If I Ran the Zoo: Quality Measures in Accountable Care and the Fit with Integrative Health and Medicine

A Short Course for Understanding the Emerging Triple Aim Landscape

Jennifer Olejownik (JO): Welcome, and thank you for joining us for today's talk on Quality Measures in Accountable Care and the Fit with Integrative Health and Medicine. My name is Jennifer Olejownik, and I am the Program Manager for the Project of Integrative Health in the Triple Aim at the Center for Optimal Integration. Today's webinar is the third in our series, A Short Course for Understanding the Emerging Triple Aim Landscape. We are very excited to be leading this discussion on quality in integrative health and medicine. Because of the rich dialogue amongst the panelists leading up to this event, we have decided to extend today's session by 15 minutes. The session is being recorded and will be posted on our website if you are unable to remain on the call. Following the presentations, panelists will discuss some questions related to quality, and you will have an opportunity to ask questions. Now I'd like to take a moment to introduce our panelists. I'm having just a technical difficulty…there we go, thank you! First up, is Molly Punzo, is a pioneering integrative medical doctor and an expert on quality and medical delivery who is certified by the Institute for Health Improvement as an Improvement Advisor. Also on the call is Jim Whedon, who is a Health Services Researcher recently with the Dartmouth ACO team. Also national award winning NIH-funded Clinical Investigator, who recently was hired by Southern California University to bring his interest in integrative health services, health policy, trauma, and Medicare to that multi-disciplinary institution. Also on today's call is David Fogel, the co-founder of a unique integrative center, the Casey Health Institute, a public non-profit, integrative primary care site in Gaithersburg, Maryland, that is working actively to bridge the worlds of integrative and ACO and PCMH in a center that is close to level 3 PCMH status, and just signed up to be an ACO. Also on the call, Regina Dehen is a Chief Medical Officer at National College of Natural Medicine, and the leader of NCNM's effort to make their teaching facility into a primary care medical home. We are thrilled that all of you can be here with us today.

Before I begin, I would to offer a primer about our sponsoring organization ACCAHC. For those of you not familiar with ACCAHC, we are a broad, multi-disciplinary organization. We advocate for five core professions, each with a programmatic accreditation body recognized by the US Department of Education. Through our member organizations we are linked to 375,000 healthcare providers, and about 180 accredited institutions and programs. We are affiliated with traditional world medicine fields, and holistic and integrative medicine organizations.

The Center for Optimal Integration is part of ACCAHC. It's a priority project to facilitate the advancement of inter-professional collaborative healthcare. The Center offers a web-based platform that serves as a virtual gathering place for anyone with a stake in the integrative health and medicine movement. Additionally the Center houses two main projects: PERL – the Project to Enhance Research Literacy; and PIHTA – the Project for Integrative Health in the Triple Aim, which is bringing today's…organizing today's webinar. PIHTA is made possible through the generous support of our sponsors: LIFE University; the National Certification Commission for Acupuncture and Oriental Medicine; Visual Outcomes; the National College of Natural Medicine; and the CHP Group.

So what is PIHTA exactly? PIHTA seeks to understand the overlap between the values of integrative health – things like using least-invasive methods first, promoting self-care, collaborating with others in creating health, with a goals of the triple aim – reducing costs, enhancing patient experience, and improving population health. One of PIHTA's goals is to continuously build up the most useful base of published research, high-quality gray literature, and examples from the field to support enhancement and engagement and implementation decisions. Other goals are to assist participants and decision makers in the optimal use of the values, disciplines, and practices of integrative health and medicine, and meeting the goals of the triple aim. We also like to feature experts in these areas to help build inter-professional and multi-stakeholder community. And with our emphasis on the Triple Aim, quality is at the heart of this work, which brings us back to today's presentation. And now we're going to shift to Molly, who will be giving us an overview on quality.

And Molly are you all set?

Molly you may be on mute?

Are you ready Molly?

Thank you all for your patience, one moment while we figure out the technical issue here we're having.

Molly Punzo (MP): Hello? Hello? Hello?

JO: Molly we're ready for you.

MP: Can you hear me?

JO: Yes.

MP: Can you hear me? I apologize for having technical stuff going on. Alright, let me just jump right in. My name is Molly Punzo and I'm very happy to be part of this presentation. I think it's a pretty critical conversation to say the least and hope that this is the beginning of many to come in terms of quality and the integrative healthcare movement. I'm going to just jump in by talking about the two, what really are the seminal reports that came out. To Err is Human, which came out in 1999, and just shook the healthcare world. Very dramatic, and really basically the conclusion of that was that not only are people injured in hospitals – this was pretty much a hospital study – but actually up to 98,000 or 100,000 people a year die in hospitals. So this report came out, and it shook us all to the core. This was followed shortly thereafter by the report, Crossing the Quality Chasm, which certainly didn't come in with as much drama, or melodrama, but really, in my opinion, is a much more important report in the sense that it's really been…established the framework for the Affordable Care Act, ACOs, and primary care medical homes in the quality-improvement movement as I like to call it. So if anyone hasn't read these two reports, or at least the executive summary, I suggest you do, it's very eye-opening, to say the least. And if you have an interest in the quality improvement, really these are resource books. Ok…my slides are not advancing. Alright, so what I'd like to describe by these reports, is that they really created a seismic influence, and I'm not kidding. I started my study of medicine in the late 80s and early 90s, and we never talked about quality. Patient safety, quality, quality metrics, public reporting, paper

