyond those initial few years.

Mr. Starnes: What about health care professionals who are well into their careers and well removed from the academic or school environment?

Mr. Hustvet: Sometimes it’s directed by a physician above everyone who pulls teams together to promote exposure and greater comfort levels with the different fields. Being outside the facility, it’s really a challenge for us. We spend a lot of effort trying to track people down and explain what kinds of services and offerings we have, asking questions about their needs, and where we can fill in the gaps.

Mr. Wingrove: I represent the profession that will literally decide for about 80 percent of you in the room today at least once whether you live or die. That’s about 10 percent of what we do. We have another 30 percent that deals with your urgent care needs, and about 60 percent that involves your social needs. Until recently, we weren’t training our professionals in how to deal with your social issues beyond some of the safety issues. That’s one of the real promises of the new generation of community paramedics. It’s taking a professional that is super-sharp in lifesaving skills and retraining them to do the majority of the work they actually perform each day, which involves more psychosocial skills.

Mr. Starnes: How can reimbursement mechanisms further collaboration?

Dr. Desai: There’ll be a shortage of 90,000 physicians within the next two to five years, and certain states are suffering from it more acutely than others. If we formed a care team with seven health care professionals and we all saw the patient together, only one of us could get reimbursed. We need to create incentives for people to want to be part of that team. If you come to see me as a patient, I will almost always refer you to a physical therapist, possibly a behavioral health specialist, an acupuncturist, or a surgeon.
Dr. Sawyer: Right now, with the fee-for-service reimbursement formula, we don’t have any incentive to talk about team-based care. If and when the payment shifts to focus on the value that the team provides, it will be more productive.

Dr. Desai: In 2018 it shifts, as Medicare makes the majority of payments based on value as opposed to fee-for-service.

Mr. Starnes: What could be gained by better relationships between health care professional relationships?

Dr. Desai: Low-back pain is the single most expensive medical condition, with costs approaching around $100 billion annually in the United States. It’s three times more expensive than cardiac care services, and it’s more expensive than diabetes and cardiac care combined. Eighty percent of Americans will have an episode of low-back pain. However, it turns out that 7 percent of those patients—around 15 to 25 million Americans—are using up 85 to 97 percent of that $100 billion. If the different health care professionals treating these patients operated more collaboratively, there could be huge cost savings.

Mr. Johnson: I think that many of our current outcome measurements are really process measurements. They’re not quality-of-life measurements, like those used in Europe, and they’re not functionally based either. An outcome that’s worth measuring, in my mind, one that moves the health of the population higher, requires a functional measure and a quality-of-life measure. I think we do need to address that and not go with just process measures or measuring whether we get the person from point A to point B and they’re happy and out the door, but, rather, on their ability to function in society and their quality of life.

Dr. Hu: At HCMC (Hennepin County Medical Center), we’re working on a so-called Limb Salvage Center, where we have people from different specialties—radiology, vascular surgery, hyperbaric oxygen, dietary—trying to save limbs. All of us bring different perspectives, and maybe we have different tools. The whole goal is not to have two different ideas about how to treat this, but to have one consensus idea of how to treat the patient.

Dr. Desai: In the large medical groups I’ve worked in, patient satisfaction is different from measuring the real outcomes—for example, that they’re functioning better, they’re able to walk, and they’re pain free. At the same time, you’re getting these little management metrics—for example, what would you as a physician do? Is the patient satisfied and happy? All of those are not necessarily the same as treating the problem. I think that trying to have patient satisfaction is a tremendous problem that a lot of physicians complain about in these large care systems, but it doesn’t necessarily correlate with better care.

Mr. Starnes: Are there examples from within your own organizations of how expanded relationships between different kinds of health care providers are producing good results?

Mr. Wingrove: Within paramedic service, we have some high-utilizer groups of patients. The people that abuse our system tend to call on different days and at different times, so they’ll see nurse Judy on Monday and nurse Tammy on Wednesday and nurse Steve on Friday. North Memorial’s community paramedics now follow patients at home who have 10 or more medications, three or more comorbidities, and time-sensitive medications. The paramedics use the same electronic medical record, so they can see all the hospital visits, all the clinic visits, and can issue a request for a physical

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Craig Johnson, PT, MBA
therapy service or a secure message to the physician. It’s part of a Medicaid shared savings ACO (Accountable Care Organization), so the state gave them a significant portion of shared savings last fall. Of course, 80 percent of it should go to the paramedic and 20 percent be shared by the rest of you, but that model is a shining star in the country.

