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Medical Home NEWS

Better Care for the Over-Serviced: Lessons from an Ambulatory ICU

By Paul E. Johnson, MD

The U.S. health care system is plagued by many paradoxes. Among them is that of the medical super-user -- the challenging patient who cycles in and out of the hospital, receives an inordinate amount of service, but fails to get his needs met. Every care system struggles with such patients. Beginning in the summer of 2010, Hennepin County Medical Center, a public teaching hospital in Minneapolis, undertook an ambitious effort to redesign care for its most over-serviced populations.

This effort would have never seen the light of day if not for the Minnesota experiment known as CCDS (Coordinated Care Delivery System). In early 2010, then-Governor Tim Pawlenty ended funding for Minnesota's General Assistance Medical Care (GAMC) program. For over a decade, GAMC had provided health insurance for 40,000 very low-income adults without dependents. In place of the GAMC program came CCDS. Instead of fee-for-service payments, the hospital received a block grant to cover care. HCMC was one of four care systems that stepped forward to provide essential medical services to former GAMC recipients.

The funding change was as draconian in degree as it was dramatic in approach. HCMC was expected to provide care that had generated $90 million in annual billing for a mere $30 million. The GAMC program, always a poor payer, had been transformed into a loss leader of eye-opening proportions. Moreover, the financial incentives in care delivery were turned on their head. The CCDS was no longer paid more to do more. It was instead paid a global fee. This change led HCMC to identify and manage high-cost patients in a different way.

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Comparing Apples and Oranges:

How Healthcare Can Move beyond Optimizing Subpopulations of Patients in Order to Provide Uniformly Good Care

By Andrew Braunstein

Healthcare is a sophisticated industry in its use of analytics to manage risks and costs from the financial/insurer/actuarial perspective. At the same time, it is one of the least sophisticated industries when it comes to making use of analytics to maximize clinical outcomes. While providers do care about patient quality, the healthcare *system* is not optimized to providing the best long-term care.

Many aspects of what I say have been true for *many* parts of our healthcare system. People will argue this is not true, but ours is the most expensive in the world with below average results across most measures.

Many of you are focused on addressing this value gap. Despite recent efforts, we are still in the infancy of using measures to drive patient care. Population measures are but a first step, similar to what we have done in measuring education across schools, districts, and states. High-level education measures are useful, but cannot replace the individual tests/quizzes we use to educate a single student.

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Editor's Corner

Raymond Carter
Senior Editor, *Medical Home News*

We continue with our op-eds and brief reports from the field this month with a commentary from Dr. Bonnie Jortberg and Dr. Michael Fleming on RDNs and the medical home team.

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Registered Dietitian Nutritionists Bring Value to Emerging Health Care Delivery Models

Health care in the United States is the most expensive in the world; however, most citizens do not receive quality care that is comprehensive and coordinated. To address this gap, the Institute for Healthcare Improvement developed the Triple Aim (improving population health, improving the patient experience, and reducing costs), which has been adopted by Patient-Centered Medical Homes (PCMHs) and Accountable Care Organizations (ACOs). The PCMH and other population health models focus on improving the care for all persons, particularly those with multiple morbidities.

These new healthcare models of care and delivery emphasize the key role of the multidisciplinary team in meeting the challenge of caring for these persons. The looming shortage of primary care physicians shines the spotlight on the other members of this team, and suggests the notion of effectively expanding the new model team to include other health care professionals such as Registered Dietitian Nutritionist (RDNs). RDNs bring value to this multidisciplinary team by providing care coordination, evidence-based care and quality improvement leadership. RDNs have demonstrated efficacy for improvements in outcomes for patients with a wide variety of medical conditions.[1]

Primary care physicians report seeing the benefit of including RDNs as part of their health care teams, and studies have shown that physicians believe that nutrition is important for the care of their patients.[2] Results from several PCMH and population health demonstration projects, including results from the Pennsylvania Chronic Care Initiative, Canada's Family Health Teams, Vermont's Blueprint for Health, and Community Care of North Carolina, have reported the benefits of RDNs as part of the integrated primary care team.

PCMH primary care practices are not truly offering comprehensive care unless their healthcare team includes a RDN. While in the past there have been challenges to integrating RDNs into primary care, most notably an insufficient reimbursement model to sustain RDN services, newer innovative payment models provide the opportunity to overcome this barrier.

Role of the Registered Dietitian Nutritionist

RDNs bring value to the PCMH team beyond MNT services. RDNs have the knowledge, skills and training to contribute to person-centered care in many ways, including but not limited to the following:

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Medicare Chronic Care Reimbursement

By Rick L. Hindmand and Marc I. Goldsand

The U.S. Department of Health and Human Services (HHS) has recently identified as a significant problem that many individuals, especially the elderly, suffer from multiple chronic conditions.[1] Indeed, among Americans aged 65 years and older, studies indicate that 2/3 to 3/4 of people have multiple chronic conditions.[2] In that regard HHS supports a variety of programs to not only prevent the onset of multiple chronic conditions, but also to manage and coordinate the treatment for such conditions.[3]

In January 2015, Medicare began paying physicians, nurse practitioners, physician assistants, clinical nurse specialists, and certified nurse midwives a monthly fee to coordinate care for Medicare beneficiaries who have multiple chronic conditions. This expands Medicare payment policy to compensate for non-face-to-face management services that previously did not qualify for reimbursement.

