Improving Our Nation's Health Care System: Inclusion of Chiropractic in Patient-Centered Medical Homes and Accountable Care Organizations

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Abstract

Objective: This report summarizes the closing plenary session of the Association of Chiropractic Colleges Educational Conference—Research Agenda Conference 2014. The purpose of this session was to examine patient-centered medical homes and accountable care organizations from various speakers' viewpoints and to discuss how chiropractic could possibly work within, and successfully contribute to, the changing health care environment.

Discussion: The speakers addressed the complex topic of patient-centered medical homes and accountable care organizations and provided suggestions for what leadership strategies the chiropractic profession may need to enhance chiropractic participation and contribution to improving our nation's health.

Conclusion: There are many factors involved in the complex topic of chiropractic inclusion in health care models. Major themes resulting from this panel included the importance of building relationships with other professionals, demonstrating data and evidence for what is done in chiropractic practice, improving quality of care, improving health of populations, and reducing costs of health care.

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Introduction

In its search to provide better, more affordable, and accessible health care, the United States is moving towards new models, such as patient-centered medical homes (PCMHs) and accountable care organizations (ACOs).^{1,2} The PCMH model aims at patient-centered, accessible, coordinated, comprehensive care, with a focus on improving quality of care and lowering costs.^{1,3} Chiropractic care has traditionally fit this paradigm, with an aim to be patient centered, accessible, and affordable.^{4–14} The chiropractic approach to health care is particularly suited for the conservative treatment and management of spinal disorders.^{15,16} However, we need to ask if chiropractic is well suited for the PCMH and ACO models. As health care is changing, more efforts are needed for collaboration and coordination within the overall health care system.

There are many socioecological factors on the individual, institutional, community, and policy levels that are essential to successful inclusion of chiropractic in PCMHs or ACOs.^{1,17–20} This is an emerging field, and there have been no articles published in this area that include chiropractic in the discussion of PCMHs or ACOs. Therefore, the Association of Chiropractic Colleges Educational Conference—Research Agenda Conference (ACCRAC) planning committee decided to have a focused plenary session on the topic of PCMHs and ACOs at the 2014 conference held in Orlando, FL; Saturday, March 22, 2014.

The purpose of this panel presentation was to address the complex topic of PCMHs and ACOs from various speakers' viewpoints and to provide suggestions for what leadership strategies the chiropractic profession may need to consider to enhance chiropractic participation and contributions to improving the nation's health.

Panel Discussion

The panelists (Figures 1 and 2) were charged to address the following issues:

1. What are PCMHs and ACOs and how do they work?
2. How can chiropractic work within and successfully contribute to these health care environments?
3. What chiropractic practice models would best function within these systems: primary care, specialty, or other model?

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Figure 1. Speakers from the closing session of the ACCRAC, Orlando, FL; Saturday, March 22, 2014.

4. What are the benefits and potential challenges with chiropractic inclusion?
5. What do we need to do for successful inclusion, on an individual level, health care facility level, and policy level, to ensure future success?

The speakers gave permission to audiotape the session so that others may gain from this presentation. Audio recordings of the speakers' presentations were transcribed, and the text was redacted for length and clarity.

Dr Bill Meeker

The importance of our topic today was highlighted in the most recent Institute for Alternative Futures (IAF) report entitled, "Chiropractic 2025: Divergent Futures."²¹ Dr Clem Bezold, the director of the IAF, presented the results of expert exercises that attempt to identify the potential future directions of the chiropractic profession. The IAF methods yielded 4 distinct scenarios that were designed to stimulate debate and actions that would be in our best interests. Typically, 2 of the scenarios represent the best case and the worst case; and the other 2 provide descriptions that are perhaps more likely, given that certain assumptions come to pass. It is interesting to examine and debate the components that are common to all of the possible futures of chiropractic. In all of the most recently developed scenarios, there are 2 common features that are the specific topics of today's panel discussion.

Figure 2. (From left to right) Drs Scott D. Munsterman, Karl C. Kranz, Bill Meeker, and R.W. “Chip” Watkins. (Color version of figure is available online.)

What are these things called *accountable care organizations* (ACOs) and *patient-centered medical homes* (PCMHs)? What do they mean to our future? In 1 scenario, the IAF report said that at least 30% of the US population will be in integrated or capitated care delivery systems by 2025 and up to 85% in another scenario. The IAF report also made the prediction that the fraction of doctors of chiropractic (DCs) that would be delivering care in these settings would range from 13% in the worst case scenario to 31% in the best case scenario. If you translate these percentages into numbers of chiropractors practicing in these settings in 2025, using the number of DCs predicted to be in practice in the United States, it will range from 5700 chiropractors for the 13% scenario to 21,000 chiropractors participating in care delivery in the 31% scenario. These scenarios are the integrated care delivery systems that we are going to be talking about in this session. This is a tremendous number of doctors, especially when we consider our current state. I have spent the last year trying to take count of the number of chiropractors that are officially part of 1 or more of these types of delivery systems however, and I cannot find 12 for sure. So, if I am doing the math correctly, that means that in the worst case scenario, starting next year, we would need to add 570 chiropractors per year to reach the predicted number by 2025. In the best case scenario, this means that 2100 DCs per year need to be added in those settings to make it up to the 31% fraction. So, based upon these figures, we have a very long way to go. The number 1 recommendation of the IAF report is this, “Integrate chiropractic into health care systems, particularly into ACOs and PCMHs.”

This panel includes experts in this area. They have been asked to address questions to include: “What are the common definitions, descriptions, and features of PCMHs and ACOs?” “Who is organizing and implementing these delivery systems, and how do they work?” “Are there opportunities in roles for doctors of chiropractic, and what are those roles?” “Are those roles as primary care or specialty role, or something in between?” “What would it look like?” “What would we call it?” “How would it work?” “What are the benefits and challenges for chiropractic inclusion?” And, I guess most importantly especially for this crowd here, “What do we need to do for successful inclusion?”