Dr. Sawyer: The Hennepin Health initiative is extremely novel. It combines the clinical services that we all think about, but then it adds social services, and throws a big net over the most complicated, vulnerable population of patients where the costs are high and the access is not good. They’re bringing mental health professionals and social workers in and dealing with poverty and homelessness.

Mr. Hustvet: We are trying to have more proactive team involvement. We are also trying to prevent emergency room visits and the expense of Medicare dollars. We do this not just with asthma and obesity but also with our general patient population. The bigger challenge is when we have to communicate with four different physicians from two different hospitals, with one to four involved parents, and three, four, or five different primary nurses. Care conferences are probably a great example as well. We get to sit with the physicians, with the family, with everybody involved and have a conversation. These meetings can sometimes raise really important, crucial questions. If the discharge is tomorrow, what happens, how do we fix this, do we rush through things? If the team does save dollars, it’s hospital-based versus home care versus maybe an extended living facility, that determines where that benefit goes.

Mr. Johnson: What’s going well? Here are a few examples. One is a primary spine program in Mankato. The primary care clinic is a medical home, and they’re using a tool to risk-adjust patients in terms of the risk of accessing services and making referrals to physical therapy. Another therapy clinic in our network is working with a primary care clinic, and when a patient is identified with prediabetes based on blood work, they refer them to physical therapy for education. They’ve shown very good results in reducing blood sugar levels over a six-month period. Finally, Courage Kenny set up a pilot program a couple of years ago as a medical home with about 200 patients. The patient population was essentially defined as dual eligible, which means they are eligible for Medicaid and Medicare. By being very preventive-focused and helping manage their health, I believe they saved the state about $2 million.

Mr. Starnes: Why are health plans so unwilling to offer fair compensation to non-physician health care professionals?

Dr. Sawyer: It’s all about coding and chasing the money. We’re starting to ditch the terms complementary and alternative because they don’t mean anything. If acupuncture is the best early treatment to use, along with reasonable medication management for a patient with acute or chronic pain, then that should be put into effect right from the start. Typically, to qualify for reimbursement for acupuncture the pain has to be four months of chronicity or longer. This delays the use of a therapy that has no downside to it whatsoever. Then, once payment is approved, reimbursement is so low that it’s not feasible to provide the care in a pain clinic or large health system.

Mr. Johnson: In our current fee-for-service system it’s obvious that the current pathway for most disease processes is too costly. We’ve done a fair amount of research into payer data of delivery partners and timing of care in relation to physical therapy and particularly musculoskeletal conditions, and there’s a huge amount of care that’s provided upstream. There have been a couple of very good research articles from Spine magazine and Health Affairs demonstrating that early access to physical therapy for low back pain—within 14 days of seeing a primary or a medical provider—has reduced the total episode cost for that back episode by 40 percent.

Mr. Starnes: Dental insurance reimbursement seems to differ from other reimbursement models. Why is this?

Dr. Gulon: I’m not sure that dental is doing it any better. In fact, in dental we get paid by procedures. In the dental world, we don’t operate with diagnostic codes, but that world is evolving. On the other hand, we’re working on a couple of novel projects with integrated physician networks, including some sleep studies right in our practice. We’ve worked out some reimbursement mechanisms between the physician network and our group.

Mr. Starnes: One of the biggest challenges comes from corporate culture and senior leadership. In some systems individuals won’t change regardless of evidence that suggests they should, and in some systems senior leadership is very proactive about change but it somehow gets bogged down in mid-level management. Any comments on this?

Dr. Desai: We do have progressive-thinking leadership, and we’re doing some things that are progressive and innovative on the training level. People who have been trained already and have been out of school, for five, 10, or 15 years, is where the gap is. What we really need is to identify and mentor and support great clinical leaders. What I mean is that health care is not going to change until health care providers buy in. You can have a great administrator, you can force it down someone’s throat, but you need a foil to that with great health care

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“We are trying to have more proactive team involvement.”

Derek Hustvet, RRT-NPS, LRT
leadership. Getting folks who are mid-career to change their practice patterns, as we’ve all been talking about, is a significantly greater challenge because they’re set in their ways. Those are the folks running the show, so to speak.

Dr. Gulon: I’m really optimistic that the ears are open from the medical administrators’ point of view. Many of us have been proud that in Minnesota, overall, we’re pretty progressive with regards to health care. Unfortunately, when it comes to the pediatric dental benefit, Minnesota is dead last, 50th out of 50, in terms of reimbursement. Switching gears for a moment, from the conversations we’ve had with chief medical officers, there’s a significant amount of waste in terms of the access for dental care in emergency rooms. Inter- estingly enough, we’ve been able to partner on dental care in emergency rooms. Inter- estingly enough, we’ve been able to partner with a physician group to leverage some of the synergies so that we can actually have those patients access the care through the dental practice rather than through the emergency room.