performance, none of those, none of those conversations were even on the radar screen. So this is really the last, probably the last decade or so since these two reports that this quality improvement has been happening in healthcare. It's been happening in industry for, since the 1930s probably in a formal way. So we definitely are behind the eight ball. I'd like to just talk about, before these Institute of Medicine reports there was very little transparency, safety and quality data, was not public, it was privately owned by the hospitals, and not shared. Hospitals and providers were really not being held to best practice. There was care variation and provider preference was the norm. I like to say this additional autonomy was tolerated at all costs, and that's not so much the case anymore, thank goodness. Formal process improvement was a rare thing in hospitals. We didn't, hospital administrators wouldn't spend money on process improvement. They didn't think it led anything to the bottom line or helped the bottom line. The administration and the board of director's focus was on the fiscal bottom line, not on quality and safety. And I like John's, how John (John Weeks) talks about the perverse incentive. This is what really led healthcare, and still is to an extent, but is hopefully going by the wayside, whereas…what this means is that it wasn't about quality, it was really about volume. So the more patients you saw the more money you made; the more patients that were in beds the more money that was made; the sicker the population, the greater the profit margins for hospitals. Since this report, and I think this is all, this is all going to be continued to grow, is that this data is now not transparent. You can go on this hospital compare website - which I have a slide screenshot of later on - and look at your hospital's quality data. And I suggest everyone do so. Quality audits are routine now, and hospitals are getting fined and punished for not having good quality. Providers are being held now more and more – not across the board – but more and more to evidence-based practice guidelines. Formal process improvement is now expected and is actually a budgeted item in most hospitals, and the administration and board of directors really have put quality and patient safety on the agenda at pretty much every board meeting. Money is now at stake for poor performance, so we talk now about value-based reimbursement, accountability, care coordination, and population health and these are here to stay. These are all wonderfully, I think , very favorable things with those two reports. So there's a lot of change that's happened in a very short amount of time. Alright, so now I want to talk about how do we define quality and who gets to define quality and that is a pretty complex question, but the answers are contained within the Chasm, what we call the Chasm Report. The Institute of Medicine actually came out with six aims, or dimensions of what quality care should look like, and I know, I think Jim (Jim Whedon) has this slide as well, and basically, it's pretty basic, but pretty darn important framework that care should be safe, it should be effective, it should be efficient, it should be equitable, timely, and patient-centered. I think no one's going to argue with these six dimensions of quality care. Then along comes the Institute of Healthcare Improvement and starts talking about how do you create population health, and this is what we're all here today to talk about – the Triple Aim. The Institute for Healthcare improvement took this concept which was radical at the time, I was actually there at the unveiling of this, of this model, and was one of the first places under the directorship and direction of Doctor Don Berwick that started talking about population health. I don't think anyone really thought population health was even possible. So they started talking about population health, the patient experience, and reduced per capita cost. And again this was a radical model that people poo-pooed at the time. This presentation was made at their annual symposium. But I believe, and we all believe on this call, and part of ACCAHC and Center for Optimal Integration, that this is where integrative healthcare practitioners and

integrative healthcare in general can shine. And ACCAHC and Center for Optimal Integration actually birthed the PIHTA Project, based on this Triple Aim, and this is a perfect fit for us, I think we all believe. I'm not going to go over these at all, but I think this is a good resource slide to have because there's this alphabet soup of acronyms in the healthcare quality industry. And these are the movers and the shakers, and the real thought leaders, the policy makers, the enforcers of the quality metrics that we're going to be talking about throughout this hour.

So now, we know we had a problem, we know we want to fix it, we have a sense of the direction that we want to go in in terms of what quality care should look like. So how do you get there? We develop the measures and the metrics. And believe me, again, I've kind of been in the trenches with this watching measures and metrics explode before our eyes and so has everyone else on this call, I'm sure.

I included this slide because this is really good quality improvement 101, and I think it's going to tee off the conversation to come because it's not enough to just look at outcome measures, or to develop outcome measures, I think we all know where we want to go, and we know what outcomes we would like to achieve, but if you focus simply on the outcomes, and don't look at your structural measures or process measures, it's too far down stream to just have outcome measures, you set yourself up for failure, so in the world of industry, again, Donabedian was a god, and really said, "We need to have this triad of measures in order to have success." This is, I think, a double-edged sword for us in many ways, and we'll talk about that in a moment. But I did want to have this as the conceptual framework for where the measures are born from.

These are just some examples of the kinds of quality measures, again these are some structure measures – equipment, supplies, your staffing ratios, your committee leadership – those are structural measures. The outcome measures I think we're all very familiar with – mortality, hospital-acquired infection rates – these are just examples, and again, I'm more inpatient-weighted on my presentation because that's been more my experience. And then the process measures are really what you do to achieve your aim. So things like, what medication are you choosing and the timing of it. So it's not just enough to give a medication, but is it the right medication at the right time for the right patient. And we actually measure all this. Hand washing rates, I don't think anybody argues, is a good process measure, but these are just examples of process measures, and again this is more inpatient-weighted.

This is…these come directly off the hospital compare website I mentioned earlier, and again, I think everyone should get online, and if you haven't already, look at your hospital or regional healthcare center and look at it and see how they're doing on these scores. These are publicly-reported measures and I have either sent patients away or sent patients to various – or family members - to various hospitals based on these scores. It's pretty important to know what your hospital scores are. This is a screenshot of that hospital compare website which is sponsored by Medicare.gov.

PQI's…I wanted to talk about PQI's because I'd like to just start now to have the conversation of where do integrative healthcare practitioners interface, where might we have opportunities to partner and interface within mainstream medicine around these quality goals. I think it's pretty obvious that there's a lot of places where we can join together as an outpatient arena, but I want to also emphasize that

there's inpatient measures that you can talk with your regional healthcare facilities about doing some improvement projects with, and I think these prevention quality indicators are going to be important.

These are outcome measures, so, your diabetes – I'm not going to go through these all but they have to do with admission rates, particularly, mostly for chronic disease. So the idea – I think this is a little bit ironic – but the idea of mainstream medicine is that prevention is really about controlling chronic disease. So, somebody's already got chronic disease is the assumption, you control the severity of it, and you control the progression of it, and that's what they consider prevention. I think we need to get a little more sophisticated than that. It's hard to prevent chronic disease to begin with, which is again, where integrative healthcare practitioners and integrative healthcare shines. But these are things that I think you should know about that your hospital is getting ranked on. Not just ranked, publicly ranked, but they also, there's money being lost, money being paid, for exceeding or meeting these particular thresholds that are established by the Agency for Healthcare Research and Quality for these kinds of outcomes, which are, which are population health outcome measures.