As educators, we know that it all starts with our educational organizations. We need to ask ourselves, “What do we need to do to prepare our graduates for what is coming down the pike?” The well-known Wayne Gretzky quote applies here, “A good hockey player plays where the puck is. A great hockey player plays where the puck is going to be.”²² So in our case, we should not worry too much about what is going on right now. What we need to worry about is where the whole health care delivery system is going to be. Therefore, to address these issues, we have invited the following panelists to make presentations.

Here is a brief introduction of our speakers: Dr Chip Watkins is currently a Senior Physician Consultant with Community Care of North Carolina (CCNC) and oversees much of CCNC’s PCMH and Quality Improvement efforts across the state as well as working directly with practices in Western North Carolina. He is also

Medical Director of High Country Community Health; an FQHC in Watauga County, North Carolina; and a Regional Medical Director for Access Care, 1 of CCNC's 14 networks. Importantly, he serves as a reviewer for the National Committee on Quality Assurance (NCQA) and is 1 of 19 physicians across the country to serve on NCQA's Physician Review Oversight Committee. He was the first medical doctor in the United States to be certified as an NCQA Content Expert.

Dr Scott Munsterman is the former mayor of Brookings, SD, and currently is on his second term as a South Dakota State House Representative. He is the Majority Whip Leader and Chair of the Health and Human Services Committee, State Affairs Committee, and Chair of South Dakota's Legislative Planning Committee. Dr Munsterman graduated from Northwestern College of Chiropractic in 1984 and has been in private practice with an integrated care clinic. He founded and operates Chiropractic Associates and the Best Practices Academy, and is also serving the role currently of Chief of Care Delivery at Northwestern Health Sciences University.

Dr Karl Kranz is former chair of the American Public Health Association Chiropractic Special Primary Interest Group. He served on the editorial review board for Topics in Clinical Chiropractic for a number of years. He is a New York state certified Firefighter and Emergency Medical Technician. He is currently serving as the Executive Director of the New York State Chiropractic Association. He has been there for the last 25 years and has for the past 14 years been the general counsel for the NYSCA as well. He earned his DC degree and JD degree and was admitted to the Bar in New York, Massachusetts, and the District of Columbia.

Dr Chip Watkins

Why is there a move towards PCMHs and ACOs? It is about providing higher quality care with better outcomes as well as higher patient satisfaction, but it is also about money. President Obama says if we do not get our arms around health care issues we are not going to be able to balance the budget. Keep in mind, this process started at least 20 years ago in the Clinton era. And, there is a firm direction from the men behind the curtain, if you will, about moving this forward. I think it is going to continue to move forward.

J Bradley Wilson, President and Chief Executive Officer of Blue Cross and Blue Shield of North Carolina, suggests that even if this federal mandate fails in some way, the system that brought us to where we are today is unsustainable.²³ Because employers, the

people who pay for health care, are demanding that Blue Cross identify providers that provide the best care at the lowest costs, that is, those who produce the highest quality outcomes at the lowest cost. That is what we are talking about today. Keep this principle in mind as we move along.

So what is a PCMH? A PCMH is a redesign of primary care, designed to meet what is called the *triple aim*. The triple aim includes improved quality, decreased cost, and improved patient satisfaction. We use health information technology and quality improvement tools to make this happen. That is the difference between primary care physicians today and the "Marcus Welby, MD" of the 60s and 70s. We are moving into the 21st century where we can use health information technology to manage populations, and that is one of the big differences between yesterday and today.

For over the past 200 years in the United States, we have trained, produced, and hired physicians who are fiercely independent, who have a "cowboy" mentality. This may be true in chiropractic as well. We are historically a group that has been fiercely independent and self-sufficient, and has a desire to be autonomous. The conversation about quality in health care goes something like this: "Are you practicing good quality medicine?" Most doctors would answer, "Yes! I have people in line waiting to get in here. Nobody is complaining and I am working very hard. Yes, I practice quality medicine." However, this conversation is moving towards "we all rise and fall on the collective performance of our organization." That is the future.

To borrow from Atul Gawande, MD, MPH, what we need are "pit crews" not "cowboys."²⁴ In this new model, everybody is working at the height of their license in a team-based approach. This is closer to the model for PCMH.

The PCMH model values the relationship between the patients and primary care doctors. It is a team-based approach. In this model, we get to use tools such as electronic medical records (EMRs), health information technology, and disease registries. This is meant to improve population health management. This means that instead of waiting for Ms Jones who has neck pain to come in to see you and her neck pain is getting worse, it means perhaps running a list of the patients from your EMRs who have chronic neck pain and who have not been in to see you for the past 6 months. Once you have that list, you can get on the phone and call those patients to come in for a checkup. So in this case, we are managing the population of patients proactively instead of managing individual patients reactively.

If you look at successful studies on PCMH, there are 4 things that are consistently part of those studies.²⁰ The first is care management. In North Carolina, the backbone of what we do at CCNC is our dedicated care managers. These are generally nurse care managers who watch over people with chronic diseases. So if we can manage a schizophrenic, diabetic, hypertensive patient with heart failure and take care of that patient and get that patient in to see their primary care doctor on a regular basis, the system, as well as the patient, is going to be much better off.

The second characteristic is expanded access. This might mean opening the office a little earlier, closing a little bit later, and opening on weekends. The idea is to see the patient when the patient needs to be seen, not 2 weeks from when they call.

The third characteristic is actionable data. Data should be real time or as close to real time as we can get it. We need to be collecting data that tell us how we are performing and what kind of quality issues we need to be addressing with our patient populations.

The fourth characteristic is the use of incentives. For example, I was involved in a multipayer initiative from the Center for Medicare and Medicaid Services (CMS), where depending on the level of PCMH that you achieved, you received \$2.50 per member per month, \$3.00 per member per month, or \$3.50 per member per month. So the use of incentives is important as we make the shift from being paid for volume to being paid for quality outcomes.

What are the benefits of PCMH that we know from the literature? The literature shows decreased emergency department visits, decreased hospitalization, lower mortality, and better preventive and chronic disease care; and the patients are happier.²⁵ Not only are patients happier but staff members are happier, burnout is lower, costs are lower. There are many benefits from this model.