The 2015 Medicare Physician Fee Schedule (MPFS) Final Rule recognizes a new CPT code (99490) for chronic care management (CCM) and establishes an average national payment amount of approximately $42 per month. CCM is designed to encourage greater contact and communication through a provider undertaking to be the "quarterback" of a multiple chronic condition patient's care team.

The Centers for Medicare & Medicaid Services (CMS) has established standards for beneficiary eligibility and consent, scope of service, minimum CCM service time (20 minutes per month), electronic health records (EHR), and electronic documentation of the plan of care. These standards are summarized below.

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Beneficiary Eligibility

In order to be eligible for CCM services, a beneficiary must have at least two chronic conditions that (a) are expected to last at least 12 months or until death, and (b) create significant risk of death, acute exacerbation/decompensation, or functional decline. CMS has acknowledged 27 diagnosed "chronic condition categories" in its Chronic Conditions Data Warehouse.[4] Though the CCM policies do not adopt the Conditions Data Warehouse for guidance on specific diagnoses qualifying as chronic conditions, it would seem reasonable to rely on the list as a starting point, recognizing that some conditions not in the Conditions Data Warehouse may still qualify.

Only a single CCM payment is allowed for services to a particular beneficiary, so if multiple providers submit claims for CCM, only one of the providers (typically the first to file) would be paid. To avoid duplicate payment, CCM billing is not allowed for patients receiving reimbursement for transitional care management or other overlapping management services.

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Scope of Services: The Five Required Service Elements

A provider must establish and implement a process covering the following five elements of enhanced care to qualify for CCM reimbursement:

1. *Enhanced Access and Communication*. The provider must grant the patient and caregiver (a) access to healthcare providers in the practice on a 24/7 basis to address acute chronic care needs on a timely basis, and (b) enhanced opportunities to communicate by telephone as well as secure messaging, Internet, or other asynchronous non-face-to-face methods.
2. *Continuity of Care*. The provider must give continuity of care with a designated practitioner or member of the care team for successive routine appointments.
3. *Chronic Condition Management*. The provider must manage care for chronic conditions, including (a) systematic assessment of the patient's medical, functional, and psychological needs, (b) system-based approaches to ensure timely receipt of recommended preventive care services, (c) medication reconciliation, (d) oversight of medication self-management, and (e) development and updating (in consultation with the patient, caregiver, and other practitioners) of a written, patient-centered plan of care for all of the beneficiary's health issues.
4. Coordinating Care Transitions. The provider must manage "care transitions," including (a) referrals to healthcare professionals, (b) visits following emergency department visits and discharges from hospitals and skilled nursing facilities, (c) communications through electronic exchange of a summary care record regarding the transitions, and (d) availability of qualified personnel to deliver timely transitional care.
5. *Quarterbacking the Care Team*. The provider must coordinate care between home and community based clinical service providers to support the patient's psychosocial needs and functional deficits, with the communications documented in the EHR.

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Medicare Begins Paying for Chronic Care Management…*continued from page 3*

20 Minute Minimum Per Month

In an attempt to quantify what qualifies as enhanced patient contact, CMS is requiring that clinicians (or their clinical staff, under their supervision) provide at least 20 minutes of CCM services within the five required service elements for the beneficiary each month. CMS loosened the Medicare "incident to" supervision requirement to allow general supervision for CCM (rather than the more stringent direct supervision standard in place for most incident to services), so that services of clinical staff members can be counted toward the 20 minute minimum even if the practitioner is not present.

Beneficiary Consent

Prior to billing for CCM services, the practitioner must (1) furnish an annual wellness visit, initial preventive exam or comprehensive evaluation and management (E/M) visit and initiate the CCM service as part of that exam or visit; (2) inform the beneficiary about the CCM services and the beneficiary's responsibility to pay coinsurance (approximately $8 per month); (3) discuss the services with the beneficiary; (4) obtain the beneficiary's written consent; and (5) provide to the beneficiary a written or electronic copy of the care plan.

Beneficiaries may revoke their consent at any time, either verbally or in writing, in which case the provider is required to record the revocation date in the beneficiary's EHR and furnish the beneficiary with written confirmation that the practitioner will stop providing CCM services after the current month. At the time of consent, the practitioner is required to inform the beneficiary of the right to stop CCM services at any time and the effect of revocation.[5]

EHR and Electronic Care Plan

The provider must use certified EHR technology to document beneficiary consent, presentation of the plan of care to beneficiary, communication with home and community providers, as well as demographics, problems, medications, medication allergies, and clinical summary records. In addition, the provider must furnish an electronic care plan accessible to all providers within the practice who furnish CCM services counting toward the monthly 20 minute minimum, as well as to care team members outside the practice.