So, I want to just summarize my talk with, again, what are the quality measures that really, I think, integrative health has an ability to impact and would have an opportunity to partner with the mainstream folks. The PQI's I think for sure, again these are inpatient measures, but if you can go to a hospital and say, "I can help you decrease your readmission rates, I can help you decrease your diabetes rates, etc," there's a lot of opportunity there. The readmission rates are big. I mean, hospitals are really being penalized for having higher-than-expected readmission rates, or predicted readmission rates. And again, in the past, we wanted patients to be readmitted. Not we meaning me, but administrators who wanted it for, because you wanted more patients in the bed and that's not the truth, not the truth anymore. Thank goodness. The outpatient or population health measures are obviously what we're going to be talking for the rest of the hour about. And this is where it's the most, we have the most direct potential for impact, at the ACO's, Primary Care Medical Homes, and the HEDIS measures, which I know Jim is going to be speaking about, so I'm going to now hand the electronic baton over to Jen, to Jennifer.

JO: Thank you Molly for that wonderful Quality 101 overview. And now we'll turn to Jim to continue with the conversation. Welcome Jim.

JW: Hi there, can everybody hear me ok?

JO: Yes.

JW: OK, great. OK so everyone listening in, thanks so much for joining. And I'd like to just start out talking, again, kind of recapping the Chasm Reports, the domains of, what is quality in healthcare? So, quality healthcare needs to be safe, it needs to be patient-centered, not about the doctor, not about the treatment. It needs to be effective, of course, timely, efficient. And also equitable, and I think this is pretty important for integrative healthcare. I think for treatments or interventions that have value, patients should be able to access those interventions if they need them and want them.

So, about quality…does it matter in integrative health? Well, it's part of the language of healthcare reform. So if we are explorers in this foreign country of healthcare reform, which is really dominated by conventional medicine, we need to speak the language, and that language is all about quality, it's all about values. If you think of the equation, the value equation, which is outcomes over cost, so much of the numerator, or so much of outcomes is about quality. It's about safety in outcomes and patient-centeredness, and effectiveness.

So, this is important, how can the principles of integrative health help to define quality in healthcare? I think this is one of the main things we want to get at with this webinar. What is our contribution to this dialogue about quality and improving quality, measuring quality? Where is the congruence between integrative health and conventional healthcare. And where are the differences? If we were to think about all the different quality measures in existence, or even all the measures we can think of, I think we would find that there's a lot of congruence. There's a large area of agreement, that dark green area, where we can all agree, yeah, these are good quality measures. But then I think, toward the left, we would find that there are quality measures that are really maybe only applicable to conventional healthcare. And maybe there are measures, or could be measures only applicable to complementary healthcare. So if we think about this issue of congruence, and, you know, where the agreement lies, what matters in regard to quality in integrative health, quality measures. Let's remember that the quality, it correlates highly with value, and value is a practical matter, it correlates with access. So, interventions that are considered to be valuable are more likely to be accessible. And this business of accessibility and equity in healthcare delivery is addressed in the Affordable Care Act under the section 2706, non-discrimination clause, it says that insurers will not discriminate based on provider type. But then it goes on to say, and I quote, "Nothing in this section shall be construed as preventing a group health plan, a health insurance insurer, issuer, or the secretary for establishing varying reimbursement rates based on quality or performance measures." So, here it is, it's right in the law, that quality measures are really going to be really important to integrative healthcare providers, and their patients who want access to their services. But whose measures are these and you know, what measures are we talking about? Do we even want to use these measures? Well, I think as we move into this era of accountability in healthcare, this kind of brave new world of healthcare reform, that question's going to become moot. We're going to have to use quality measures of some kind, even if the whole idea of accountable care organizations somehow just turns out to be not such a great idea and the ACOs turn out to be not a workable innovation, the n-(sound cut out briefly 24:53) accountability's not going to go away. We're not going to go back to the idea that the doctor knows best, I mean more and more patients don't want that, and nobody wants it, so…Let's take a look, again, thinking about kind of congruence with integrative health, let's take a look at some selected quality measures. These are process measures, and they're concerned with treatment or prevention specifically you know, certain health problems.

So, let's look at the NCQA quality measures for ACO's, for Accountable Care Organizations. These are measures that I think are still under development. And let's focus on this one anti-depressant medication management. So here's a measure that focuses on a particular population; adults with major depression. And the criterion here for management is whether or not the patient is on an anti-

depressant, and whether or not they stayed on an anti-depressant. Is this a measure that's congruent with integrative health? Is it evidence-based? Is it a measure that an integrative health practitioner would want to be accountable for? If an integrative health practitioner joined an accountable care organization and became responsible, or accountable, for a population of patients, you know, accountable for their cost and quality of care, would this be an appropriate measure by which to measure the quality of care that the integrative health practitioner's providing?

Let's look at another set of measures; Medicare's quality measures for ACO's. These measures are in effect, there are 33 of them. Let's focus on number 32, drug therapy for lowering LDL cholesterol. Again, is this an evidence-based measure? Is it important to lower LDL cholesterol? If so, is it important for this population of patients with high LDL, or with coronary artery disease? Is it important to lower LDLs and is it important, or appropriate as a first-line therapy, to be using statins? Again, is this congruent with the practice of integrative health? Is it patient-centered? Or is it pharmica-centered? Pharmico-centric?

So here's another group of quality measures (NCQA Quality Measures for Wellness and Health Promotion). These measures, I think, are congruent with the practice of integrative health. These measures are about reducing risk for chronic disease, they're about primary prevention. And so, I think most of us probably would have no argument with these. Here's a set of kind of in-between measures (Physician Quality Reporting System used in Medicare/Medicaid system), I think. These are not measures for primary prevention, but for secondary prevention for screening. I think some of these measures would be controversial whether you're an integrative health person or not. Some of us may kind of disagree with whether or not these measures, for instance, flu shots, breast cancer screening, colorectal cancer screening, are really well-grounded in the evidence, but that's not really what this slide is about. Even if we were, let's say for the sake of argument, we agree with these measures, these are good things to do to…good measures of quality to perform these screenings. This slide is about inclusion of integrative health practitioners, because under Medicare, under Medicare's PQRS system, chiropractors, although part of Medicare and participating as physicians under Medicare, are not considered qualified to report on these measures. Except for one, the one at the top about high blood pressure. So this is an issue, I think of, you know, maybe another instance of discrimination on the part of CMS with regard to the services that integrative health providers can provide and measure, and report on measures.