So where do chiropractors fit in? The *ACA News* provides a definition of PCMH. It says DCs provide comprehensive care that includes diagnosis, treatment, prevention, and management of acute and chronic disease, integrating with other providers in the system and being a patient advocate. In this article, the authors state that there are challenges to fulfill some of these expectations.²⁶ There seem to be turf wars going on within the chiropractic profession in regard to those who want to do more primary care and those who want to stay in a subluxation-based approach to patient care.

Let us take a look at the 6 standards that define a PCMH. These are the standards in the NCQA PCMH:

1. Enhanced access and continuity. Do you have extended office hours? Are patients able to get in or is it “the doctor will see you in 2 weeks. Sorry we are full.” This would not be good to tell patients that they cannot access you, and it certainly is not patient centered. So improving patient access by having same-day appointments is important.
2. Identifying and managing patient populations—including comprehensive health assessments. For example, to meet this standard, you would have to choose 3 preventive measures and 3 chronic diseases that you monitor regularly, and then be able to have your disease registry or electronic health record pull up lists of these patients or pull up a list of patient who you have not seen in 6 months or a year. You would also be required to pull up lists of patients who are taking a certain medications and show how you manage those as well and to identify patients who have been prescribed a brand name drug instead of a generic drug or notify patients about a recall.
3. Plan and manage care. Our actions need to include planning and managing care. Patient management in this standard, at least in part, has to do with medication management, medication reconciliation, ePrescribing, and these sorts of activities.
4. Provide self-care and community resources. This standard deals with whether your practice is tied in to local community resources where patients can get more support if they need it and how you manage those referrals.
5. Tracking and coordinating care. This is an extremely important standard. It is concerned with doing laboratory work and your practice does not let anything fall through the cracks. Do you have a process in place, and do you have policies in force that, if you order a laboratory test, you can close that loop and ensure that that patient got the laboratory test and it is entered into the medical record? This also includes imaging and specialist referrals.
6. Measure and improve performance. This standard deals with quality improvement. Can your practice look at lists of patients dealing with 3 preventative measures, and 3 chronic or acute clinical measures, do an intervention or PDSA (Plan, Do, Study, Act) cycle, look at that list again, and see if there has been any improvement or decrease in the quality metric you are looking at? Then are you able to do another cycle to see if you can improve that process even more?

To obtain PCMH recognition, you must understand that it is a “points game.” There are 3 levels, and there

are 6 “must-pass” elements. If you miss any of the “must-pass” elements, you do not get recognized as a PCMH. (<http://www.ncqa.org/Programs/Recognition/Practices/PatientCenteredMedicalHomePCMH.aspx>).

What might be the difficulty for chiropractic? First thing: eligibility. That may be a problem, as the first requirement is whole-person care. Most chiropractors have a holistic philosophy. However, it is the personal, primary care physician who provides first contact and continuous and comprehensive care. And it is care that is integrated across the health care system. It is team-based care so that whole-person provision is comprehensive care and emphasizes the spectrum of care needs, ranging from ear infections to Papanicolaou tests and everything in between. (For detailed information about the NCQA criteria, please visit www.ncqa.org).

There are the “must-pass” criteria. Factor 2D in the NCQA submission has to do with using data from the EMR for population management. You could choose 3 preventative services; oftentimes, these are procedures like mammograms, immunizations for kids, and chronic care services. It could be for chronic low back pain or chronic neck pain; but typically it is diabetes, hypertension, heart disease, or asthma.

Factor 3C is regarding “care management.” You have to use evidence-based guidelines and show NCQA what you are doing for your patients at the point of care. Where do those evidence-based guidelines come from? They come from organizations like the American Diabetes Association or Joint Commission on Hypertensive Care.

3D is about medication management. 3E is e-Prescribing, which is sending in prescriptions from your EMR. 4A is a must-pass element regarding developing an evidence base around self-management plans for patients and families and helping them manage their care. So an example of that might be doing an action care plan for a child with asthma.

Factor 5B is the must-pass item having to do with referral procedures. It has to do with referral tracking and follow-up. Element 4 of factor 5B has to do with comanagement agreements with your referral sources whether they be with orthopedics or cardiology. For a cardiology patient with atrial fibrillation and they are on Coumadin, we need to ask, “Who is managing the Coumadin? Who is taking care of the other medications? Who is doing what?” This is something that medical doctors struggle with, so this may be an area that is also challenging for chiropractors.

Factor 6C is a must-pass factor having to do with assuring quality improvement. How well does your

practice do PDSA cycles? How good are you at looking at an issue that needs improvement, putting an intervention in place, and then measuring how well you are doing with the improvement? This is a big part of the changes that are happening in medicine.

What are ACOs? An ACO is a new model of care delivery. This is the first time in history that medicine has been asked to be accountable for the care that it delivers. Accountable care organizations consist of providers that are jointly held accountable for achieving quality improvements and reductions in spending growth. These include quality improvement, better outcomes, and lower costs overall.

How are ACOs different from PCMHs? There are 2 things that separate PCMHs from ACOs. Patient-centered medical homes are foundational and can be thought of as a starting place for becoming part of an ACO. However, the differences are financial. With an ACO, there is risk. This means shared savings contracts where there is currently upside risk. For example, if the group or the organization saves money, the provider gets to split a little bit of the shared savings. Down the road, maybe 3 to 5 years from now, we are looking at double-sided risk. So if you have gains or improvements that save money, all will participate. However, if you lose money, your savings are going to be at risk. So if the entity saves money, everyone wins. If the entity loses money, the providers lose money as well, hence the double-sided risk.

The second characteristic that is different between ACOs and PCMHs is the medical neighborhood, including the specialists and the hospitals that are tied to the ACO. They are an integral part in the ACO model and are a necessary part of the medical neighborhood.

Here are some challenges for the chiropractic profession that you might need to talk about and work through. Only your profession can decide where you want to go with this information. For example, if you were to become part of an ACO, one of the struggles might be that CMS has already drawn up the rules for engagement and for success or failure. For instance, they have already set up the performance measures on patient care experience, care coordination, patient safety, preventative health, and vulnerable populations (eg, patients that are at financial risk or the elderly.)