Mr. Wingrove: When we encounter a patient who has congestive heart failure and has significant breathing difficulty, we have two choices. We can intubate them, or we can put them on CPAP (continuous positive airway pressure). If we intubate them, what do you suppose happens to the hospital-acquired infection rate? It has nothing to do with the hospital, but it’s in an unsterile environment, and it’s an invasive procedure. On the other hand, if we use CPAP and maybe even get a better result than intubation, we can drive the hospital score into a better position. Those are some of the things that have value to patients as well as to the payers.

Mr. Starnes: Under the Accountable Care Act (ACA), reimbursement for health care services will migrate from a volume- to a value-based methodology. How does expanded collaboration between health care professionals respond to this migration?

Mr. Johnson: The whole notion of collaboration has been spurred on by the ACA. The Centers for Medicare & Medicaid Services (CMS) has announced that they’re moving towards 50 percent of their payment being value-based by 2018, and that will certainly foster innovation around collaboration. I am a firm believer that we should manage what we measure, so measuring outcome is going to be very critical in this collabor- ation. Financial incentives, when they are aligned, will also drive collaboration, and financial incentives really do drive our provider behavior.

Mr. Starnes: Part of the health care reform is going to deal with attempts to reduce rehospi- talization. How can penalties for rehospitaliza- tion drive better collaboration?

Mr. Hustvet: From a home care perspective, we actually have some incentive right now to keep patients out of the hospital. We can’t bill for our equipment, and we can’t bill for the pieces or parts or supplies they use if they’re in the hospital. We have a clinical piece that often does not get reimbursed. If it does get reimbursed, it’s not a full reim- bursement, but that piece of equipment is necessary to keep that patient out of the hospital. We’ve noticed, in the last three years, more focus from the hospital facility level at care management and discharge planning. There’s a lot more focus on providing 24-hour, 7-day-a-week support. There used to be just a daily discharge plan, after which you didn’t have a lot of commu- nication and cooperation. I think from our perspective, we’ve been trying to do this because it’s good for our business model and it’s good for our patients.

Mr. Starnes: Can an increased emphasis on prevention foster improved collaborations?

Dr. Desai: It’s very unlikely that prevention can be achieved with just one provider. It’s unlikely that just one specialist or one primary care provider could achieve preven- tion. I think that in itself provides the foundation for greater collaboration. One of the things I tell patients all the time is, I don’t have to be the one to fix you, I don’t have to be the one to make you better, but if I can get you to the right person, it still makes me look good.

Dr. Sawyer: I’m not sure who is able, by virtue of their training and experience, to actually provide preventive services. I’m not talking about pap smears and mammograms, I’m talking about the discussions, the coaching, and visiting with the patient. We’ve got a mixed bag, and I think it’s too early to know for sure how that’s going to work, but we certainly have to put that in place because it’s now mandated.

Mr. Starnes: Are there future legislative actions at the state or federal level that might drive collaboration?

Mr. Johnson: It can be demonstrated that silo management mentality is ineffective. From our association’s standpoint, we are trying to promote innovative clinical pathways, and research has shown that early access to physical therapy is key to saving dollars throughout that whole episode. We have a very innovative national association...
I applied for a grant from them to run a pilot study around worker’s compensation patients directly accessing physical therapy. We have had discussions with stakeholders at high levels including the Chamber of Commerce, the Department of Labor, brokers, and the worker’s compensation insurer for the state. I think this is definitely beginning to show up on their radar. I think that will obviously affect future legislation and the way that the worker’s compensation fee schedule works. Ultimately, we are hoping to change legislation.

Mr. Starnes: We recently had landmark approval from the House and Senate on new Medicare reform. Is Medicare reform going to help foster better relationships between health care professionals?

Mr. Hustvet: I think it’s a good start. I think anytime you’re getting physicians involved with alternative providers, there’s going to be more collaboration. There’s a push right now on both physicians and even physician assistants to see how much work they can get done. If we can spend 10 minutes, 20 minutes, or a half hour with the patient and then have a five-minute conversation with the physician—versus the physician only getting five minutes with the patient—I think that’s going to drive a little more collaboration, and offer a little more exposure. The physician, I think, will end up ultimately being more of a coordinator and manager of the other therapies and services.