So, I guess I want to leave you all with some questions about, you know, what do we want to do about all of this? Do we want to work toward inclusion of integrative health practitioners in using existing quality measures? Do we want to supplement existing measures with measures that are perhaps more congruent with integrative health? Do we even want to develop new measures, say, that are really just applicable to integrative health. Now your saying bio-manipulation or massage or nutritional supplementation. So these are questions that maybe we can come back to towards the end of the presentation, and thank you so much for your attention.

JO: Thank you Jim for posing such thoughtful questions, and we will turn to those towards the end of the presentations when all the panelists will have an opportunity to weigh in on that. Now we're going

to turn to David Fogel, and he's going to be giving us a more experiential understanding of what it's like to live with some of these quality measures. So, welcome David.

David Fogel (DF): Hi, whoops! Do you see my regular, oh, show my screen, ok, you got me?

JO: Ummm…

DF: Uhhhh…something happened when you switched over I think…

JO: There you are!

DF: Ok, good, great! And it's the right screenshot, correct?

JO: Yes, you're all set.

DF: And full screen.

JO: Yes.

DF: OK great! Thank you! This may sound strange but I find this topic really exciting. I am going to give you really more of an experiential snapshot of what it's like to be on the frontlines or what many people call the trenches of integrative primary care. But I really think value-based healthcare and integrative health together is like adding rocket fuel to the engine, or as my wife and the co-founder of Casey Health Institute likes to say, it's like somebody putting together the chocolate and the peanut butter and going, "Wow! That really tastes good!" Anyway, but it's a mixed bag. So let me first start by telling you who we are at Casey Health Institute. Well we are a not-for-profit, free-standing, integrative primary care center. We are team-based, collaborative, and we're a staff model which means that people are on salary. These are not independent contractors all practicing under one roof and that is a very important piece of our model. We have internal medicine, family practice, acupuncture, chiropractic, we have a naturopathic doctor on staff too, psychologists doing behavioral health, and that means a lot of mindfulness, among other things. Therapeutic massage, we have a Reiki master, a nutritionist, a yoga therapist, probably the first yoga therapist that's a fulltime employee in a primary care center. And we have a wellness center that has healthy eating, fitness, yoga, and mindfulness classes, among other workshops that we give too.

We are an insurance-based model, meaning that we take most major insurances. We take Medicare and we take Medicaid. We, in addition, have a charity care policy for primary care as well as for all our integrative modalities if you meet certain federal poverty guidelines. We felt that was very important to be an insurance-based model in the current fee-for-service environment.

We started about two-and-a-half years ago with zero patients and we're now at about 3,000 patients, and, importantly, we started with a grant from the Eugene Casey Foundation which is really spearheaded by Betty Casey who we owe great, great thanks to.

We have an interesting patient distribution. We have a bi-modal kind of picture, where we have the sophisticated integrative patients, is what I'll call them, where they really know a lot about integrative

health. They've often been to many, many doctors, and kind of failed allopathic treatments, and they know exactly what they want and are coming to a place to get exactly that. Then we have a large patient population that has no knowledge or very little knowledge of what integrative health is, and they just need a primary care doc, and they either find us through their insurance, or we're close by in their neighborhood.

So, I will say that I was not aware of all the nuances of measuring quality and outcomes, it is not for the faint of heart. When we just started this thing I had a very steep learning curve. It's not for those without time, money, and a lot of patience, and I will explain.

So, it's a confusing world. Molly talked about the alphabet soup of acronyms for organizations involved in this. I call it, and it really is, an acronym nightmare. And I'm just going to show you a few of the different organizations. And people don't talk about their long names usually, they talk about the acronyms. I have to ask over and over, ok, so what is this? And sometimes they have standards, they compete. Anyway. Ok

So what is Casey Health Institute's platform for quality measures? And I really believe you have to have a platform. Our platform is different than other peoples' platforms. We have a large collaborative group and somebody with a smaller group may have a different platform, but I'm going to tell you ours. I really believe that the integrative staff model, which, where you're salaried, and it incentivizes collaboration and not competition between practitioners.

I think it's essential to have an electronic health record, and with a patient portal. Again, for our kind of practice, we are team-focused and have a population health-oriented medical and business model. We spent a lot of time putting together our business model before we opened.

We started up with a goal to achieve Level III Patient Centered Medical Home benchmarks. Now you don't always have to get certified, although that's got some cost associated with. We started out with a goal to become level III benchmarked.

Cultural norm in the organization, is that, and we talked about this, fee-for-service is really not a healthy incentive structure. And the cultural norm that quality and value-based care, i.e. payment to keep people healthy is a better way to have a healthcare culture.

So, we also stress a culture of transparency, accountability, trust, innovation, and honest feedback. All this is important in the quality world, I believe.

Also, you have to have a platform…it takes money to measure quality, and so, that's an important piece and a struggle for…in primary care that's a big struggle.

So, we had to decide where we were going to focus our energy, because the bandwidth of your practice really matters, and (loud background noises) so we started out really focusing on patient experience and we just completed, and this is a big deal, to just do patient satisfaction surveys that go out and how you do it and the methodology. We've had patient focus groups, patient advisory teams, we are now looking to put a patient on our board of directors. Also, we focused a lot of energy into creating a team-

based culture that is part of the Patient Centered Medical Home model, but really a focus on high-performing teams, is really important when it comes to quality.

Care coordination is where we focus a lot of energy, and ended up hiring a dedicated nurse care coordinator.

You have to spend time and energy on your electronic health records, if that's what you have, which I think it's almost impossible not to these days. But it's really essential for tracking quality metrics and outcomes.

And over and over, everything is about process improvement. Lean healthcare is another way of framing it. We are always going back and creating teams to reevaluate our processes, and that's really a part of the dialogue in quality and value-based healthcare.

So, we decided to take the plunge into this quality measurement world, and I've got to say, it's not without anxiety. So, where are we? Well we really have currently met or are above most of the PCMH Level III, which is the highest level standards for quality metrics, and here's what they are:

It has to do first with access; you have to have access to your practitioner or your care team during and after hours. And electronic access as well as phone access.

You have to gather data and put it into your system in order to manage patient populations and demonstrate that you're giving quality patient management, and have up-to-date problem lists and things like that. So there's a lot of data input.