Indeed, the CCM revenue for a medical practice (or even a single physician) can potentially be substantial. For example, a primary care physician with one thousand qualifying patients could potentially receive approximately $40,000 per month for CCM services.

CCM Revenue Potential

The CCM policies provide new opportunities for medical practices to furnish coordinated care while finding new sources of revenue. In many practices a substantial majority of the Medicare patients may be suffering from multiple chronic conditions and therefore potentially eligible for CCM services.

Physicians in practice settings that are conducive to the CCM model may find that with careful structuring CCM can potentially improve the health of their patients as well as the bottom line. Indeed, the CCM revenue for a medical practice (or even a single physician) can potentially be substantial. For example, a primary care physician with one thousand qualifying patients could potentially receive approximately $40,000 per month for CCM services.

Compliance Challenges

The potential revenue needs to be weighed against compliance challenges facing providers who bill for CCM services, which are likely to generate close scrutiny and a corresponding need to implement effective systems to address a morass of compliance concerns. Practitioners should be mindful of the potential for second-guessing from government auditors and qui tam whistleblowers if documentation fails to clearly show satisfaction of all required standards every month for which CCM claims are filed.

To protect themselves, physicians and other providers who desire to bill for CCM services need to invest in technology, training, and related infrastructure capable of both offering the enhanced services and documenting them. Providing CCM services will require advance planning and investment, so it is important to allow sufficient lead time to engage and train appropriate personnel, develop infrastructure, implement policies and procedures, identify eligible beneficiaries, and take other steps to provide effective and compliant CCM services.

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[1] http://www.hhs.gov/ash/initiatives/mcc/.

[2] Id.; http://www.nejm.org/doi/full/10.1056/NEJMp1410790 .

[3] Id.

[4] See https://www.ccwdata.org/web/guest/condition-categories .

[5] These communications must be documented in the EHR.

Comparing Apples and Oranges…*continued from page 1*

Unlike education where all the students are measured across their learning for uniforms subjects, every patient's healthcare issues are different. Many real-world systems have been created to allow us to compare non-uniform and differing subjects.

If I go to the movies, I can look up a rating on Rotten Tomatoes (RT). RT is a service that aggregates and averages the reviews of multiple professional reviewers and then generates a rating of 0 to 100 for each movie. Even though Blockbusters, Documentaries, Cartoons, Foreign Films and Romantic Comedies are completely different, the RT methodology allows us to compare them in a uniform manner. The Academy Awards mix them together when awarding a best picture.

Healthcare has spent a fair amount of effort segmenting and measuring populations of patients with *like* conditions. We have measures that look at our Diabetes (DM) patients and our Heart Failure (HF) patients. We typically use a subset of patients in looking at measures -- i.e., if a patient has DM, they are included in the DM measures, and if they don't they are excluded. This is the equivalent of rating the movies only within its subcategory. While this is useful, there is substantial value to looking across entire populations to identify gaps and overlaps.

An important aspect of such a measurement system is the ability to identify not just how sick a patient is, but how well one is doing against *ideal* standards of care. Why focus on care gaps versus acuity? Knowing that a patient is sick tells us that they may need more care than someone else, but does not tell us if they are getting the right care. Let's use Hospice patients as an example. They obviously are very sick or they would not be in Hospice.

An important aspect of such a measurement system is the ability to identify not just how sick a patient is, but how well one is doing against ideal standards of care. Why focus on care gaps versus acuity? Knowing that a patient is sick tells us that they may need more care than someone else, but does not tell us if they are getting the right care.

We can't easily distinguish between patients within this class just by looking at their acuity. However, not all the patients within this population may be getting the *care* they need. There are approximately 21 consensus based clinical measures that apply to the Hospice subpopulation. Instead of focusing on the acuity, we can instead focus on which measures apply to each of these patients. Of the 21 measures for quality care, Patient A may have 6 that apply, and Patient B has 12 -- due to different ages, disease states, etc.

Once we know how many standards apply to each patient, we can figure out how many of the standards have been met. Let's say Patient A met 3 standards and Patient B met 6 standards of care. Patient A has complied with 3 of 6 measures, for an average of 50%. Let's call this measure a *Care Index*. Patient B, who has twice as many measures of care, also has a *Care Index* of 50%, meeting of 12. Although they may be completely different in all aspects of why they are in Hospice and what their issues are, we can still compare them.

Now make this situation more complicated by saying that Patient B also has Diabetes, and let's say that adds an additional 12 measures – all of which are complied with -- leading to an overall *Care Index* of 75% (18 out of 24). Overall, Patient B may have a disease than Patient A, but we can still compare the two. Although Patient B has more measures that apply (24), overall we could say that Patient B is getting better care than Patient A. Patient B achieved a *Care Index* of 75% while Patient A achieved only 50% of the recommended best practices.