Mr. Starnes: In every legislative session, there are bills introduced that redefine the scope of practice for specific provider types, and there are always “turf-war” conflicts over their passage. How do we best address this?

Mr. Wingrove: Sometimes that’s healthy tension, and sometimes that’s not healthy tension. We’re in a time when change is here and it’s being made everywhere, and I think we just have to recognize there have been changes over time in all of our professions, and those are cyclic. This is a new time when the professions will change. Technology also plays a role in how safely different providers can do different things. The professional protection, I don’t think, will ever go away, but we’ll have to respond to it based on what the payment system forces on us.

Mr. Johnson: We don’t really like this licence turf battle, but it does happen. There’s a filter that describes scope and helps legislators make decisions. Legislators make decisions about scope for every profession in this state, and they’re not really the experts most of the time. They’ve actually appreciated that here’s something that you can measure when somebody comes to you and they want to expand in a certain area. I think we need to get beyond that as well and be very proactive, because the time that it takes and the resources it takes to fight those battles are pretty wasted. I think we need to recognize that and try to maximize the training level of each provider on the care team and not have legislative turf battles about scope.

Dr. Sawyer: The real issue is that everybody ought to be right at the top of their license, and if these care models can change and the reimbursement can change, then the commercial payers will follow what Medicare is doing. Getting this shift to value would allow clinicians like Gary and me to sit down at the table and say, well, if we’re in the shop together, if we’re in the same practice together, what can we do to elevate the model of care and the delivery of it and the efficiency of it and go right to a payer, along with nurse practitioners, pain specialists, and acupuncturists and say, we’ve got a proposal from you and it’s too good to turn down.

Dr. Gulon: Dentistry, as I mentioned earlier, has added mid-level practitioners in the form of dental therapists and advanced dental therapists with expanded functions. Dentistry was not unlike other professions that were slow to recognize the shortgages that we are encountering. We have to be more creative, and I think that’s driving a lot of the behaviors out there.

Dr. Hu: If you can get the collaborations to work, is it going to be revenue neutral? If it’s revenue neutral, basically you’re redistributing income from one group to another group. From a practical stand-

“"We're in a time when change is here.""
Gary Wingrove
of the work to me, or other folks that aren’t billing quite as much, and still see quality patients and allow the physician to see the higher-needs patients that maybe are getting delayed or pushed off or even going into the hospital.

Mr. Starnes: An emerging model involves community-based initiatives, many of which could be duplicated and expanded. Can you give some examples?

Mr. Wingrove: Our state got a grant from CMS to work on different sorts of models, and one of the ones they’ve chosen is to create opportunities to expand three emerging professions: community paramedics, community health workers, and dental therapists. They are contracting now for each of these to create tool kits for potential employers. The goal is to speed the adoption of the professions by employers. It will set the stage for the employer to learn about the training they come in with, the sorts of things you can expect them to do, and how reimbursement works—if it works at all. They are also, at least in our case, subsidizing the employment of a handful of professionals so that employers can test it out and make sure it works and learn about the intricate details of actually putting the profession into practice.

Dr. Sawyer: I’m not sure that the innovations would have happened in either the state innovation model initiative or the Hennepin Health initiative if there hadn’t been legislation and direct involvement by state agencies with provider groups. In other words, I’m not sure that would have evolved or happened if the payers weren’t the ones responsible for it, and I don’t think they would’ve taken the initiative.

Mr. Johnson: Under one community-based program that, in its original form, our association worked on, we developed an education program that assessed seniors for their risk of falling. Reducing the number of falls has an impact on that individual’s health as well as on the health of those in the community. The program was first developed for assessment and then for intervention, and oftentimes the assessment revealed that a community-based strengthening program would help to reduce the risk of falls. This was a grant-funded initiative with a train-the-trainer model, which trained community health nurses and others to assess and then to address the issue. Now the Department of Health is reviving this initiative, with about a dozen health care providers and community organizations working on reducing falls by seniors in the community.

Mr. Starnes: How could a value-based care model promote interprofessional relationships or address the turf or silo mentality?

Dr. Desai: The greatest advantage of a value-based reimbursement model is that, for the most part, the value of a person’s contribution to the care team gets equalized a little bit better. The traditional system is quite hierarchal, with certain people on the top and others along the way. By bundling care and by providing reimbursement in a value-based system, long-term management becomes more important than incident-based management, which also then shifts away from the silo effect.

Mr. Starnes: If we increased the focus on the patient experience, might we break down some of that silo mentality?