Planning and managing care, so developing care plans, sending reminders, active medication – demonstrating that you're actively looking at people's medications and manage them, not just seeing that a problem with medications and I have to speed up here.

Providing self-care and support and community resources – education. Track and coordinate care, tracking labs. Measure and improve performance – clinical outcomes.

So here's just a quick snapshot of a PCMH scorecard, report card. We're about to join this patient-centered medical home – Bluecross Carefirst program.

This is a snapshot of our electronic health record, quality management tab. And you can see, it's mostly kind of allopathic measures of outcomes, but just to give you a flavor of what quality management looks like in the health record.

We're just signing on the dotted line with Aledade, a physician led Medicare Shared Savings ACO, and I just (loud noise) quickly because I had a conversation with the executive vice president about whether we're going to be forced to medicate when we don't believe in it, we think, you know, lifestyle change is indicated. And he said, "Look, we just care that you keep people out of the hospital and out of the emergency room, and we'll be happy and we'll have a dialogue about it."

So what are we learning? High touch needs high tech in this brave new world. Measuring quality metrics, you have to collect a lot of data – not a big surprise. You have to have a functioning electronic health record, which we were really delayed by numerous EHR inadequacies, a lot of people have been. It's a steep learning curve to create integrative health templates gathering the right kind of data for that kind of quality. And tracking allopathic outcomes is also important in an integrative primary care setting. Figuring out integrative quality metrics is really an exciting challenge for us, and it gets patients, employers, and payers attention when you do it.

So, last slide; what do we want to do as integrative health practitioners? This is more of an editorializing by me. My experience is that integrative practitioners, and a lot of health practitioners period are just not very well-informed and even resistant to this whole quality/value based healthcare movement. That it's moving forward, the movement is going forward and gaining speed, traction, and a lot of dollars whether people like it or want to look at it or not. And practitioners are increasingly going to be incentivized and they'll be penalized in whether they adopt the measures or not. That integrative care and lifestyle-focused treatments will replace a lot of the things that are currently standard of care in terms of treatment because they work and they cost less. And that's going to be demonstrated, I am sure. Quality metrics hold us accountable in ways that we have never been held accountable before, and we as integrative practitioners have to be a part of this quality dialogue, because after the dust settles, I really believe it's going to be a good thing. And that is it! Sorry I went a little over.

JO: That's alright, thank you David. It's very exciting to learn about the pioneering work that you're undertaking at Casey. And now we're going to turn to Regina to hear another perspective on PCMHs.

Regina Dehen (RD): Hi folks. Thank you for giving me the opportunity to tell you what we've been up to here at NCNM. And it actually is a well-organized webinar because it got progressively more granular as we went. And it was a great overview by Molly, and then more information about perspectives and the appropriateness of the measures, whether or not integrative providers should be held accountable to the same sort of measures as Jim was talking, and David then gave a sort of perspective on how it's working at their integrative clinic from a sort of allopathic but integrative perspective, and now I can kind of talk about the same activities coming up from the grassroots of the naturopathic and very much alternative perspective. So, NCNM undertook a challenge to become a patient centered primary care home, so what David was talking about as a PCMH, we call a PCPCH out here in Oregon. But a primary care home model has the same sorts of principles. Oregon is sort of leading the vanguard in compensation for alternative care providers, and they see naturopaths as primary care here, so that gave us the opportunity. We looked at that as an opportunity to sort of, we wanted to hold our feet five inches from the fire that everybody else was having to hold their feet to. So, there are also opportunities for us here because paragraph 2706 of the Affordable Care Act, everybody knows, identified that insurance companies, insurers, cannot discriminate on the basis of the type of scope of practice, if people are working within their scope of practice, the insurance company is required to compensate them. But they can – sort of the corollary to that is – they can determine payment on the basis of quality measures, and so we could get paid less, for instance, if we fail to prove that we can meet the same quality measures as others. So it is mildly incentivized, not to the point where we actually get the same

larger incentives that are provided for hitting tier one status, tier three status, and we'll talk about that a little bit later.

Here in Oregon we also had house bill 2468, and 2468 was kind of the corollary to 2706. It said that insurance companies had to actually include the types of providers that people wanted to see, so it couldn't exclude from the list of providers folks like chiropractors, acupuncturists and naturopaths. If that was who the population wanted, they had to incorporate that into the payment model. So it gives us the opportunity to hold ourselves accountable to quality if we actually want to use objective measures of what we do. The opportunity is open to us now to step up to that and say "We're willing." But then the question becomes, "what should we actually hold ourselves to?" And of course using the model that already exists is less work than trying to create one from scratch. And so I think it behooves us to try to fit as much as what we're doing as possible into the already extant model to demonstrate that we can do it, it's not beyond our capacities, and we really are focused on the improvement in patient care for all. The Triple Aim very much suits what we're trying to do.

This is a model that Care Oregon puts out, and you see the same six measures that both Molly and Jim were talking about. It needs to be comprehensive, continuous, patient and family-centered. We need to be accessible, coordinated, and accountable, and all of those things break down into those three measures that Molly was talking about. There are structural measures within this, outcome measures, and process measures.

So, we were lucky in that the Oregon Health Authority sponsored a series of learning collaboratives and they gave very small grants to clinics in the area, clinics in the state of Oregon, who were trying to improve their quality measures in some manner. So, we applied for a grant and NCNM won one of the integrative medical, was the only integrative medical clinic that won one of the Learning Collaborative grants. And when you guys are talking about a steep learning curve, I would say yes, very much so, because for us, following this concept of becoming a high-performing clinic, we didn't have a culture. And I'll talk about that in a second as well. We really didn't have a culture of quality improvement, we didn't have team-based care, we didn't have a platform, as David was talking about. We lacked the platform. And even though we got a little bit of money, the amount that they gave us really wasn't sufficient…well I shouldn't say that because in a sense we essentially have created that platform, even with that small amount. It was a $5,000 grant, so it was pretty minimal. But even with that, together with the coaching that we got from coaches at the University of California San Francisco Center for Excellence in Primary Care and Care Oregon as well – we met monthly and twice – and they came on site, and we went there and had day-long learning collaborative sessions, and that kind of support was absolutely crucial for us to figure out how to become a patient-centered primary care home.