For example, one of those performance measures is the rate of readmission within 30 days of discharge. Does the patient see the primary care doctor within 30 days after that patient has left the hospital? Has there been a medication reconciliation done? Looking at the number of admissions of chronic obstructive pulmonary disease

(COPD) in your practice: are those levels going down? What is the number of patients with COPD in your practice? Are you measuring metrics in that population? Are you monitoring these types of conditions? A place where chiropractic might fit in is providing chiropractic care for a patient and the treatment affects the nerves that function within the intercostal muscles and the treatment improves lung expansion resulting in better breathing. This may not be able to be measured directly, but it is a change that may allow patients with COPD to do better. What medicine in the New Order is looking for are outcomes; what are the things that you do that make patients objectively better?

For preventative health, we look at conditions like influenza immunizations, pneumococcal vaccinations, mammograms, colorectal screenings, and other prevention measures. Those are the things that are being measured for preventive health in this model.

The big question is, “how can chiropractic get involved?” Based upon my experience working with NCQA in regard to standards and eligibility, the lines are drawn pretty firmly in terms of eligibility. Frankly, I do not think chiropractors will be allowed to participate there. That is, it will be unlikely for chiropractors to be considered as potential providers in terms of becoming recognized PCMHs. So you might want to consider looking at URAC (formerly the Utilization Review Accreditation Commission) or The Joint Commission (formerly Joint Commission on Accreditation of Healthcare Organizations) as other purveyors of PCMH who I know are a little bit more accepting of alternative care, such as chiropractic.

The Patient-Centered Specialty Practice is a new program for NCQA. This might be one way for chiropractic to approach them. I think a viable approach is for chiropractic to enter as specialists of spinal health as a possible consideration. For example, one model suggests *primary spine care specialists* as a designation. But whatever model is chosen, the main thing to focus must be on what gives patients better outcomes at lower costs.

Another challenge for chiropractic is getting claims data from the insurance companies. That can be a full-time job. Try to get as much of that information as you possibly can. You should do more pilot projects and publish in scientific journals. Is an integrative medicine program at a hospital that has a great preventive medicine program or integrative health or family practice residency willing to open their minds and include chiropractic, especially since 20% of the health care expenditures are on musculoskeletal issues?²⁷ They could offer chiropractic care as another model as

opposed to the typical medical model which is a nonsteroidal anti-inflammatory drug, a narcotic, and a muscle relaxant along with some physical therapy perhaps. This type of approach seems reasonable and then we can measure what the outcomes are.

Find out all you can about contracting with payers. This is different than practicing office-based medicine, and you may need some colleagues who are skilled in this area to make those connections. Make sure that you show them the data that chiropractic is producing in terms of outcomes and financial impacts.

To be included, I suggest that the chiropractic profession participate and support primary care organizations. For instance, consider sending a representative to the American Academy of Physicians meeting. Attend the meeting and educate others about what you do and the research you have done.

Learn about quality improvement. Consider additional training from various quality improvement programs such as the one that the NCQA offers (<http://teamstepps.ahrq.gov/>). You can go through learning collaboratives; maybe there is a collaborative already in your state or regionally. Get together with other colleagues in your area. Come up with some metrics that you want to measure. Do an intervention and measure the improvement and then get that research published.

Develop relationships with primary care doctors. If you see a patient, find out who his or her primary care doctor is and send a letter. You do not have to include that you adjusted subluxations at C5 and C6. You do not have to get into a lot of detail. Include in the letter that you saw the patient, you appreciate their willingness to work with you, and maybe you could have lunch sometime. Whatever you wish to include is fine, but send them a follow-up letter.

Become more involved legislatively. And it is important to support your political action committees (PACs). When I was president of North Carolina Academy of Family Physicians, we looked at who was giving the most to their PACs in the state; trial lawyers and hospitals were ahead of everybody. Chiropractors gave more than family doctors by quite a bit. Giving to your PAC (for better or for worse) allows you to get the ear of your legislators. This is an important action to consider.

Chiropractic needs to show that it can improve outcomes and lower costs. That will get you a place at the table. Any of the arrogance that you may feel coming from the medical community goes away when you prove to third-party payers that when a patient with low back pain sees their medical doctor and a chiropractor, patient outcomes improve, either through total costs, shorter time out of work, or whatever metric

you want to measure. Or perhaps you want to investigate if chiropractic can get patients better without as many drugs and that will save money for those who pay for health care. These are the things the payers of health care will counter the naysayers with. You present your evidence of better outcomes and lower costs with chiropractic to the payers of health care and then you will have a place at the table.

Dr Karl Kranz

My experience with PCMHs or medical homes is different. As an attorney, I am focused on law and regulation.

Regarding the genesis of medical homes and the care organizations, the defining moment was issuance of *To Err Is Human*.²⁸ If the 1980s was the era of variations in health care, then the 1990s was the era of medical guidelines and managed care. There were issues in quality that preexisted that crescendo. There was a catharsis with *To Err Is Human* and the *Crossing the Quality Chasm Series* that followed.

Some may say that the current system cannot do the job. Trying harder will not work. Changing the care systems will. If you look at the Affordable Care Act, title 3, subtitle a, it is about transforming the health care delivery system. And the key word is *transformation*. This is a big change.

Back in 2004, I came across pay for performance in a health affairs journal. So I started attending pay-for-performance conferences, which were largely industry driven. It was a very employer business-driven kind of movement, which was kind of novel. What they did with Bridges to Excellence was to focus on disease management and chronic care issues. They would certify credential physicians, primary care physicians, through NCQA in, for example, diabetes management, cardiac care, and what have you.

If you attend these conferences long enough, the names start to become familiar: Arnold Milstein, MD, from Stanford University and the Pacific Group on health; Karen Davis from the Commonwealth Fund; Ken Kizer, MD, from the National Quality Forum; Don Berwick, MD, from the Institute for Healthcare Improvement; Peggy O'Kane from NCQA; Carolyn Clancy, MD, from the Agency for Healthcare Research and Quality and who was behind the Ambulatory Care Quality Alliance. This is the hospital counterpart to the Bridges to Excellence type of program. They were a little astonished when I showed up to these meetings because I was the only chiropractor there, which took them by surprise.