Dr. Hu: I think so. Like anything, you want to do the best thing for the patient, and it’s rare that you’re the only one who can do it. I think centering on the patients, giving them the best experience, requires you to seek out all the other things that they need. I think, yes, that will help break down some of the silos.

Dr. Gulon: Patients who go through different levels of care—whether it’s with a dentist or a physician or a chiropractor or whomever—will benefit if there’s a high level of transparency, communication, and coordination within the care team. Certainly we recognize the challenges of achieving that, but also it’s pretty obvious how that might feel to the patient.

Mr. Starnes: Even though different types of providers have similar goals, they may not talk to each other. Why not?

Dr. Desai: Synergies are often unrealized because of time and maligned financial incentives. Those are the two primary reasons. Right now there’s no incentive to learn what the other guys do. He might be the specialist in this, I might be the specialist in that. In order to get that 360-degree view or that spherical view of what the patient’s going through, you need to get all partners involved. If you do that, then the value of your partnership increases and your incentive to learn about what others do, at least to some extent, increases.

Dr. Sawyer: If we’re in the same practice business together, we sit down at the table and figure out how are we going to be
successful, because we’d like to approach this particular payer, public or private, with a proposal to do X for a new model of care and delivery. We’ve got to get to know each other, on both a professional level and a personal level, so we have some trust and assurance that we’re watching each other’s backs. Being in business together is a big deal.

Mr. Hustvet: We lack easy communication and easy access tools. Just because I’m only free at noon and you’re only free at one doesn’t mean I couldn’t have gone into a shared system and put in a note or a comment for you. That’s better than a system in which one physician calls, one emails, and one faxes or leaves a note on the nurse’s desk. I can’t communicate with three or four of the hospitals that use different electronic records, and one physician who prefers to use a pager and calls me back when I’m already out on the road seeing somebody else.

Mr. Starnes: Do patients need to be educated not to fear being part of a collaborative process?

Dr. Desai: I think so. I think, increasingly, you have patients who have been exposed to advocacy groups. Also, patients are increasingly more educated about their disease states. Patients come to me all the time and say, well, PT (physical therapy) doesn’t work for me, or chiropractic doesn’t work for me, or acupuncture doesn’t work for me. That ties back into that initial conversation we had about training and understanding what your collaborators bring to the table. I say to the patient, well, it’s not that PT doesn’t work for you, but it’s that therapist.

Mr. Johnson: I think that’s exactly right. We have a joke in physical therapy about a patient making a comment to the doctor: “I tried physical therapy, and it didn’t work.” The comeback is, “Have you tried doctoring?” It’s the individual. There is a provider in town that is absolutely selective about which therapist he sends his patients to because he’s taken the time to build a relationship. Understanding the person who’s delivering the care is really critical, and I think that’s a great point.

Dr. Desai: A lot of us who believe in multidisciplinary or interdisciplinary care have taken the time to create our own networks. I have already identified the folks I’m going to send people to. I have preferred providers, and those are the only people I’m interested in sending patients to if I have a choice. I know at the end of the day, the patients are going to get better, and it’s going to make me look good, and everyone, so to speak, is happy at the end of that experience.

Mr. Starnes: What must be done to expand interprofessional relationships in health care delivery?

Mr. Wingrove: I think it centers on the people and the relationships between the professionals. It will go faster if we spend time on the front end managing that process well.

Mr. Hustvet: I think the most basic piece is just increased communication, whether that involves meetings, discussions, or electronic communications. That’s really going to be the main driver.

Dr. Desai: In my estimation, it’s financial misalignment. Until we align the financial incentives to collaborate, there’s going to be some resistance. I think that with the Accountable Care Act and with value-based reimbursement, we’re moving in the right direction, and I think there are some really creative ideas with regards to that, but finances need to be aligned.

Dr. Sawyer: I think it has to be initiative and motivation. In other words, when I’ve got a reason to reach out, I should make that phone call or send that email and ask if we can have lunch so we can start talking about some different ways of working together.

Dr. Gulon: From the consumer point of view, I would ask patients to continue to access the system and to understand how relationships and overall health are interconnected and to continue to demand from the medical care system that which seems obvious but which may be more difficult to achieve. I think that with continued persistence, that will happen.

Dr. Hu: If I had to pick one, I would say good communication between the different specialties and the different providers. Concurrent with that would be a good understanding of the capabilities of everyone on the team and what they can do for the patient.

Mr. Johnson: I would echo those. It’s a long list, but I believe that aligning the financial incentives and relationships and understanding what each provider does is most important.

“I tell patients all the time, ‘I don’t have to be the one to fix you.’”—Mehul Desai, MD, MPH