So, what you're looking at right now is a slide that represents Tom Bodenheimer's Building Blocks of Becoming a High-Performing Primary Care Home, and what we've been taught is that unless you actually establish the basis of this pyramid, you can never get to successful achievement of the triple aim. You won't be able to get there if you don't have these basic building blocks. So, engaged leadership was part of the initial scope, so was the idea of data-driven improvement. So I want to reiterate what David said, which was, without data, without an electronic medical record or some way of capturing the

data that you need to be able to present, demonstrate your outcomes, it would be almost impossible. And, you know, according to this pyramid model, it is impossible because it's a building block that will get you to where you need to go.

We needed to become impaneled; that was a new concept for us. And we needed to develop teams, and that was also a new concept.

So, this slide (10 Must-Pass Criteria for PCPCH Recognition)shows you that for us…I think Jim was talking about there are 33 Medicare quality measures for accountable care organizations. Here in Oregon, the Oregon Health Authority requires us to have 10 must-pass criteria, so that's really not an onerous burden. Most clinics can actually, will actually find that they're doing a lot of this anyway, and when we analyzed these 10 criteria when we first started this project we discovered that we met all but these two. So, we were not tracking a quality metric, and we didn't have clinicians assigned, we had not been assigned as primary care providers. And both of those things turned out to be seminal in our ability to be able to attest as a primary care home, but they also made a significant change in the culture here at the clinic. Once we actually assigned patients to providers, and the providers were their primary care provider, even though we could do it either as their official primary care provider throughout all networks, or their naturopathic primary care provider. Either of those categories allowed us to capture quality improvement data on the basis of a patient cohort. So the idea of going back to that population-based care was new, and started to happen for us once we actually assigned our patients and we became impaneled.

So, where we started was, we really had no concept of quality improvement measures. We had an electronic medical record that we had had for only two years and we were still in the throes of learning how to use its ins and outs. We use Epic here, and it's a bit of a beast. It's been extant since 1976, and it's a database that works on the basis of Accreta so things have just been added into it over the intervening 40 years it's been around. So, it's not what I would call "user friendly". Extracting the information we needed was actually quite challenging. But, we started small. We identified that we had two basic goals; we were going to impanel all of our patients, and each provider was going to choose some quality improvement measure, just one of the required…those required from Medicaid.

So, we did create a sense of urgency. We socialized the concept at faculty meetings, we sent out emails, we would speak about it whenever the faculty would get together at their monthly meetings. And then we actually sent out the QI measures set to the doctors. Let's see if this scope will open. So you all can see. Ok, so, these are the measures from the Oregon Health Authority, and David was talking about shooting for tier III. We are shooting for tier I, so we started small, we started humble. We knew we didn't know anything about this and that our learning curve would be steep, so we started with things that we thought…we started at the lowest level of achievement. So you're going to see, as we go through, that there are 10 must-pass measures that pop up. To hit those 10 must-past, you get to attest as a primary care home, and you do not have to have any of these additional points. So you can see that each quality measure allows you points as you achieve each successive level of proof; and some of them are structural, some of them are outcomes-based, and some of them are process-based. You accumulate points, and you can attest at a different tier. So it's intended to be an ongoing improvement

model. You continue to work towards better and better quality of patient care. We are just starting with the must-pass measures. And you can see, here's a must-pass measure, that you have to have continuous access to clinical advice by telephone. And, so, this list goes on. There are actually, I believe, 10 basic attributes, but there are many, many within them. And so you eventually…this will take years, honestly, and what we were told by our coaches from UCSF is that a really high-performing clinic doesn't get that measure of performance for about 10 years. So this is a long road. We encouraged questions. We identified for the doctors what sorts of measures – actually I think I have two, and I want to be able to get to the second – which sorts of health measures we thought that the doctors would resonate with.

The self-assessment tool gave us an idea of where we were starting. And you can see which ones the must-pass measures are. This is not daunting. To most of us, when we looked at this it was like, this does not look as bad as a 60 page document of technical standards that you have to meet. So, we then sent around to our doctors an idea of what resonated with them. We created teams on the basis of availability – days of week. We also have the benefit, as David did, of having salaried physicians, so there's very little internal competition. There's more of a sense of collaboration, and integration. We created teams on the basis of compatibility of skills. So we combined chiropractors, acupuncturists, naturopaths – and naturopaths that had different focuses in their practice. So we made sure that folks had women's health, pediatrics, folks who were willing to do immunizations, and then we made sure that there was availability across the calendar, so that we had someone Monday through Saturday, which are all the days that the clinic is open. And so our teams were sort of temporally and skills-based, and made collaborative groups. So each team was then given the opportunity to choose which measures they felt they resonated with most. These are all of the measures we will eventually have to attest to our quality, but all we wanted to do was prove that we could do one. And we didn't want to force it on our practitioners, we wanted our practitioners to choose one that they felt, as a team, that they felt was meaningful to track. So each team chose a different measure. And what we ended up with, after providing them with protected time, so there's some of the money… the money piece that David's talking about, getting 35 practitioners together in a room for at least an hour is a chunk of change. And doing that on a monthly basis is an investment that we are making in our community and in our providers, as well as in our ability to care for our patients. So we think it's going to be a beneficial investment. But it is definitely some money and some time.

We created these care teams, and we allowed to discuss and prioritize which measures they resonated with. And what we got was this. So these are the participants in our teams. Each team is color-coded – they picked their own color. The folks in the center are our clinical support staff. So they are shared by all members of all teams. And the teams each picked their own quality measures. So Team Teal chose blood pressure monitoring. Team Purple chose colorectal cancer screening. Team Orange chose blood pressure. Team Yellow went for basal metabolic index. And Team Green went for hemoglobin A1c. Our specialists have independent practices, and so they were not actually included in this model, but we refer to them as necessary when we need some other kind of specialty services.

So then, we had to actually use the database to collect the data that we were looking for, and that turned out to be quite challenging. Some of it was just because the database is such a bear. Some of it is because it's novel to us, and we had to find whether or not it created the reports that we were

interested in. It took a long time, and it could not be done through a single…through just the electronic medical record. It had to be done in addition using some ancillary software that is available to extract data from the database. So, this took a lot of work. We used a plan-do-study-act method for determining...for piloting small projects rather than throwing it out for everybody all at the same time. We started small with my team, and seeing how we could call the colorectal cancer screening information out. And once we discovered that it was doable, we began to create regular reports that could be run on a monthly basis so that we could bring those to the doctors at the monthly meeting.