Bridges to Excellence developed different programs, such as cardiac care and diabetes management. Primary care physicians who were certified through the NCQA were paid an extra incentive to provide follow-up case monitoring, coordination of care, continuity of care and longitudinal care, with a focus on chronic disease management issues, elements that were missing in the contemporary health care system.

And from Bridges to Excellence, the idea of pay for performance found its way into the Affordable Care Act. Pay for performance established incentives for quality improvement and cost efficacy at the level of physician practice. Primary care specialties involved were general physicians or family physicians, internal medicine, and geriatric medicine.

The 5-year pay-for-performance demonstration project involved 10 large pay-for-performance or physician group practices. Each had more than 200 physicians involved. The idea was to improve management and coordination of care, shared savings. Center for Medicare and Medicaid Services was going to share savings with the medical groups. Up to 80% went back to the physician group practice, and 20% went to Medicare.

The first time I heard about a medical home was at a pay-for-performance conference. The chronic care model was Wagner's creation and came about in 2001.²⁹ The implication was that chronic care, even with a minority of patients, has an effect on the overall cost of care. And although primary care providers are adept at handling acute care episodes, there are quality care issues and cost overruns with the chronic care issues. So there was devotion of refocusing of and incorporation of these chronic care models into the Affordable Care Act.

Around 2000, Wagner collaborated with Donald Berwick at the Institute for Healthcare Improvement (IHI). The IHI had an instrument called the Breakthrough Series that was meant to rapidly introduce novel concepts from strategic thinkers who really wanted to instill change in the system, like a model of Chronic Care (CCM) that Wagner produced. If you examine Wagner's CCM, it looks like a proto-type of an ACO and includes elements of a medical home as well.

This chronic care model (http://www.improvingchroniccare.org/index.php?p=The_Chronic_Care_Model&s=2) looks like an ACO, and it outlines a medical home as well. But if you notice down in the lower right hand corner, it says "prepare a proactive practice team." This is a theme that runs throughout the Affordable Care Act and is this relationship of care.

In 2006, Congress passed the Tax Relief in Healthcare Act. In section 204 of the Tax Relief in the Healthcare Act, the medical home demonstration

project included various care management fees and incentives payments to physicians providing services at a medical home.

Around the same time, the Patient-Centered Primary Care Collaborative formed, which included a large coalition of more than 1000 organizations and individuals comprised of employers, physicians and other professionals, consumers, patient family advocacy groups, patient quality organizations health plans, hospitals, and unions. The list of entities included IBM, Microsoft, Lilly, Merck, United Healthcare, and Xerox.

In 2007, the American Academy of Family Physicians, the American Academy of Pediatrics, the American College Physicians, and the American Osteopathic Association published *Joint Principles of the Patient-Centered Medical Home* (Joint Principles) (http://www.aafp.org/dam/AAFP/documents/practice_management/pcmh/initiatives/PCMHJoint.pdf). They promoted that each patient has an ongoing relationship with a personal physician trained to provide first contact and continuous and comprehensive care. That was physician-directed medical practice in which the personal physician needs a team of individuals. The primary care provider would be the center, the hub of all the coordination of care dispensed. The primary care physician is at the center of the medical home. He/she does all the directing and coordinating of the care of the patient.

Part of the clamor of Pay-for-Performance involving medical homes found its way into section 204 of the Tax Relief and Health Care Act of 2006 (TRHCA), which provided federal funding for various Medical Home Demonstration Projects. Almost 100 different demonstration projects were funded by CMS through the TRHCA. At around the same time, the Patient-Centered Primary Care Collaborative (PCPCC) formed, established by a large coalition of more than 1,000 organizations and individuals who joined together to advance a health system built on a foundation of primary care and the patient-centered medical home.

To their credit, the American Academy of Family Physicians had a national demonstration project where they funded demonstration projects as well as going through CMS. You are going to get a more honest appraisal if you look at the demonstration projects that were done by the American Academy of Family Physicians. They are a little less favorable, and they highlight a lot of the issues and problems that primary care physicians are going to face.

There are other demonstration projects that are ongoing. CMS is through section 3021 of the Affordable Care Act, and CMS is testing a number of

medical home projects. One of them is multipayer advanced primary care practice demonstration project. This is being tested in Hudson Valley area in New York and involved 75 different primary care practices. There are no chiropractors involved that I am aware of. That is an ongoing project that is currently proceeding.

There are different accreditation organizations. According to the Urban Institute, there are roughly 10 different accrediting agencies. The top one is NCQA. It is the most frequent one that accredits organizations. Joint commission on Accreditation of Healthcare Organizations comes up frequently.

Patient-centered medical home growth has really taken off. The Affordable Care Act did not pass until March 10th, 2010; but medical homes had already started to take off in the time that act was passed. The primary care physicians that are involved are proportional to the number of primary care physicians that are in the system.

When it comes to chiropractic, what is our position in the PCMH? How do we relate to them? To understand, we must read what the actual statute says. It says the Secretary of Health and Human Services shall establish a program to provide grants or enter into contracts with eligible entities to establish community-based interdisciplinary interprofessional health care teams to support primary care practices including obstetrics, and gynecology, what have you. The grants or contracts shall be used to establish health teams to provide support services to primary care providers and to provide capitated payments to primary care providers.

Section 3502(a)(4) says to ensure that the health team established by the entity includes an interdisciplinary interprofessional team of health care providers as determined by the Secretary. Such a team may include medical specialists, nurses, pharmacists, doctors of chiropractic, and licensed complementary and alternative practitioners. It says “may” include; thus, it is discretionary. It is not required to include chiropractors. The requirement for the health care teams is that you must establish a contractual agreement with the primary care providers to provide support services. This is a novel idea where chiropractors may or may not be direct access anymore.

