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## Medical home leading to greater collaboration *Multiplayer initiatives gain steam*

Payers and providers are like the cartoon cats and mice of the healthcare industry. But just as Tom and Jerry ultimately became pals, payers and providers have begun to work together too.

There are several collaborative multiplayer, multi-payer initiatives focused on adopting care management technology, guidelines, and best practices popping up nationwide.

The medical home movement has been mostly responsible for this move from propriety business and information technology (IT) models to a more collaborative approach.

Payers are recognizing that propriety IT and business models regarding care management don't work, and the collaboration makes sense, says **Vince Kuraitis, JD, MBA**, principal and founder of Better Health Technologies, LLC, a technology consulting company in Boise, ID.

"Health plans and doctors who traditionally have been Hatfields and McCoys now have incentives to work together. It's a very different landscape than what we have seen in the past," Kuraitis says.

Health plans have gotten nowhere using the proprietary IT and business models and have not resolved the problems of quality of care, patient outcomes, and healthcare costs, he says.

Multiple payers working collaboratively and creating one set of guidelines on one computer platform allows physicians to more easily follow guidelines. Rather than handling a different set of guidelines for each health plan, physicians can focus on one set developed by a collaborative. This also helps health plans because having one set of clinical guidelines means a physician is more apt to follow them. Forcing physicians to follow multiple proprietary guidelines doesn't work, Kuraitis says.

"The only way to solve that problem—to truly get care management coordinated—is to have a collaborative model where the payers in a region or a community come together and agree the only way to make this work is to have common guidelines," he says. "And, eventually, where I think this is headed is common information technology to support the implementation of those guidelines."

The shift is a different way of thinking for health plans that have viewed IT and data as proprietary tools, Kuraitis says. Payers have seen that information as a competitive advantage. "That is a major cultural shift to take on the stance that it is not really our data, it's the patients' data, and we need to share that with others on behalf of the patient to get better care. It's a really profound shift," he says.

### Medical home drives collaboration

The patient-centered medical home concept, which puts patient care coordination in the hands of the provider, is the engine behind the recent collaborative trend.

RMD Networks in Centennial, CO, which offers Web-based collaborative care software, Web services, and networks to allow interactions between physicians and patients, has been involved in several medical home collaborations. RMD Networks' computer platform tracks patient clinical data points, and an automated system is tied to the guidelines that alerts physicians and patients about the latter's care plan. For example, if a diabetic patient is due for an A1C test, an automated reminder is sent to the physician and patient.

**Steve Adams**, president of RMD Networks, says his company has been promoting the idea of a collaborative care platform that coordinates care for multiple providers,

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and the patient-centered medical home fits that model.

“We, from our founding moment, have felt that the lack of communication and coordinated care is one of the real burdens of our healthcare system,” Adams says, adding that payers are working together to transform the healthcare system because they see the benefits of the medical home.

“This is the first time in my 20 years in healthcare IT that I see payers who are truly open to collaborate and working together to make a difference,” he says.

RMD Networks is providing the computer platform for several medical home demonstrations, including those in Colorado and Pennsylvania.

The Colorado Clinical Guidelines Collaborative is running the two-year medical home pilot in hopes of reducing system fragmentation, and implementing systems and processes using evidence-based clinical guidelines. In Pennsylvania, the Governor’s Office of Health Reform is spearheading a collaborative (see July’s **DMA** article “Pennsylvania kicks off medical home project”).

Six payers are involved in the Pennsylvania initiative, which is implementing the Chronic Care Model that includes learning collaboratives, practice coaches, and incentive alignment strategies for providers and consumers. The program will include 220,000 patients and 150 PCPs in Southeastern Pennsylvania.

As these two collaboratives show, states can take different paths to greater collaboration.

“The formula is different for every state, but the underpinnings and keys to success are willingness to be open and honest and work with each other in a collaborative fashion,” Adams says.

Although the catalysts have varied, each collaboration has brought together stakeholders from across the state as part of the initiatives. Getting everyone together to agree upon one set of clinical guidelines on chronic diseases allows payers to create pay-for-performance initiatives that physicians can more easily follow.

“Our hope is that eventually there comes a time when there is a national standard for clinical guidelines for all chronic disease and everyone works on the same

guidelines and reports them nationally,” Adams says. Payers are linking arms in these kinds of projects because they see that computer platforms that go across multiple players have the potential to improve care, lower costs, and improve outcomes. “[The medical home] is going to fail if just one payer is doing it,” Adams says. “They all have to join hands to make it happen.”

## Medical home collaborative

IBM organized a coalition called the Patient-Centered Primary Care Collaborative (PCPCC) in 2006. IBM created the collaborative because the company was spending \$2 billion on healthcare and getting little value out of it, says **Paul Grundy, MD, MPH, FACOEM, FACPM**, director of IBM’s healthcare, technology, and strategic initiatives for IBM Global Wellbeing Services and Health Benefits and chair of the PCPCC in Washington, DC.