So we did use Excel to plot our data – what we're looking for, what we've taught…we've been taught is what we want is run is runtime data. So that means real month-to-month data, month over month, as a graph of how much, how well you're improving, or failing to improve. We were also taught that un-blinded data is the norm. So each team is up there, identified, and they actually see one another's information. We posted the graphs, we make them public. They're actually in a hallway in our clinic so our patients can see them as well. And we're encouraging our staff to actually go to the bulletin board and look at their data, and we're doing that by creating monthly trivia contests. So people can actually win prizes for going and answering questions about how the data looks, just as a means to get folks sort of socialized to the concept that we do this on a regular basis.

So, it worked. We now have managed to shift our culture here, and when we talk about quality improvement data, folks in the clinic know what we're talking about. They know we have a board, they know where to go to look for it, they understand that it comes out in the newsletter, they know that there's a trivia contest that they can win prizes for. And we're going to keep this going, because as I said, it's a ten-year-long road, and we've only just begun. We did achieve our goal of impaneling all of our patients, and also of getting each clinician – each team clinician – involved in one QI effort.

The things we encountered that were challenging? As I said, the database is a bear. It took over 300 hours for our site specialist, our epic site specialist to determine how to pull the reports for all of the quality measures we were interested in. But at this point now we have that infrastructure in place and we can keep doing it repetitively. So it was an upfront investment that will continue to pay off over time.

We also had a cultural issue in that doctors had never had their work exposed before. So the idea of posting it on a bulletin board where everyone could see it definitely generated some concern. People were afraid that there would be some shaming, but we coached around the idea that transparency is the norm, that this is what is recommended by UCSF Center for Excellence, and if they can do it, we should be able to do it. And after the first bumps in the road the first few times we posted it, it became a non-issue. Doctors were not ashamed of their data, and started actually coming to me towards the end of the month and saying, "Is the new data posted yet? I want to see how we're doing." So that was a complete transition in attitude, and it didn't take a whole lot of work, it just took a little bit of coaching.

We do have some issues around making sure that our, what this is, is our lists are dirty, meaning that sometimes when you impanel patients, when you impanel a physician with patients, those patients aren't necessarily assigned correctly. So the doctors actually have to go through their lists and identify

people that have been assigned to them that they have never seen, or that they did a phone consult with only, and they shouldn't be considered their primary care providers. So the doctors are still in the process of cleaning up their lists. The data will become more accurate once those lists are better assigned.

And we didn't have a whole lot of people actually engaged in the trivia contests, so not a whole lot of people took the time to go the board if they didn't have to.

What we think has to happen next is to spread the model. We need to go beyond just what's happening here in clinic and we need to incorporate our lab, as well as our medicinary, and just sort of spread this model out across more people. We also need to do a better job in terms of incorporating patients. We would really like to start using patients on advisory teams and in focus groups. We just sent out our first patient satisfaction survey and we have just gotten back the first set of data about that. So we haven't crunched it yet, we'll be very interested in seeing how we did.

And we still need more time and more work on creating team cohesion. It's challenging, the sets of doctors that come to our meetings do not always represent the entire cohort of a team, and so it's difficult to make sure that everyone equally is engaged in the project.

So, I think sort of this is my opportunity to editorialize it a little bit. I think the implications of quality improvement for integrative healthcare practitioners, what we are basically being asked to do is recognize that reimbursement is now, and is going to be based on meeting quality measures. So we have an opportunity to achieve equity. We can demonstrate that we have the opportunity, the capacity, to provide quality care, and I'm really pleased at what David was saying about, it's not about making sure the patient takes their medication. What it's about is making sure that their blood pressure comes down, or that the depression improves. So if the outcomes are still malleable, our role as integrative practitioners is to influence the types of outcomes that count as quality measures. If what you're looking at is an improvement in depression index score, or anxiety index score, we can demonstrate that fairly readily, and the database gives us the capacity to do it. If what they're actually looking for is that each patient who is depressed is on an anti-depressant medication, we need to argue that that's not the outcome measure that most represents patient wellbeing.

So, we need to use the available resources we've got, we need to find the areas of congruence, build coalitions with those that we already know in the integrative field, as well as allopathic and conventional fields, and definitely celebrate the small successes. Each of the things, each of the small hurdles that we overcome, each of the learning curves that we throw ourselves at and gain from, those are successes, and they create a stronger collaboration among healthcare providers, and I think ultimately, that's how we're going to get to the Triple Aim. And it's actually a quadruple aim. Besides better healthcare for a greater population at lower cost, we also need to have happy practitioners and happy patients. And that is really, I think, what will really get to if we can all operate together.

So, I think, I think that's all I have to say.

JO: Thank you Regina for taking us into the trials and tribulations of your journey into the world of quality. There's certainly a lot to learn.

RD: Continues to be!

JO: So, just a reminder to the attendees, you have an opportunity to type in any questions with the time we have remaining. We'll get to as many of those as possible. Right now I wanted to go back to some of the questions that Jim Whedon posed, and kind of ask our panelists and query them about what they think, now they've heard everyone else's presentations, do they want to work toward the inclusion of complementary and integrative health practitioners as users of existing quality measures that are within the scope of practice? Who would like to open the conversation?

RD: Well, I'm happy to talk about it – this is Regina – as I was just saying, I think it's incumbent on us to actually step up and do those things. We, if we are already included by law and by the way, by the way the measure is written, then why would we not use the existing quality measures?

DF: Yeah, this is David. I agree with Regina. I think there's a lot of malleability. I mean, we start where things are in the policy world, and as I said in my presentation, I think we have, we have potentially a lot of influence at these early stages. I mean it really is a wild west of healthcare right now. And people are seeing what works and what doesn't. So, I think we start there, and it's not possible for everybody, I mean we're…not every integrative health practice is primary care based, but again, I think it's really…you start where it is.

