New Directions:

Corporate and Academic Leaders Forge Healthcare Change

Dr. Richard Payne surveyed the talent arrayed in the conference room before him: CEOs and vice presidents of some of the nation's largest home-health and hospice companies. National experts in bioethics and health economics. Geriatricians and oncologists, nurses and ministers. People who have spent their careers healing the sick or, when they could not be healed, trying to comfort the dying. And yet none could give Payne the answer he sought: What to do with a 79-year-old retiree — and millions of chronically ill Americans like him — who is not ready to die, but who may not live much longer, either?

Payne, the Esther Colliflower director of the Institute on Care at the End of Life, based at the Divinity School at Duke University, had invited these experts to participate in a six-part, three-year "New Directions Roundtable" aimed at influencing delivery of quality care for people with advanced, chronic, or life-limiting illness. They were charged with finding consensus first about what elements of chronic and end-of-life care need fixing, then developing politically and fiscally feasible solutions. The first Roundtable, a sort of icebreaker headlined "The Common Good" held in May at Duke's R. David Thomas Executive Conference Center, was geared toward making the first step: Building new alliances among a disparate group of professionals who, despite their shared focus on chronic care, rarely talk with one another.

When he addressed them that first night, Payne told participants about his brother-in-law, who married Payne's oldest sister 52 years ago, and who had been managing his heart disease and diabetes pretty well until being diagnosed with multiple myeloma last year. Medicare pays for a home health aide to visit twice a week, but it's not nearly enough — he needs help around the house, Payne's sister is overwhelmed and isolated, and the last time she tried to take him to the doctor, he passed out four times. He doesn't need to be in a hospital, but he is not ready for hospice, either. And there's little available in between.

"We are really here to have some very interesting discussions about what care looks like at the end of life, and how we should define quality care," Payne told the Roundtable participants by way of an introduction.—There clearly isn't a delivery mechanism that works… I would like catalysts, movement, talking across our silos, [solutions] testable by research and demonstration, and to create a working community, a viable working community, to meet the needs of patients and families . . . dealing with complex and chronic diseases."

Most in the room nodded along. Many had friends or relatives in similar straits, or had themselves faced a potentially fatal illness. But even if they agreed they could serve the common good by providing better care for the terminally or chronically ill, particularly at home, their routes to that goal vary.

At times, they even conflict.

Richard Payne, MD, Director of the Duke Institute on Care at the End of Life introduces New Directions Roundtable themes to participants attending the inaugural meeting held at Duke University May 17-19, 2010

For Jim Robinson, executive vice president of Amedisys Hospice Services, part of the home-health giant Amedisys, a key part of the equation is holding down costs. Claire Wimbush, a 2008 graduate of the Divinity School who soon will be ordained as an Episcopal priest, wants to make the home-health system more flexible. Living with cerebral palsy, she uses a wheelchair and cannot bathe or dress herself, but she calls herself a refugee from home-health agencies, driven away by what she sees as bureaucratic inflexibility. So she hires aides on her own through Craigslist.

It isn't easy to find them, and she told her new colleagues she dreams of an eHarmony-style Web site that can match nurses with patients. "Could someone here please create the caregiver dating service?"

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Dr. Ray Barfield, a pediatric oncologist at the Duke University Medical Center who teaches at both the School of Medicine and the Divinity School, is urging faith leaders and physicians to start people thinking about end-of-life care well before they need it, "so you can be making decisions based on your needs and resources, not hurtling off to the biggest crisis of your life with no preparation."

Katherine Rosman, author of *If You Knew Suzy: A Mother, a Daughter, a Reporter's Notebook*, which chronicled her mother's death from lung cancer, told the group it would help if some in the profession worked on their bedside manner. Her introduction to choices facing the terminally ill was a surgeon who pinned an image of her mother's lungs on a light board and tapped at the tumor. "Inoperable!" he declared. Then he stalked out of the room. She and others wondered if it might not help to pair seriously ill patients and their families with special advocates, to help them navigate the system. Peggy Pettit, a registered nurse and the executive vice-president and COO of VITAS Innovative Hospice Care, envisioned the creation of a position held by "someone who manages care, touches base, and draws interdisciplinary services together."