By looking at how far a patient is from the ideal care, and not by looking at how their health is, we can identify gaps in how we are providing care. We can look across the continuum and take an overall Patient Centered Medical Home (PCMH) measure, or we can break it by care areas and see how a patient is cared for within settings or specialties.

By looking at how far a patient is from the ideal care, and not by looking at how their health is, we can identify gaps in how we are providing care. We can look across the continuum and take an overall Patient Centered Medical Home (PCMH) measure, or we can break it by care areas and see how a patient is cared for within settings or specialties. Using such a system to identify gaps in known care standards could have identified the issues within the VA system much earlier than we did.

Using compliance with evidence-based standards of care helps us separate needed care from actual care. We can project a plan of care, even if there are no orders for visits or procedures. It would have been clear that many patients were not meeting the standards of care for their particular issues.

By aggregating the average *Care Index* for the patients in Phoenix, and comparing them to other VA sites, we could have seen that the patients in Phoenix were getting a lower level of *evidence-based care*. Unless we fake the medical record, there is no way to skew the analysis. It does not matter if we put the visits in the schedule, or that people were being rewarded for productivity. Objective clinical measures shift the discussion from what could to what should -- which is a pure patient focus.

By plotting these patient measures over time, we can truly identify improvements or declines in overall care. The Veterans Affairs Department in DC could have a simple dashboard and quickly see trends and compare processes across sites. With a single integrated record, identifying what isn't being done is a straight-forward process.

The key to doing this is a robust set of measurements that can be applied across a diverse set of patients. We are fortunate to have a group such as the National Quality Forum (NQF). They collect, analyze, and seek endorsement for measures that cover almost the entire population. There are close to 700 active measures that cover almost 100 different conditions -- from preventative care through chronic care, and even emergency conditions. Once there is a large enough set of measures, this comparative technique becomes fairly accurate.

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Comparing Apples and Oranges *...continued from page 5*

Today, the clinical measures for an ACO treating a diabetic patient is a single measure of A1c being less than 9.0. If you were to sweep the standards for all the measures that can be computed by looking at a diabetic's chart data, you would find more than a dozen such measures. Applying more measures allows us to identify key pieces of missing care (gaps), and maximize the odds that the patient gets the care they need.

So, unlike other industries, more is better. Thousands of measures is more helpful than hundreds. The more specific they are, the better. Bring them on.

Now if we could just standardize how the data for these measures was recorded within a given EMR ...

Andrew Braunstein is CEO and Co-Founder of ClinLogica, pioneering identification of gaps/risks in care across the entire continuum, independent of disease states. ClinLogica also uses this information to drive oversight of the care process especially in large complex medical organizations. Braunstein can be reached at braunstein@clinlogica.com.

Better Care for the Over-Serviced *...continued from page 1*

Root Causes of Over-Service

Every health care system has over-serviced, high-cost patients. In the GAMC population at HCMC*, about three percent of patients generated 50 percent of total program charges.* Notably, diseases with high-tech solutions did not drive cost in this population. Rather, common chronic medical problems -- diabetes, COPD, congestive heart failure, cirrhosis -- were at the root of excessive care and cost. Social and behavioral determinants of health jointly conspired to transform these problems from routine to insoluble. Traditional ambulatory models of care provided, at best, an ineffective response. For these individuals, inpatient care, an expensive and inappropriate Band-Aid, was often the only option.

Anecdotes give clues about the root causes for over-service:

- A man with type 1 diabetes, experiencing homelessness, and caring for his disabled brother, had ongoing struggles with glucose control. The onset of a Minnesota winter led him to skip insulin, and he had nine inpatient admissions in 10 weeks. While the one brother was hospitalized, the other took temporary shelter with him in his hospital room. A successful housing placement brought stability for both.
- A frail, middle-aged man with COPD and rheumatoid arthritis was admitted nearly 80 times in eight years for a variety of cardiopulmonary complaints. Unrecognized substance use led to repeated medical destabilization in a wide variety of ways. Treatment of his addiction led to near total cessation of inpatient care.

Notably, diseases with high-tech solutions did not drive cost in this population. Rather, common chronic medical problems -- diabetes, COPD, congestive heart failure, cirrhosis -- were at the root of excessive care and cost.

Homelessness, mental illness, and addiction, especially when coupled with cognitive impairment, chronic pain, medical non-adherence, and lack of community support, drive patient over-use, ineffective care, and high costs. Identifying and addressing such drivers and proposing and implementing solutions are just not in the medical toolbox. A new model of care is needed.

Re-Engineering Outpatient Care

HCMC re-engineered its outpatient model toward intensive, multidisciplinary, team-based care. Non-physician professionals, including social workers, chemical health counselors, nurse practitioners, RN care coordinators, pharmacists, and mental health specialists, teamed with primary care providers in an integrated outpatient setting. A new clinic, called the Coordinated Care Center (CCC), opened in late-summer 2010.