RD: I do think it does require a certain degree of thinking outside the box. I agree with David that it is a bit of a wild west. This is a new model of healthcare that is being implemented, and no one is really sure exactly what it's supposed to look like in the long run. So, if the model is designed for folks using an electronic medical record, that are prescribing certain pharmaceuticals, and you're a naturopath or a chiropractor or an acupuncturist, if the measure is prescribing it's not necessarily going to work for you, but if the measure is an improvement in the number of patients that are coming in for screenings, that's not impossible to achieve, especially if the clinic itself has a malleable model and incorporates massage therapists and chiropractors and acupuncturists under the same roof so that everyone has access to the same database, and that those people can be made part of a team, and then, if the quality measure is then, "strived for by the team" as opposed to "by the individual" then it pulls…what is it…rising tide floats all ships.

MP: This is Molly. I'm also really intrigued by – well, obviously I'm intrigued by this whole conversation in many ways – but when David was talking about how he approached, they approached the insurer directly, I think that's a really, very important piece because again, the insurance company doesn't necessarily care how you get there, but they're, they care that you get there. So, those outcomes are very important to work with. I think particularly the insurers are going to be a lot easier than working with the government right now.

JO: OK. Thank you all. What about the next question, you know, should we supplement specific quality measures that are medication-oriented with evidence-based quality measures that are lifestyle or more function-oriented?

DF: Absolutely:

All: Yes! Yeah! Absolutely. (Chuckling)

JO: The panel is emphatic.

(various vocalizations of enthusiastic agreement)

RD: One of the places that evidence can be, can come to us from, is PCORI, I think Patient-Centered Outcomes Research Institute is beginning to provide us with evidence-based quality measures that are lifestyle and function-oriented, that are more than just pharmaceutical-based. Their interest is in patient-centered measures. So, I think the implementation of those, the data that's coming out of that as quality measures will help us in the long run.

JO: Thank you. Anything else before we move on?

Ok, I think we have a few questions from the attendees. Deb, could you share with us one of the questions you have?

Deb: Yeah, sure. This question is for Regina. Has striving to reach any of the outcomes compromised any of the things that make the (unintelligible) MDs different? If always chasing numbers it's harder to stay focused on the relationship with the patient.

RD: It is and it's not. That's one of the things that - Thanks for the question, it's a really good one, and it's definitely something that we looked at as a potential threat when we were figuring out how this was going to work. So we wanted to have some kind of strategy in place for how to address it, and one of the things that we've used fairly successfully is, we are talking about thinking outside the box. Yes, in many practices the folks that actually provide some of the measures, that actually do some of the things that end up in the database as you know checking a box, are provided for by MAs, medical assistants, physicians' assistants, and support staff. NCNM doesn't have that. So one of the things that we did that we tried to make a win-win situation out of was, we started training our third-year medical students to be sort of ersatz medical assistants. They have greater responsibilities now when they're rooming the patients, to get vitals, therein achieving the BMI measure, and achieving the BP measure. So, that was happening anyway, but we assigned it to the secondary students, and we did some outreach and training in their courses so that they understood the importance of being an active member of the team, that they were contributing to the college's ability to attest as a PCPCH, which is a step up for us in terms of our objective quality measures. So we tried to pitch it as a win-win situation across the board. It also enhances their education, it makes it more easy for them to slide into any other kind of primary care or family care practice because that is what's going to be expected of them, or of someone on their team. So it familiarized them with the structures that exist in conventional practices. So, it works across the board to make it easier for us to achieve what we're trying to do without giving up anything about

naturopathic interactions. The doctor and the intern, the fourth-year student, still spend just as much time face-to-face with the patient. The secondary is no longer just a fly on the wall. The secondary now has active roles and responsibilities that they are expected to perform, which we can also measure as outcomes for the program.

JO: Thank you Regina.

RD: Does that answer your question?

JO: I think so, it's from our attendee and they aren't able to comment.

DF: (starts speaking)

JO: David, do you want to weigh in?

D**F:** Yeah I just want to have – I know we're running out of time but just another aspect of answering that question, even though I'm an MD, not an ND, but I think it's a nuanced answer. It really does…it depends on the culture that you're creating, but it also forces us, as Regina was saying, again and again to think outside the box because a lot of the quality measures are focused on the patient's experience. And if you are getting in the way of the interaction and you're really following the patient's experience, which I think is at the center of all this, then you will hear about it and your scores will go down. So it really kind of puts your feet to the fire to not just focus on numbers but to really keep the human being in front and center. And in a way I really like that.

RD: Mhmm. I agree.

JO: Alright thank you both. Deb, we'll take one more question and then we'll wrap up.

Deb: Great. We have another question here addressed to Regina and David. The question is, are patients aware of the objective of keeping them healthy, and is this meaningful for them yet?

RD: David, do you want to go first?

DF: Sure. It really depends. In my presentation you saw the bi-modal patient distribution that we have of people who are very aware of integrative health and they come because they are already in that place. The other patient distribution, not so much, and it's really up to us to bring them along. And it's not about telling them, it's…education is important, but to give them a healthy experience is really the key to get them…to really change them. So I'll stop there.

JO: Thank you David. Regina.

RD: From, for us, because this was a novel set of experiences and challenges, we advertised it. When we were socializing the concept to our doctors, we socialized it to our patients as well, and we got our marketing department involved and we put up big posters in the lobby that tell the patients that we have assigned you to a care team, and the care team has the capacity to do all of these things for you. And we created fliers for each care team. We also put up a poster that identified that we were becoming

a patient-centered primary care home, and we talked about the six themes of what are…what we're trying to measure, what we're trying to provide our patients with. So, we encouraged questions, and we got lots of them, and we wanted our patients engaged in the process. This is a new area of growth for us, we want to provide good care, the whole reason we're doing this is to improve the quality of care that our patients get. And the scope of the services that they think about having a naturopath providing. And it seems to be working. It seems to be working. The fliers are going home with patients and we get questions about the advertisements and – I shouldn't call them advertisements – the posters that we have in the lobby.

JO: Wonderful. Thank you Regina and David. We are a little over time, so I would like to thank everyone for participating – our panelists and our attendees, and as we mentioned before, the webinar will be up on our website along with a copy of the handouts. So, once again thanks so much, and look for us for another webinar. Take care.