IBM saw care coordination as a way to cut costs and improve outcomes. “We decided that we needed to work together to change the covenant,” Grundy says.

The collaborative promotes the medical home model and has grown to include large national employers, PCP associations, health benefits companies, trade associations, professional groups, and healthcare quality improvement associations. PCPCC has created an open forum in which healthcare stakeholders can freely communicate and work together.

The collaborative has conference calls each week and regular meetings. Grundy says as the leader of the group, he reminds stakeholders to stay focused on real change and not simply rearrange the deck chairs on the Titanic.

“We are on a sinking ship. We have to be bold, we have to think huge, we have to think beyond our individual constituencies,” he says.

A successful partnership is created by sharing a common purpose and not attaching an individual group’s agenda to the ultimate goal. “When you work with multiple groups, they all have this cherished outcome they want to protect. You have to keep reminding them to put the patient at the center. What would you want for your grandmother?” says Grundy.

## Model to emulate

More than one decade ago, several healthcare players in Minnesota came together to form the Institute for Clinical Systems Integration (ICSI) to improve patient care through collaboration and innovation in evidence-based medicine.

HealthPartners, Mayo Clinic, and Park Nicollet Health Services created a collaborative that included medical organizations, health plans, and business representatives.

Since it was created 15 years ago, ICSI has changed its name to Institute for Clinical Systems Improvement and has been involved in evidence-based guidelines in Minnesota, as well as improving the value and quality of healthcare. The collaborative grew further in 2001 and 2002 when Blue Cross Blue Shield of Minnesota, Medica, PreferredOne, UCare Minnesota, and Metropolitan Health Plan joined HealthPartners as sponsors.

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## What about DM?

Although the medical home concept has brought payers and providers together, there is one sector that has been largely left out: DM.

DM advocates say their programs, call centers, and predictive modeling could play a large role in the medical home, but the medical home pilots have been built for physician practices and without the collaboration of DM companies.

This movement of medical homes without DM companies answers the question as to whether DM should view the medical home as competitive or complementary, says **Vince Kuraitis, JD, MBA**, principal and founder of Better Health Technologies, LLC, a technology consulting company in Boise, ID. DM officials say the medical home needs DM (see “Physicians need DM in medical home model” in the February **DMA**).

“In theory, DM companies and physician groups could be complementary. In reality, it’s hard to believe physicians will look to DM vendors as a top choice for resources and infrastructure, especially given rocky relationships from the past,” Kuraitis says.

The trend is to have providers perform DM functions, says **Kent Bottles, MD**, president of the Bloomington, MN-based Institute for Clinical Systems Improvement, a group of 57 medical groups and six health plans that promotes collaboration and innovation to deliver patient-centered, value-driven care. “I think some of our providers are actually transitioning away from disease management companies and bringing them in-house,” Bottles says about disease and health management services.

DM companies are welcome to take part in the collaboratives, says **Steve Adams**, president of Centennial, CO-based RMD Networks, which provides Web-based collaborative care

software, Web services, and networks that offer interactions between physicians and patients. However, he adds, the adversarial relationship between DM and providers has led the two health players down different paths.

Adams says he’s beginning to see DM companies changing that dynamic. “I think they’re starting to adapt and evolve their model to be more collaborative and to do it in a more coordinated way with the providers,” he says.

The medical home concept is a positive for DM and health management, says **Tracey Moorhead**, president and CEO of DMAA: The Care Continuum Alliance in Washington, DC, an industry organization that promotes population health. DMAA’s executive committee is exploring several medical home initiatives that fit into the organization’s new population health definition, says Moorhead.

DMAA changed its name from Disease Management Association of America in 2007 as the DM industry has moved to a population-health based model. The multipayer, multipayer initiatives such as the medical home work well with population health, she says, adding that the organization has expanded beyond DM companies and now includes hospital and lab systems, physician groups, pharmacists, and pharmacy benefit managers.

Having all of these players on board to offer remote patient monitoring, health-risk assessments, and personal health records will play a key role in medical home collaboratives, Moorhead says.

“When you are talking about multipayer, multiplayer initiatives, that fits perfectly with our new definition of population health improvement,” Moorhead says. “Without these types of interconnecting health information technologies, you can’t be successful in these broad-scale initiatives.”

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The collaborative made Minnesota the first state to create a science-based best medical practices document developed by physicians and sponsored by major health plans.

ICSI now includes 57 medical groups, which represent 85% of Minnesota physicians, and some recent collaborators have looked upon ICSI as one to emulate.

The initiative has been successful because Minnesota has traditionally enjoyed an active, progressive payer community, and the area has a collegial atmosphere, says

**Kent Bottles, MD**, president of ICSI in Bloomington, MN, adding that ICSI has created trust among all parties in healthcare. To create a successful partnership among multiple players, the stakeholders need a place to discuss the issues, Bottles says. He describes ICSI as “a Switzerland,” where all sides can come together.

“The biggest thing, I think, is not the content knowledge and not the computer platform; it’s really a cultural or political way to get enough people to agree there is a better way to do it,” Bottles says. ■