HCMC re-engineered its outpatient model toward intensive, multidisciplinary, team-based care. Non-physician professionals, including social workers, chemical health counselors, nurse practitioners, RN care coordinators, pharmacists, and mental health specialists, teamed with primary care providers in an integrated outpatient setting.

This new endeavor experienced multiple challenges. Because medical super-users had experienced ineffective care under standard clinical models, building their engagement and trust was difficult. Previously, patients struggled to keep appointments. When they did come, they were often referred to other sites for mental health, chemical dependency, or social services. The CCC was a different experience. Clinic services were designed around patient multi-disciplinary needs. Many times a patient would come for a medical appointment, but depart having seen a pharmacist, a social worker, and a psychologist, as well. The clinic has the flexibility to accommodate walk-in visits from patients, offering them multi-disciplinary, team-based care, too. To the surprise of some, this historically disenfranchised group of people has been able to engage in clinic-based care. Close work relationships with clinic staff, access, and a proper blend of service have been key.

Critical to the success of the CCC has been the creation and growth of the new multi-disciplinary team. This has not been without challenges, as various professional cultures have been blended into a new paradigm. Care teams meet twice a week for formal care planning sessions about patients in crisis. Team members collaborate in daily pre-visit planning and frequent impromptu patient-centered discussions. Team members are uniformly challenged by the complex reality of patient problems, but they find it rewarding to treat such complexity.

Return on Investment

As the CCC experience seemed to resonate with patients as well as providers, HCMC conducted a review of the utilization experience of the clinic.

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The initial small sample showed striking progress in reducing over-service. Inpatient admissions were reduced by 45 percent, and emergency department visits decreased almost 40 percent. Ambulatory care contacts increased by nearly eight-fold (mostly in the CCC). Further study of a larger panel over a longer time frame has reinforced early findings and shown related cost savings.

	Pre-CCC year (thousands)	In CCC year (thousands)	Change
Inpatient/observation	$ 13,450	$ 9,454	↓30%
ER	$ 890	$ 570	↓36%
Outpatient	$ 790	$ 1,360	↑72%
Ambulance	$ 560	$ 320	↓43%
Total	$ 16,030	$ 12,370	↓23%
Annualized per patient savings	$ 105	$ 81	↓$24,000

This degree of savings is only possible in the context of extreme over-service and can only happen with upfront investment and effort. Total CCC outpatient costs average around $500 per patient, per month. There is, however, an overall (total cost of care) savings of $2,000 per month.

Patients love the new system. Contact is frequent. Caregivers are familiar. Patient satisfaction scores are off the scale. Many patients are connected for the first time to an effective care system and feel empowered about their health. Finally, a team can address their complex issues. People can get the service they actually need. Given the cost savings, the CCC is a striking solution to the health care value equation.

Although the CCDS funding formula ended in spring 2011, HCMC continues to enroll high-risk, high-cost patients in the new clinic. Additional staff has been added to expand the reach of this innovative approach to care. The clinic now cares for a selected group of more than 300 high-need patients.

The clinic population has grown, enrolling patients with insurance other than that of the original CCDS (total cost of care reimbursement), even when the business case is lacking. In the current, largely fee-for-service reimbursement environment, the savings ($24,000 per patient per year) largely accrue to the insurer. However, HCMC continues to invest in the model, wagering that this novel approach to care will pay dividends in the future.

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Registered Dietitian Nutritionists Bring Value…*continued from page 2*

- Provide medical management, patient self-management support, and care management services
- Manage disease prevention services and outreach to the practice's patient population
- Participate in and lead continuous quality improvement efforts within the primary care practice
- Measure and report on quality and effectiveness

Call to Action and Next Steps?

It is imperative that physicians, administrators, payers, and other stakeholders in PCMHs and ACOs fully recognize and embrace the value RDNs bring to new health care delivery and payment models and integrate them into the care team. The Academy of Nutrition and Dietetics' white paper, "Registered Dietitians Nutritionists Bring Value to Emerging Health Care Delivery Models", issues a call to action for doing so. Specifically, stakeholders should work collaboratively on the following fronts to create a health care culture that recognizes the value of RDNs and the role of nutrition in person-centered care:

1) **Advocacy**: impact federal, state, and local laws and regulations to support inclusion of and payment for RDN-provided services in the PCMH/population health management models of care.
2) **Positioning**: Demonstrate the value of RDN participation in the PCMH/population health management models as the team member to optimize health through food and nutrition.
3) **Collaboration**: Leverage existing and new partnerships to demonstrate the value of RDN participation in the PCMH/population health management models.

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Thought Leaders' Corner

Each month, *Medical Home News* asks a panel of industry experts to discuss a topic of interest to the medical home community. To suggest a topic, write to Editor@MedicalHomeNews.com.