But Ruth Anderson, the Virginia Stone professor of nursing at Duke's School of Nursing and an expert in nursing home management, offered a slightly different take. "Why would we have a solution that protects patients from us?" she said. "There's something about the system and the fragmentation that leads us to think about advocacy, but maybe there's a more root place to look. Why wouldn't we all be advocates?"

Bob Miller, a senior executive at VITAS, would create Medicare coverage for home-based palliative care, to fill in the gap for patients who are living with chronic illness, or who may be terminal but aren't yet ready for hospice — that No Man's Land that Payne's brother-in-law inhabits. And Don Taylor, a healthcare economist at Duke's Sanford School of Public Policy, says American consumers need to get more value from the healthcare system they already pay for — at costs well above the rest of the world.

More value, better care, more cost savings, more time with patients — that's quite a list, and it isn't hard to imagine how Duke's attempt to chart a new direction for chronic and end-of-life care could collapse on itself. What's more, the Roundtable is trying to drive reform at time when Medicare costs are skyrocketing, an enormous influx of Baby Boomers soon will begin jamming the elder care system, and the political appetite for more health care reform is far from certain. This is, after all, an election year, and the public is still wary of the major healthcare reform bill that Congress passed this spring.

Payne, whose first career was as a physician, understands all of this, and he made clear at the start that he's comfortable with tension, comfortable with tough questions, comfortable with gray areas. This was a three-year process, worth working through. A large man who tempers his directness with humor, Payne spent the Roundtable coaxing his guests out of their "silos" and urging them focus on the patients whose lives they hope to transform. When the conversations slipped from the pragmatic to the obtuse, or devolved into gripe sessions about the system, and the bureaucratic intransience that many feel characterizes Medicare, he often asked his fellow puzzlers, by way of getting them back on track, "How is this going to help my brother in law?"

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Three decades after Congress first created a hospice benefit under Medicare, in 1982, hospice has

The first New Directions Roundtable wasn't aimed at providing solutions right away, but most participants agreed they should begin to focus on several critical areas that could improve end-of-life care.

The Bridge: Developing a level of care, covered by Medicare, for chronically ill patients between treatment and hospice care that would give them access to home-based palliative care — including pain management, counseling for themselves and their families, and end-of-life planning — before they are physically or emotionally ready for hospice.

Bedside Manner: Fostering a culture, beginning in medical school, that helps doctors speak realistically yet compassionately with patients whose conditions are terminal, or likely may become terminal.

Spiritual Counseling: Recruiting clergy to start talking with congregants and parishioners about their desires regarding end-of-life care before they encounter a medical crisis.

Home Health: Encouraging more flexibility within the home-health industry – and more flexibility in Medicare for how it pays for such care – to make it easier for the chronically ill to remain at home before they enter hospice.

> *“We live in a very particular death-denying society. We isolate both the dying and the old, and it serves a purpose. They are reminders of our own mortality. We should not institutionalize people. We can give families more help with home care and visiting nurses, giving the families and the patients the spiritual, emotional, and financial help in order to facilitate the final care at home.”*
> — Elisabeth Kubler-Ross, author of *On Death and Dying*, before the U.S. Senate Select Committee on Aging, 1972

become an integral part of American health care, providing access to around-the-clock care for the terminally ill that includes pain management, counseling, spiritual support and help for families of the dying. It is beloved on Capitol Hill, and surveys of patients and families routinely show satisfaction rates of over 90 percent.

The number of Medicare-certified hospice programs, most of which are home-based, has jumped from 31 in 1984 to more than 3,300 today, serving 1.2 million patients per year, according to the National Association of Home Care & Hospice. However, even though recipients of Medicare, the government health plan for seniors, accounted for about 80 percent of all deaths each year, only about 40 percent of those who die each year use hospice, and their average length of stay is just about three weeks — well short of the six months allowed under Medicare.