Subsection (c) of 3502 requires that members of the PCMH health care team establish contractual agreements with primary care providers to provide them with support services including the following: care must include personal physicians or other primary care providers, whole-person orientation, coordinated and integrated care, safe and high-quality care through evidence-informed medicine, appropriate use of health

information technology, continuous quality improvements, expanded access to care, and payment that recognizes added value from additional components of patient-centered care. These are the “Joint Principles” that were adopted by the 4 primary care groups.

Section 3502(d) stipulates that a primary care provider who contracts with a care team will provide a care plan to the team for each patient treated by the team and meet regularly with the care team to ensure the integration of care provided to the PCMH patient. Does this mean that you lose direct access to patients if you have to go through a primary care provider? Although they are disclaiming that and they are hedging their bets on that, we are really not sure because chiropractors for the most part have not been part of these demonstration projects. They have not been included in the process.

This topic alone with the PCMH could take a conference of 2 to 3 days by itself, as well as ACOs. There is so much that can be said about the Affordable Care Act.

Dr Scott Munsterman

As we begin to look at this challenge of ACOs and PCMHs, it is important to have a good perspective from a lot of different directions. And I will try to provide that for you today.

I have spoken with hundreds of DCs and probably some other health care providers in that mix just the last year and a half on this subject. When I ask the question, “do you know what a patient-centered medical home is?” very few know. Typically, they think it is a nursing home.

It was around 2010 when I started paying attention to what was going on in regard to these models. It was during this time that I took the time to read the House version of the health care reform bill as it was going through the House side and then the Senate version. I dove into this because I knew it had some great implications for our profession moving forward. I wanted to learn as much as I possibly could about PCMHs and ACOs.

I took the PCMH training from the NCQA and the ACO training before they had their content expert course work. I also took the URAC patient-centered health care home training and took their patient-centered health care home auditor training to try to learn as much as I possibly could. And so at 2010 is when this PCMH movement really took off. It was mentioned before by Dr Watkins in his presentation that the marketplace was taking off at that time. There was still a lot of talk about will this health reform movement even go anywhere because of issues surrounding the legal authority of the Patient Protection Affordable Care Act at the time. And it did because the marketplace is driving this transformation in health care.

Back when I started practice in 1985, all I need was a license to practice. Along came the mid-90s, and with it managed care came. What we needed to do then was not only have a license, but we had to become credentialed. We had to meet certain standards to be on a provider panel and were subject to utilization management. And now with this new transformation we have another criterion, which is a game changer. And that is pay for performance, the triple aim, ACOs, and PCMHs. This is the core of the transformation.

About a year and a half ago, my mother-in-law was in the hospital. I stepped out of the hospital room with my brother-in-law. He asked me, “so what is going on in health care?” I thought how in the world do I explain this to my brother-in-law?

And then as soon as I asked myself that question, it occurred to me, my brother-in-law is a farmer so I should use his terminology. So I said, “You get paid for your yield do you not?” And he says, “Yeah.” And I said, “You go out and you plant, you work the ground, you spray, you put your own gas in your combine and your tractors, and you harvest. Then when you bring it in, whatever the market price is you get paid, correct?” And he goes, “Well, yeah.” And I said health care is the opposite of that today. However, we are moving to the way that your industry is, where we will be paid based upon the outcome of our work.

Health care is being driven towards efficiency; much like precision agriculture practices have driven the agricultural industry to do things better. That is the way health care is going to be pressured into this whole system.

We can imagine that the ACO is an umbrella covering the PCMH. This umbrella seeks to achieve the triple aim: better patient care experience, improved population health, and lower costs. How is this done? This is done through contracting with practices that have aligned themselves with the PCMH or health care home guidelines, which improve care coordination, collaboration, and communication within that system. Outside of that is the medical home neighborhood. You have a population of patients that the PCMH practice takes care of and has a long standing relationship, a continuous relationship. The primary care clinicians within the PCMH provide a comprehensive look at the care needs of the patient, are provided direct access to the patient, and make the decision on whether the patient needs further services from a provider within the medical neighborhood.

Who is accrediting PCMHs? The NCQA has developed PCMH primary care and, more recently, specialty care standards. Whereas specialty practices focus on comprehensive care for a single disorder, are usually not first contact, and coordinate with primary care, the PCMH primary care focuses on the whole person, is first contact

for most health concerns, has a clinician that leads a team of providers, and provides comprehensive and coordinated care. As you take a look at the descriptions for each, keeping in mind that we know our profession and we know our industry, can the chiropractic clinician practice under one or both of these categories?

Where is the opportunity for chiropractic in care delivery? We need to take a look at the marketplace and we need to listen closely to the voice of the customer. The voice of the customer is the individual that is in their business writing the check at the end of the day for health care services.

This customer is looking for a primary care solution. They are looking for care that is evidence based and evidence informed. They are looking for something that is out of the box, alternative, whatever you want to call it. They are looking for strategies that will stop health care problems from happening or to manage them better. Our patients want the triple aim.

This makes sense because it makes business sense. This solution is what the customer and the public are looking for. The key is population health management, which is identifying high-risk patients and creating a proactive plan to address those risks that will get this under control.

Can chiropractic physicians play a vital role in population health management? We are well recognized for our neuromusculoskeletal work. But is there more that could be provided?

There are 2 levels of services that we can provide as clinicians within this transformation or new care delivery system. We can imagine ourselves in both of those columns of specialty and primary care services. We are trained in physician-level services. And the key group of words there I would like you to pay attention to is that we *differentially diagnose* (Table 1).

As I speak to legislators, I explain that our profession can diagnose from A to Z; but we are also fully aware that our treatment scope is narrower than that. That is who we are. It is our responsibility to diagnose. I do not think that should be an argument. We need to continue with that responsibility.

We provide physician-level services that are primary health service portal of entry. We cannot ignore this. Just because the public does not know, does not mean that our value should be ignored. In addition, we provide specialized care for neuromusculoskeletal conditions that the public may be very well aware of. The chiropractic profession is capable of providing portal-of-entry primary health services consisting of evidence-based/informed approaches from well-being care to more specialized neuromusculoskeletal care. Natural,

Table 1 Types of Services

Specialized Care for Neuromusculoskeletal Conditions	Physician-Level Services
Manual therapies (spine and extremities)	Consultation
Low-cost rehabilitation	General or focused physical examinations
Education, home exercises, and recommendations	Differential diagnosis Conservative, drug-free treatment Wellness and health promotion Patient management Referral to specialists

holistic, conservative care is the key component that is missing in the primary care medical homes today.