Q. What area is most in need of further research when it comes to patient-centered medical home implementation?

"Evaluating the impact of behavioral change is hard, but future research on the PCMH must overcome the difficulty. *The New York Times Magazine* of May 2, 2010, published an article entitled 'The Data-Driven Life,' which asked this question: 'Technology has made it feasible not only to measure our most basic habits but also to evaluate them. Does measuring what we eat or how much we sleep or how often we do the dishes change how we think about ourselves?' Further, the article asked, 'What happens when technology can calculate and analyze every quotidian thing that happened to you today?'

Technology must never blind us to the human. Bioethicist Onora O'Neill commented about our technological obsession with measuring things. She echoes the Einstein dictum that not everything that is counted counts. She said, 'In theory again the new culture of accountability and audit makes professionals and institutions more accountable for good performance. This is manifest in the rhetoric of improvement and rising standards, of efficiency gains and best practices, of respect for patients and pupils and employees. But beneath this admirable rhetoric the real focus is on performance indicators chosen for ease of measurement and control rather than because they measure accurately what the quality of performance is.'

The research required for PCMH will be on things hard to define and harder to measure, but that is where the research must focus."

James (Larry) Holly, MD
CEO
Southeast Texas Medical Associates (SETMA)
Beaumont, TX

"There are many areas where we have much to learn about regarding the delivery of truly comprehensive primary care to a population in a patient-centered fashion.

I would focus on determining how we can most effectively get patients to change their health-related behaviors. So many of the needed elements -– whether it is wellness or chronic disease care -- are dependent on patients making meaningfully different choices on a daily basis for long periods of time. Unless we can figure out how to help them do this, we will not be successful in creating health."

Thomas Graf, MD
Chief Medical Officer for Population Health and Longitudinal Care Service Lines
Geisinger Health System
Danville, PA

"Does strategic proactive care improve outcomes and by how much? Having population metrics for prevention and chronic illness management allows a provider to reach out and get patients into care they may not seek on their own initiative.

Anecdotally, this has improved population outcomes, but more rigorous research is needed to mandate this as the new standard of care."

Joseph E. Scherger, MD, MPH
Vice President, Primary Care
Marie E. Pinizzotto, MD Chair of Academic Affairs
Eisenhower Medical Center
Annenberg Center for Health Sciences
Rancho Mirage, CA

Thought Leaders' Corner

"Care Coordination. From my perspective, in pediatrics, it is demonstrating once and for all the value of patient and family-centered, team-based, care coordination. This should be shown using clinical and functional outcomes, consumer engagement outcomes, and family/system costs outcomes. Care coordination research should also measure professional satisfaction, exploring the relationship of professional contributions to effective care coordination longevity in professional positions.

Current efforts in Indiana with families whose children may have neurodevelopmental and behavioral conditions show that it takes months, if not longer, to obtain a skilled evaluation and diagnosis. Time allowed during such evaluations leaves families with a complex, hard to comprehend diagnosis(s) and an uncertain future. The joint creation of clear next steps as a function of care coordination can help them to understand a diagnosis and to see their child in the context of strengths as well as developmental needs. Guidance for how to obtain access and eligibility to recommended interventions and treatment is sorely needed, as is help to understand and fully benefit from complicated recommendations.

Our complex systems of health, education, and resource interventions are not cleverly designed to help the parents, grandparents, and other caregivers involved gain the increasingly evident need for early access to services warranted. We know that care coordination makes a difference, holding real value, but degrees of significance must be shown. "

Jeanne W. McAllister, BSN, MS, MHA
Associate Research Professor of Pediatrics
Indiana University School of Medicine
Indiana Children's Health Services Research
Indianapolis, IN

"We have so many questions to answer about medical home implementation. My top three are:

1. What kind of practice facilitation (also known as coaching) and learning communities are most helpful to different types of practices as they undertake transformation?
2. What approaches to risk-stratified care management are most effective at identifying high-risk patients, providing them with the care management they need, and ultimately improving health and reducing costs?
3. How can practices effectively incorporate patient feedback to improve care?"

Deborah Peikes, PhD, MPA
Senior Fellow
Mathematica Policy Research
Princeton, NJ

"There needs to be more rigorous research into understanding patient risk, including predictive analytics and patient engagement, as well as the cost-benefits of specific interventions for the patient-centered medical home care models. Medical group practices need to know which patients to target, and how best to stratify the interventions to achieve overall higher quality and lower costs.

There is also a need for further research into the coordination of care for patients with specialty needs, the impact of the Patient-Centered Medical Home on racially and ethnically diverse populations, and the specific roles for expanded care team members. Finally, the payment models need more testing to assure that sustainable, successful practice changes are incentivized."