These numbers are important for two reasons: First, many more dying people could avail themselves of hospice, or use it longer, and based on the experiences of others, they and their families could probably benefit. Second, studies show home-based hospice saves money. However, patients and their doctors, spiritual leaders, and families are not talking about and planning for long-term and end-of-life care much better now than when Kubler-Ross testified before Congress, four decades ago, Roundtable participants said. They agreed that needs to change.

“When you look at a patient that has six months, they say, “Well, that patient isn’t ready for hospice,’” said Miller, the senior vice-president of clinical development and bioethics at VITAS, where the median length of hospice stay is only about 14 days. “How do we make a smooth transition for the patient that gives them some . . . continuity of care?”

The ministers at the church Payne’s sister and brother-in-law attend certainly aren’t bringing it up. Amy Laura Hall, an assistant professor of theology at the Duke Divinity School, gets plenty of questions about death from the 80- and 90-somethings in the Sunday school class she teaches, but not about hospice or palliative care. They’re more concerned about ending up at a different nursing home than their spouse. “And they really want to know about heaven, and if I actually believe in it, she said.

Dr. Michael Fleming, chief medical director at Baton Rouge, La.,-based Amedisys and a former president of the American Academy of Family Physicians, said many physicians are reluctant to discuss with patients anything short of how they’re going to get well, and they’re not comfortable discussing chronic care for advanced illnesses or end-of-life care. “Even after 30 years [in practice], it wasn’t at the front of my mind,” he said. “There’s a cultural mindset that says, when you say someone is terminal, and is going to die, that’s failure.”

> *“What you need is a cultural change. People all come from different backgrounds and have different beliefs about what you should do when people are dying: Preservation of life versus recognizing the end, and facilitating a good death. So helping people understand those different perspectives might help, so they can say, ‘I see it this way, but this is what this patient needs at their time of dying.’”*
> **Ruth Anderson**, the Virginia Stone professor of nursing at Duke’s nursing school and an expert in nursing home management.

One small group discussion at May’s roundtable yielded the idea of creating a checklist for doctors and other caregivers to follow, to ensure they discuss all relevant issues with patients who are facing long-term, chronic illnesses or who may be terminal, from how they enter the exam room to how they share bad news with the patient or her family to what next steps they recommend. Although some were dubious that doctors and nurses would follow it, Mark Leenay, Chief Medical Officer and Senior Vice President of United Healthcare Medical Solutions, said he believed it would catch on with proper persuasion.

He equated the concept, and the execution, with the pre-surgery checklists that now are routine, but that once met with resistance. “It took checklist zealots to make it part of the system — someone to say we’re not going to move forward until we do it,” Leenay said. “And now everybody wants to do the checklist, because they want that 20 percent decrease in the co-morbidity rate.”

Ray Barfield, the Duke oncologist and Divinity professor, insists that improving communication about death is the best place to begin changing how Americans deal with it. He has begun lecturing to seminarians at Duke about the need to incorporate end-of-life counseling into their ministries.

“The biggest thing I see with all comers — kids, 40-year-olds, 80-year-olds, all comers — is that when we come up against our own mortality, we’re surprised,” he said. “Preparing for death is part of the patient’s —rights and responsibilities,” he added.

"When you combine the lack of preparedness with an absurd incentive plan for people to make money doing additional procedures motivated by our fear and that lack of preparedness, it's crazy."

And yet even the director of Duke's Institute for Care at the End of Life wouldn't dare suggest end-of-life care to his brother-in-law, even though, as a 79-year-old with moderate to advanced myeloma, diabetes, and heart disease, his prospects aren't good.

"My brother-in-law needs something like hospice now – but if I went to him now and said, 'Look, it's time to go to hospice,' he would say, 'You mean, you're telling me I'm dying?' He would get very depressed, and my sister worries . . . that he would give up. That it would push him into his grave."

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So let's say Dr. Payne and his brother-in-law had that discussion, and his brother-in-law decided he wasn't ready to give up on treatment — less than a year ago, after all, he was active in church and keeping a garden. He has a lot to live for. But he agreed he could use some level of palliative care, including home visits from nurses or the occasional doctor, pain management, and counseling about the care he wants at the end of life, whenever it might come. "He needs comprehensive health care — not just medical treatment, but someone asking him, 'What are your goals?'" Payne said. "You are 79. What do you see your future looking like? Do you have a living will? Nobody is talking to him about this."