Both (URAC and NCQA) standards have components of wellness and health promotion that are not being delivered as effectively as they could be with a chiropractic physician as a part of a team-based care approach. In addition to treating neuromusculoskeletal conditions and participating in the care pathways that those patients should have, the diabetic patient, the obese patient, the chronic pain patient, and the hypertensive patient could greatly benefit from conservative neuromusculoskeletal care and a well-being natural care approach that can be combined with traditional biomedical approaches in an integrative care pathway. This is the role that we as chiropractic physicians can play.

What are the practice requirements to make this happen? We need to use evidence-based and evidence-informed best practices. We need to align our practice operations with the PCMH standards. We need to adopt an electronic health record so that the practice technology piece is in place. We need to track outcomes. We need to implement shared decision making and self-care management with our patients to improve patient engagement. Then, we need to set the stage for collaboration with care coordination and comanagement with other clinicians within the team in the PCMH setting.

These are the requirements that practices will need to have in place to play in the ACO and PCMH playground. Part of the challenge we have today is that our educational institutions need to get themselves up to speed, emulate this way of practice, and teach this model so our new doctors can proceed further into their role in the new care delivery system.

Our chiropractic doctors need to know now how to identify and manage patient populations. This means collecting good patient information, demographics, and clinical data, and providing comprehensive health assessment using the data for population management. We need to provide a comprehensive health assessment and then move towards preventative medicine examinations and provide preventative care and chronic care services to become a normal role in practice. And of course, a comprehensive health assessment includes a health risk appraisal and identifying again what are the key things that those patients have that they either are at risk for and/or have a comorbidity.

According to the NCQA guidelines, it is important to understand that you need to identify the top 3 conditions in your practice and then ask yourself, "What are your protocols? What is your care management approach for those top 3 conditions?" Well if you think about the top 3 conditions in the chiropractic industry, low back pain, neck pain, and headache usually are the most prevalent. What are our protocols, evidence-based/informed protocols, to manage these conditions? How do we wrap around with our physician-level services and provide more preventative care screening that can be done as outlined in the US preventative services task force guidelines? These are just a few of the questions we need to ask ourselves.

We also need to address the preventative medicine examination, the general examination, that our educational institutions teach us as clinicians and that we should not ignore because, again, we have a responsibility to differentially diagnose.

We also need to address preventative care services and chronic care services and identify what we are looking for with our patients. When do our patients need to have a proper well-being care follow-up? And if they do have a chronic condition or comorbidity, understanding they have other providers taking care of them. How do we contribute to that care pathway in a collaborative and meaningful manner to make it truly integrative? Therefore, integrated care pathways will be extremely important and will be important for us as we meet the requirements within our practices to be a part of that decision-making process for those patients.

As we look at the general scheme of things, here are some strategies for moving ahead. We know we have a certain patient population. That patient population could be a senior living community, it could be an employer group, it could be an ACO, or it could be a health plan. Wherever those populations of patients have accumulated within a management system, that is the patient population we are working with.

We need to ask the following: What are the care models that the patient population needs, and how do we contribute to that? How do we provide care pathways? How do we collaborate with those? What is the business model that sustains that care model to be able to provide care to the patient population? These are the fundamentals of care delivery.

We also need to consider the CMS rules for ACOs. The chiropractic profession is not recognized as ACO professionals. And in part that is because we currently do not have Medicare coverage for evaluation and management services. And so do we have barriers as a profession? Yes, we do. And we are hopefully addressing those.

We have to make changes happen throughout this transformation process. Team-based care. That is what the patient-centered medical standards are all about. We cannot have a team if the team is not allowed to suit up. And, I would argue, we are an integral part of the team.

Dr Bill Meeker

I thank our panel of speakers for their collective work in drilling down to the details about what these concepts are really all about.

Here are some of my thoughts on these presentations. First, I think you noticed that NCQA alone has credentialed over 6700 PCMHs in the United States already. So this is a movement that is well under way. Second, I noticed that we are using a lot of health policy jargon. There are a lot of buzz words flying around. Some of these terms are pretty familiar to us, but some of these terms are new. But basically, the devil is in the details. And we must understand the details.

The third observation was from my thoughts as an educator, "Oh my goodness, what do we need to do tomorrow that is different than we are doing now to train our current students to prepare to be able to walk in the doors of these organizations so they can make a case for being included and thus do a good job for their community and have a nice career for themselves?"

Here is a question for the panel. Some recent data have come out that the cost savings impact of PCMHs and ACOs may not be quite as dramatic as what was expected. And this may or may not put a damper on the mood toward these care structures. I am curious to hear what our panelists may have to say briefly about the implications of these data and what it might mean.

Dr Chip Watkins

You are talking about the study that came out recently from Pennsylvania about the health plan. I

think it was actually a multi-team-payer plan in Pennsylvania. I think I would be quick to say that the data came out of medical homes that were under the 2008 NCQA standards. They were not nearly as stringent in terms of health information technology and meaningful use. As a matter of fact, you did not have to have an EHR to achieve a level 3 PCMH in the 2008 Standards. So I think I would say these data are very early. More of the later studies that have used higher standards tend to be showing more positive outcomes.

Having been involved with our multipayer project in North Carolina, there is a process that a practice has to go through. First thing is “checking the box.” You must complete all the NCQA standards and get recognition, and then the process of transformation follows. It is a big lift to go through NCQA, to implement an EHR, and to go through NCQA recognition within a year. This is a lot of work. So we are beginning to see transformation in the practices we have been working with. I think that is where we are headed.

Dr Karl Kranz

NCQA, they are the most ubiquitous accrediting credentialing of medical homes of the 10 organizations that actually accredit these entities. But they are the most heavily criticized as well for being too process oriented or too heavily process oriented. And even the 2008 changed. The 2008 standards I believe were borrowed from Bridges to Excellence, but then they updated them in 2011.