Jerry Penso, MD, MBA
Chief Medical and Quality Officer
American Medical Group Association
Alexandria, VA

Thought Leaders' Corner

"There is still much research that needs to be done to determine which features of the PCMH result in the best outcomes for the best value. Physicians continue to struggle with implementation costs and how to sustain the model in the current fee-for-service payment environment. Researchers must examine which elements of the medical home are most cost effective for practices to implement that put them on the road to achieving the triple aim. This would allow practices to invest their transformation dollars in a manner that delivers the most bang for the buck while not threatening the sustainability of their business. Physicians need solid data that shows where they can expect the highest return on investment for their efforts. Absent such proof, we risk losing PCMH momentum that has the potential to change the way care is delivered and how the primary care workforce is compensated for achieving better care, better outcomes, and better value for the patients they serve. As we identify the components that result in the best value and the best outcomes, we need to create a simpler, more streamlined mechanism for certification that truly exemplifies the PCMH."

Robert Wergin, MD
President
American Academy of Family Physicians
Leawood, KS

"We need better methods and measures of patient experience. We need to be sure that the medical home is delivering on its promise to be patient-centered, and improving patient and family experience is critical to achieving better outcomes at lower costs. But our current instruments are not widely used, and often don't do the best job measuring essential concepts like care coordination."

Christine Bechtel
President, Bechtel Health Advisory Group
Former Vice President and Current Advisor, National Partnership for Women and Families
Washington, DC

"While research continues to help us regarding how to build a better mousetrap, I believe we need more research on which mice are best served by the PCMH. Instead of a one-size-fits-all approach to all patients with all needs, data from the Pennsylvania Chronic Care Initiative suggests that the special resources of the medical home may be better suited for only some health care consumers. That's especially true when cost-savings have to be demonstrated within a fiscal year. Is there a 'market segment' of chronic illness 'customers' who are most likely to have a 'return on investment' within a 12 month window? If so, where are they?"

Jaan E. Sidorov, MD, FACP
Chief Medical Officer, medSolis
Author, Disease Management Care Blog
Harrisburg, PA

"There is much about the PCMH for which we still need more evidence, such as which features are most impact outcomes. We know, for example, that expanding hours of access to care on weekends and in the evenings keeps patients from using the emergency room unnecessarily. However we don't know which aspects of the PCMH most impact quality of care, population health outcomes, and even cost control. We have strong suspicions, but we need more empirical evidence. Much of this work is being done now in the Comprehensive Primary Care Initiative (CPCI) and the Multipayer Advanced Primary Care demonstration (MAPCP). Finally, we need evidence around the ways in which patient, family, and caregiver input into the quality improvement process can impact the Triple Aim. As we learn more about what most impacts outcomes, we can streamline and simplify the certification process, helping practices, payers, and ultimately patients and their families."

Marci Joy Nielsen, PhD, MPH
Chief Executive Officer
Patient-Centered Primary Care Collaborative (PCPCC)
Washington, DC

Industry News

CMS Seeks Input on Advanced Primary Care Initiative

CMS recently released an RFI seeking broad stakeholder input on initiatives to test innovations in advanced primary care, particularly around more comprehensiveness in primary care delivery, care for complex patients, the medical neighborhood and community-based services, and movement to value-driven rather than encounter-based reimbursement. Comments are due by March 16.

New PCPCC Evidence Report Touts PCMH Success

The Patient-Centered Primary Care Collaborative (PCPCC) has released its third Milbank-funded PCMH evidence report. The publication includes an aggregation of PCMH outcomes from a combination of 28 peer-reviewed studies, state government program evaluations, and industry reports. Seventeen of the 28 studies reported reductions in cost, and 27 reported improvement in utilization (not all studied both). All of the reports can be found on the Primary Care Innovations and PCMH Map of the PCPCC web site at http://www.pcpcc.org/initiatives.

Lessons in Consumer Engagement from Lowe's

In a *Health Affairs* Blog Lowe's describes valuable lessons about trust and individualization from its early, failed disease management program. The authors note that "real engagement begins with a relationship built on a foundation of trust over time. To gain the confidence of consumers, you must make the experience about them — not you."

Medical Homes and Chronically Ill Patients

A new analysis of PMPM costs among HMO patients found that after accounting for differences at baseline, PCMH practices achieved lower total, inpatient, and specialist costs, as well as lower relative utilization of hospital admissions and specialist visits, vs. non-PCMH practices.

Understanding the Patient-Centered Medical Home

HealthIT Analytics has begun a new series looking at PCMH basics and later more complex best-in-class models.

Registered Dietitian Nutritionists Bring Value …*continued from page 7*

4) **Development**: Incorporate into entry-level and continuing education for all health care professionals the training and skills development needed to provide team-based care that includes RDNs.

The overall health of our population depends upon the health care community providing coordinated and comprehensive care that focuses on the needs of the individual. RDNs are uniquely experienced and positioned to be one of the critical healthcare professionals in our U.S. healthcare model of today and the future. Building on the efforts of the Academy and RDNs, decision-makers within health care delivery and payment, both in the public and private sectors, must create policies and systems that recognize the contributions of RDNs toward achieving the Triple Aim.