Payne believes these questions are integral not only to hospice care, but to the physician's office, when the patient is far from death, yet not far from needing extra help at home to live comfortably and productively. If participants at the Roundtable agreed strongly on one course of action to pursue, it was this: Such a bridge, as it they called it, must be strengthened to provide appropriate services for patients in nursing homes or assisted-living facilities, or for patients who get long-term care at home. But Medicare often doesn't recognize a broad range of palliative care unless it is prescribed by a doctor in a hospital. And Medicare pays the bills.

"If you elect hospice, you can have that," said Ruth Hancock, a nurse who specialized in end-of-life care for more than 30 years before joining HCR ManorCare as director of palliative and chronic care. "But if you don't elect that, you're in a gray zone – there's nothing out there."

Peggy Pettit, the COO of VITAS, and others said they see a huge need among chronically ill people who are sent to the hospital when what they actually need is more options for care at home. "The doctor says come in, and the patient's caregiver says they can't get in, and the doctor says, so go to the ER," Pettit said. "What kind of system is that? It's insane. And . . . it's not cost-effective."

Although some organizations, such as VITAS in south Florida, are contracting with hospital systems to provide in-home follow-up and palliative care for discharged patients, such programs are limited. Bill Borne, a registered nurse and founder and CEO of Amedisys, which has some 35,000 home health patients and 3,000 hospice patients, said, "If we can outline and define this bridge, it would revolutionize the industry."

Ruth Hancock, Director of Palliative and Chronic Care for HCR ManorCare, summarizes small group recommendations for collaborative group action.

Kirsten Corazzini, Assistant Professor of Gerontology at the Duke University School of Nursing, said the lines between curative care and palliative care and hospice care look bright and clear in terms of what Medicare covers, but in real life they are blurred as patients with chronic or terminal illnesses course through a continuum. The Medicare reimbursement system needs flexibility "so your care needs are met regardless of whether you fit neatly into a bin," said Corazzini. Although end-of-life care is clearly a focus of the Roundtable, Payne and other participants believe the type of care those in hospice receive also must be available for those with chronic or advanced illness, including disabilities — people for whom *getting* better may not be an option, but for whom *living* better is. People like Claire Wimbush, the 2008 graduate from the Duke Divinity School who is soon to be ordained as an Episcopal priest.

When she addressed the Roundtable, she urged participants to seek for their patients not simply health, but “wholeness.” “Basically,” as she put it, “the ability to live a good and rich life in the midst of disability and illness.”

“Most people with disabilities I know value ingenuity and flexibility. We are used to devising offbeat strategies for moving through our days. We go to the doctor’s office and the home health care agencies when, for whatever reason, our usual strategies aren’t working,” she said. “What we want from you is a little sane and compassionate advice. . . . Here’s the bottom line: I don’t go to the doctor expecting you to solve all my problems. I go to the doctor hoping that you will help me function a little better. I don’t look for solutions; I look for tools.”

Wimbush is confined to a wheelchair, and cannot drive, dress herself, or get herself to the bathroom. She needs significant help, from bathing to fastening her clerical collar. “Most of all, I look for doctors and advisors who will treat me as a competent adult, not as just a ‘constellation of problems,’” she said. “My body is not a problem. My disability is not a problem. It is just a fact. When I walk into your office, please remember that.”

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The hospice industry loves to quote Don Taylor.

Taylor, a health economist and associate professor at Duke’s Sanford School of Public Policy, was lead author of that 2007 study in *Social Science & Medicine* that found hospice use cut Medicare expenditures by about $2,300 during the last year of life. It also found that the longer people used hospice, the more the government saved — as much as $7,000 for cancer patients who used hospice for 58 to 108 days, and $3,500 in savings for patients with other diseases who used hospice the same amount of time.