There is a new set of NCQA standards that is supposed to come out in March. Even those are being criticized by François DuBryant who is now running Bridges to Excellence. So yes, these were under the 2008 standards, and they have been heavily criticized. Because they are the earlier version, you have to take everything they say with a grain of salt.

At the same time, the Patient-Centered Primary Care Collaborative and NCQA were very defensive about the outcomes of that study, noting in particular that they were the 2008 standards. As well, the state of Minnesota issued their findings of their PCMH projects as well as the state of Vermont. And those 2 states were very positive, had very positive outcomes for PCMHs.

Dr Scott Munsterman

I agree with what has been said. The way the standards are made, it will create efficiency if they are followed. But that needs to be couched with the question, “Where are all the savings going to come from?” All the savings

are going to come from the decrease in hospitalizations. Who owns the practices? Large health systems. It is going to be an interesting process, as these large health systems that have hospitals that all of sudden used to be profit centers are now cost centers. That is quite a quagmire to think about.

As we move down this road, I think the studies need to be very specific as to the background of those practices and what is driving some of the decision making and driving the referral patterns and driving how they are using those standards. Independent practices are doing the same thing. It will be interesting moving forward to see how that is all managed.

Dr Christine Goertz

This has been a very interesting discussion. Two of the panelists mentioned something about primary contact or portal of entry within these systems. Dr Watkins, I am just curious about your perspective on how realistic is it that we would be able to successfully sell a model with chiropractors as portal of entry or first contact within these systems.

Dr Chip Watkins

I think you are asking will chiropractic have a place and how do we get to sit at the table, right? In terms of NCQA standards, the way things stand right now, it is probably not going to happen with NCQA. However, there are a number of other purveyors of medical home models that might be more willing to accept that. But from the NCQA standpoint, which is the one I really know, not so much.

Dr Christine Goertz

A question to the other 2 panelists. To what extent should we fight for this?

Dr Karl Kranz

The letter of the law says that, as part of the health care team, we are supportive of primary care and primary care is taking the center role. So what does that mean? It is not really clear because we really have not participated. We really have not seen the collaborative contracts that we are supposed to have with primary care PCMHs. At this point in time, I think it is too early to say.

What bothers me about this process is that all of these elements that are in the Affordable Care Act were

being developed over time. And we have not been part of that conversation. I do not think we can afford *not* to be in that conversation mix and in that discussion. So far, we just have not been.

Dr Scott Munsterman

Who is the primary care provider in rural areas such as Isabel, SD? Who is the primary care provider in Lemmon, SD? Or in Harding County? Or I could go to a good friend of mine from North Dakota who asked me exactly the same question. I'll tell you: the doctor of chiropractic. This is a primary issue of access.

We have to look at how we are prepared in primary health services. What are the things that we do? We are portal-of-entry providers. Yes, we have a narrow focus of treatment in what we do. But we have primary health service skills that could be used on a portal-of-entry basis and especially within a team-based care approach. So am I willing to fight for that? I believe that is the truth because I have seen it in action.

Dr Bill Meeker

Okay, we do not have a lot of time left, so quick question, quick answers please.

Dr Ian Paskowski

I am Ian Paskowski from Beth Israel Deaconess Hospital, Plymouth, MA. At our group, we participate with 2 ACOs: 1 pioneer and 1 Medicare ACO. We are strategic parts of an integrative care pathway we helped to develop. We have been doing this since 2008. We watched the evolution of this process in which it moved to almost 100% insurance which is what is going on in the rest of the United States. If we do not move on this process as a group, I feel that we are going to be in trouble.

Dr Watkins alluded to the idea that rules continue to be made. If we do not get a place at the table and be part of contributing these rules, we are going to be left behind. We are already participating as primary spine providers. My question is to Dr Watkins. If the chiropractic profession approached this as a primary spine provider or as a primary care physician, what would be the easier conversation to have?

Dr Chip Watkins

I do not know the answer to that question. I can tell you that the focus is on outcomes and lower costs. Someone from this group could go to a health care

administrator and say, "Look! We have participated and here are our data." I am aware that this has been going on with chiropractic. That is the goal in getting into the system.

As a primary care provider and as a citizen of the United States, I do not care. If it helps my patient, particularly helps them without surgery and my patient can have better outcomes and can live a better life without all the drug adverse effects and so forth, I think it is something we ought to be thinking about. It makes sense. It is where we are headed. It is the right thing to do.

Proving data (ie, outcomes and lower costs) to the medical community and having discussions will help. You must have conversations. I think we are better off talking to one another and having a dialog about it than standing in our silos, which, at the end of the day, ends up hurting the patient. That is something that I am not willing to do.

Dr Tony Hamm

I am Tony Hamm and I represent the American Chiropractic Association. Given the fact that we have been virtually unrecognized through these efforts, such as NCQA, despite all our best efforts, what could the individual doctor of chiropractic do to get recognized and participate in some of these models?

Dr Bill Meeker

I think we know the answer, but just a quick answer from all 3 speakers.

Dr Scott Munsterman

Right now, there is not an organization that will accredit DCs. Can we prepare them? Absolutely.

Dr Karl Kranz

I agree. It is going to be a long process and something that requires the undivided attention of the profession. I am not saying that this is something that the Association of Chiropractic Colleges, the Council on Chiropractic Education, or the National Board of Chiropractic Examiners should be doing alone. It must be a profession-wide plan that everybody is involved in. Everybody has to be rowing in the same direction because that is the only way we are going to change the outcomes.

Dr Chip Watkins

We need to remember that health care is local and will always be local. We should foster local relationships with primary care providers and with specialists. Take an orthopedist to breakfast like you need help or something. Foster those relationships. Make those connections. So when time comes around at some point in the future when the published data come out, you can have the conversations with them to remind them that you need to be part of this, you need to be at the table.

Dr Bill Meeker

So we are done here. My summary is that it is all about *data* and *relationships*. Both of them need to be pushed forward.

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