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Catching up with … …*continued from page 12*

Medical Home News: *Our Thought Leader question for January asked experts what they thought the biggest challenge was for the medical home movement in 2015. What's your take?*

Rushika Fernandopulle: I think we need to raise the bar on how we define Medical Home. I have seen too many practices hire consultants to certify themselves as Medical Homes, but without changing anything about how they actually practice. It may be an obvious statement, but if you don't change anything, it's hard to expect improved results. We need to go beyond the simple structural criteria and focus on what I think is more important -- which is getting the culture right.

Medical Home News: *Finally, tell us something about yourself that few people would know.*

Rushika Fernandopulle: I love traveling and have had the fortune to visit all 50 states, and over 50 countries on six continents. My oldest daughter and I have a goal to get to all seven continents before she goes off to college, which is in two years, so we are plotting how to get to Antarctica soon!

Catching Up With ... Rushika Fernandopulle, MD, MPP

Dr. Rushika Fernandopulle is the Founder and Chief Executive Officer of Iora Health in Cambridge, MA, and one of the great innovators in primary care models. He was the first Executive Director of the Harvard Interfaculty Program for Health Systems Improvement, and served as a Managing Director of the Advisory Board Company. He serves on the faculty and earned his AB, MD, and MPP degrees from Harvard University. He completed his clinical training at the Massachusetts General Hospital. He talks about the suppression of Renaissance Health, atypical services at Iora Health, moving away from transaction-based payments, a population health management tool, the biggest challenge for medical homes in 2015, and himself.

Rushika Fernandopulle, MD, MPP

- Founder and Chief Executive Officer, Iora Health, Cambridge, MA
- Former CEO, Renaissance Health, Cambridge, MA
- Former, Executive Director, Harvard Interfaculty Program for Health Systems Improvement
- Former, Managing Director, The Advisory Board Company
- AB, MD, and MPP degrees, Harvard University

Medical Home News: *Your model of care is now successful and replicated in many cities, yet your first venture in Arlington, MA as Renaissance Health was effectively suppressed by the very system it sought to reform. How did this happen?*
Rushika Fernandopulle: I often say if you aren't upsetting anyone, you really aren't innovating. About 10 years ago when we started the Renaissance Health practice outside of Boston, we were pretty radical for our time -- we allowed patients to see their whole medical record online and self-schedule visits, did email and text messaging, had a 30 minute wait time guarantee, and more. As we grew, we got opposition from some of the health plans and other providers in town. We were accused of raising expectations, making other practices look bad, and that we could be upsetting the status quo -- all of which we of course had to plead guilty to, because it was exactly what we were trying to do! In the end we very reluctantly had to close that practice, but we took the lessons we learned into our next stage of work, which was doing the same thing for sponsors -- self-insured employers and union trusts who would pay for the more intensive, redesigned primary care for their employees/members and their families, would protect us from existing forces that wanted to "squash us like a bug", and would allow us to get the data to prove our impact.

Medical Home News: *What kinds of services do your practices offer that one won't typically find in the traditional primary care office?*
Rushika Fernandopulle: It is not just that we offer a number of unique services, but that we completely rethink our job, which isn't to do the best job we can with each patient in front of us, but that we have a clearly defined population who are our responsibility, and we need to improve their health and keep them out of trouble. To do this we build very robust teams around our patients including health coaches who can work 1:1 with patients to make and execute upon customized shared care plans; we provide patients the ability to interact with their doc and coach in person as well as by email, phone, and text; we offer lots of group visits (we call them clubs) to help patients learn and engage with each other; we reach out proactively instead of just waiting for people to come to us; we integrate mental health into the practice; we co-manage tightly with hospitalists, and we build a de-facto narrow network of high value specialists to help with other downstream care. This isn't a little different, it's completely redesigned.

Medical Home News: *You describe your payment model as moving away from transaction-based payment. How does it actually work?*
Rushika Fernandopulle: I believe fee for service is simply the wrong way to pay for primary care, period -- so we refuse to do it. Primary care should be about continuous healing relationship, and fee for service and especially the games around coding and billing simply get in the way. So we get a risk adjusted block payment for each patient each month, which allows us to be creative in how we help improve their health and keep them out of trouble. Our billing in general is a one line email to each payer once a month: this is the # of patients we have x the rate we agreed upon per patient = the amount on the check you should send us. We are now also moving to more advanced value based payments where we also share in the economic value we create by improving health and reducing downstream utilization.

Medical Home News: *Your website describes a tool that you built that manages not just an individual's health, but an entire population's. How do you do that?*
Rushika Fernandopulle: We realized when building a completely different proactive model of care that the IT systems available (EHRs) are, not surprisingly, built for the old world. Their main design principle, despite the rhetoric, is to help document, code, and bill higher. Not engage patients, manage teams, deliver optimal care, do population management, etc. So we've had to build it ourselves, and we have been doing so using agile development in close tandem with developing and evolving the model. Thus we have a truly integrated operating system with a process, culture, and IT system that all works together to deliver optimal care.

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