“Given the length of hospice use observed in the Medicare program,” the study concluded, “increasing the length of hospice use for 7 in 10 Medicare hospice users would increase savings.”

Powerful stuff for the PowerPoint, especially considering this statistic: About 25 percent of all Medicare dollars each year are spent on people in the last year of their life. So of the roughly $500 billion that Medicare will spend this year, some $125 billion will go to care for patients, mostly the frail elderly, who will die within a year.

That’s a huge percentage of resources going to a small percentage of Medicare recipients, Taylor said. “And that’s because everyone dies, and most everyone

“Since I left for college, I have moved through my days with the help of caregivers, usually professional home health aides, who meet me every few hours throughout the day. . . . The first few months I worked with caregivers, I tried to keep everything strictly professional. I was eighteen years old, and there were strangers helping me in the shower, and I was petrified. But a ‘strictly professional’ relationship is hard to maintain when someone is soaping between your toes. Gradually, I came to realize that my body is not my own property. It does not belong to me, or not solely to me. It belongs to the women who help me soap my toes. It belongs to the women who dress me, and brush my hair, and fasten my clerical collar. They know my body at least as intimately as I do. It is theirs to move. And, at the same time, their own bodies are not solely their own, either. I depend on my caregiver's physical strength; I quite literally borrow their bodies to do the things my own body can't manage.

“In return, I try to offer them what I have. I use my own body. I pay them a living wage. I listen a lot. Sometimes, in the midst of our daily stumbling along together, I catch a glimpse of God's Kingdom. Tina helps me wash myself. I buy heating patches for her sore back and bake brownies for her grandkids. Maybe this is what being the Body of Christ is, after all — this ordinary, unheroic caring for each other's needs. This giving and receiving of each other, body and all. If that's so, then it's something I would not have known if my own body had not needed so much help.”

Claire Wimbush, a 2008 graduate of the Duke Divinity School who is living with cerebral palsy, on the theology of disability. She will soon be ordained as an Episcopal priest.

is sick before they die, and we do lots of expensive stuff to try to keep that from happening."

Don Taylor, Duke assistant professor of Public Policy, steers conversation to the economics of change in the healthcare system.

Researchers, caregivers and home-health providers hoping to expand hospice and home-based palliative care believe that's key to the message they want to take to Washington. Health care costs already are rising more than twice as fast as inflation, and thanks to the advancing age of the Baby Boomers, the number of Medicare beneficiaries is expected to jump by nearly 50 percent over the next 10 years, to more than 62 million. Medicare expenses, meanwhile, will jump from $521 billion in 2010 to nearly $1-trillion in 2020. Policymakers desperately want to cut costs where they can.

"We have a compelling story to tell the world about . . . care at the end of life. There's a misconception that this is giving up care," said Fleming, the former family physician and the medical director at Amedisys. "End-of-life care makes patient-driven care the issue – it's focused on what the individual patient needs."

But as Taylor explains, there's a hitch: "That 'last year of life' is inherently a retrospective concept. You don't know when it started until in ends."

Taylor frequently speaks to Rotary clubs and the like, and he always shows a slide that he projected on the screen on the last day of the Roundtable. It was a L-shaped graph, with life expectancy up left side, and health care expenditures along the bottom. It was peppered with little circles representing nations, showing how their life expectancy compares to their per-person costs for health care. At the top was Japan, with a life expectancy of 82 years, and relatively low costs (even though the Japanese are heavy smokers). Mexico and other developing countries were clustered near the bottom, with low life expectancies and low expenditures.

And the United States? It stood off on its own, in the lower right quadrant, with the lowest life expectancy among Western nations but by far the highest expenditures, at about $7,000 per person per year.

When he shows the graph to civic groups, "their reaction is always, 'Yeah, well, ….. we've got the best health system in the world,'" Taylor said. "Well, maybe. But you certainly can't get it from this slide . . . . To me, the outlier is us. So what do we need to do to purchase value in the healthcare system?"

Is it to let go of the notion of American exceptionalism, as Dr. Mike Magee suggests? Change our lazy lifestyles and lousy eating habits, as Bill Borne proposed? Provide better health care to the poor earlier, so they don't need more critical care? Edward Skloot, director of the Center for Strategic Philanthropy and Civil Society at the Sanford School of Public Policy, said no discussion of health care is complete without considering those who don't have it. Jeff Moe, the executive-in-residence and adjunct associate professor in Health Sector Management at Duke's Fuqua School of Business, looked at Taylor's chart and complained that conclusions were being drawn that the data didn't support. And he declared the United States spends so much because good health care commands a high price irrespective of quality.

Taylor shrugged. "Maybe we just like health care."

"Maybe Americans just like to be fat," Moe countered.

"Maybe we have to decide what we want to spend money on."

Taylor said healthcare spending should either extend life, or improve patients' quality of care. That's pretty easy to accept. But "when you go and try to say which dollars are not doing that, that's when the blood hits the floor," he said.

Given the huge amounts we spend now on people who are close to death, many care providers at the Roundtable said it's time to start diverting chronically ill patients from the hospital, when possible, to more flexible care at home, where they could still pursue treatments. For those who don't get better, that makes an easier transition to hospice, which garners high marks from patients and families. "When you do it well, everybody walks away saying this was an incredible experience," said Michael J. Reed, vice-president and general manager of Heartland Home Health & Hospice.

Taylor and Dr. Amy Abernethy, director of the Duke Cancer Care Research Program, said chronic and end-of-life researchers and providers still lack hard, scientific data on the quality — not satisfaction — of the care they provide, and that absence makes it hard to drive policy decisions. Duke now is coordinating a major quality monitoring project with palliative care programs in North Carolina to collect information on symptom control, pain management, and other markers, and it has created the Palliative Care Database to track the findings. In a separate study, Taylor, Abernethy and colleagues are involving 600 cancer patients in a game-like decision-making project intended to inform Medicare on the type of care people with advanced cancer want in the last year of life.

"To make a compelling statement," Abernethy told the Roundtable, "we need data."

If end-of-life discussions are tough for patients and doctors or patients and families, the conversation can get downright ugly in the cauldron of current political debate. Despite support for hospice at the U.S. Capitol, two recent issues make end-of-life care advocates want to throw up their hands: Terri Schiavo, the brain-damaged Florida woman whose parents' attempt to stop her husband from removing her feeding tube became a major legal and public relations battle. And, more recently, the specter of "death panels" that clouded the debate over President Obama's health care plan.

The Death Panel charge grew from a provision in the bill that, for the first time, would have required Medicare to pay for an end-of-life counseling session between a patient and his or her doctor. Many chronic and end-of-life care providers saw it as an important, worthy step. But any opportunity to foster a dialogue about how we die was overwhelmed by the fear that government-sponsored panels would spring up to decide which patients would receive life-saving medical treatment and which would simply be allowed to die.

"The entire discussion around end of life was eliminated around that period," said Tom Koutsoumpas, vice president of ML Strategies, a Washington health care lobbyist who briefed the Roundtable on the political appetite for change.

He also worries the new law's provisions giving the government more power to chase Medicare fraud and abuse reach "a point well beyond reasonable and rational, to a point where it will become disruptive to healthcare providers," and inhibit innovation within the existing Medicare reimbursement structure.

But Koutsoumpas told the Roundtable he sees opportunity for participants to push end-of-life care reform in Washington, too. The health care bill Obama signed is probably only the beginning of legislative attempts to make health care more affordable, and the Death Panel charge or other distortions can be beaten through education. Getting that first bill out of the way "gives us an opportunity as innovators . . . to engage in process and really drive reform," he said.

But they need to find a way to craft their message so it doesn't appear as if people must choose between seeking a cure, or "giving up" and choosing hospice, he said.

"The way people have been talking about the message … (yields) two options: Give up on curative care and go to hospice, or palliative care," he said. "If the conversation is always about, 'How close are people to death? Now let's start saving money,' it's always going to fail."

> *"When it comes to defining the common good, people can never agree on that, because they have different political philosophies, and different positions in life. But I think what they can agree on is the face of injustice, when a healthcare worker or a patient isn't being treated humanely. It is easier to define the common good in its absence."*
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> **Stephen Post**, director of the Center for Medical Humanities, Compassionate Care, & Bioethics at Stony Brook University in New York.

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On the first night of the Roundtable, Dr. Mike Magee, editor of HealthCommentary.org and a senior fellow for policy at the Center for Aging Services Technologies, gave a well-received speech that argued it was a mistake to cut the home from the loop of health care, which now mainly runs between the doctor's office and the hospital. People need to get care at home, particularly those who are chronically ill, he said. "At home, people are awash in personal capital."

Amy Laura Hall, an assistant professor at the Duke Divinity School, found the term odd. "'Awash in personal capital?'" she said later. "The theologian would call it community. Or the faith community."

She added, "You have a corporate-academic split in the room. At this point, we're just trying to figure out how to communicate with each other."

"We're talking about the common good without a common language," Taylor said.

"Three decades of health information empowerment. Doctors, nurses, hospitals agree, 'The best patient is an educated patient.' Paternalism must give way to partnership. Teams over individuals. Mutual decision-making. All good. But health information is giving way to health activism, led mostly by informal family caregivers – family members, almost all third-generation women age 40 to 70 – managing frailty above and immaturity below – now laboring as both providers and consumers of care in nearly 25 percent of all American homes, without formal support or even acknowledgment. For them, it's not lack of information that's literally killing them, it's the lack of a system."

Dr. Mike Magee, a physician, editor of HealthCommentary.org, and senior fellow for policy at the Center for Aging Services Technologies. His mother died of ovarian cancer while caring for his father, who had Alzheimer's disease.

Language is, after all, more than an expression of ideas — it's an expression of values. By Day Three, during the final morning session before adjournment, Jim Robinson was ready to express his. "I listen to the debate, but I need to make it happen. Tomorrow," said Robinson, executive vice president of Amedisys Hospice Services.

The way he sees it, the Roundtable must take two parallel tracks that may or may not converge, the softer "values" side and the hard-edged cost side. He'll work on the cost side.

"I'm a doer. The real value to me is, Can I put it into action and how quickly?" Robinson told the group. "I'm going to the cost side, because that's what I can do."

"But how?" Payne asked him. "Even if you degrade care?"

Robinson hoped not, but said Medicare and rising health care costs require him to provide care "at the lowest price possible."

"You're coming to a fork in the road already," Borne, his boss, interjected. "At some point you're going to have to address costs with a blunt dissection, and 'quality' is going to be what it is. And you're not talking about a surgical dissection."

The room went quiet for a moment. "Quality is going to be what it is" is not exactly a rallying cry. Yet without some changes, it would also come true. Andy Burness, a nationally known healthcare communications consultant hired to serve as moderator, stood up at the front of the room.

"Consensus?" he asked, hopefully.

"No," said Moe, of the Fuqua School of Business. "Striving for consensus soon is dangerous," because it could quash the diversity of opinions – one of the Roundtable's greatest strengths. "It's very apparent what's been put on the table here, and I think it needs time to form. . . . I think the bias towards action is showing.

"Maybe before we try to get action," Moe added, "we should decide what we want to talk about first."

Borne and some of the other business leaders looked surprised. They'd been talking for three days. He noted how they had all been to conferences where participants discussed big ideas, then did nothing.

Payne stood up. "We hear you, about how we don't want this to be a think tank," he said. "This is always the tension, about what you *do.* But what you do is not going to be effective if you don't think through it . . . We're trying to navigate that tension."

The digital clock on the wall blinked toward noon. The first Roundtable was over. People had planes to catch. But before they left, members agreed on two things: First, they would all come back for the next session in October, which will focus on technology. And second, that the next session should be longer.

Each of the semi-annual New Directions Roundtable meetings is
thematically organized to address complex issues and multiple dimensions of
caring for people with advanced illness.

May 17-19, 2010	The Common Good
October 25-27, 2010	Technology
May 16-18, 2011	Communication
October 19-21, 2011	Leadership
May 21-23, 2012	Quality Care
October 17-19, 2012	Public Policy