

Congratulations!

Thank you for your cooperation with the EHR usage survey. We are approaching the deadline, and if you have not responded, please do. As a reminder, we are gathering information from all member practices on EHR usage, including system names and version numbers, to assess preparedness in the Hudson Valley for Meaningful Use and health information exchange. Currently, 41 percent of ambulatory providers and 48 percent of primary care providers are using an ONC-certified system. Another 15 percent plan to adopt one in the next 12 months, putting the Hudson Valley ahead of most national benchmarks for readiness. In fact, the solo adoption rate in the Hudson Valley is more than twice the national average. **To our knowledge, this is the most complete, granular study of EHR adoption currently underway in the nation.** The TIPA board believes so strongly in the potential of this project to further the Hudson Valley's position at the forefront of health care transformation they have made participation mandatory for all member practices.

To participate in this project or for more information, please contact May-Lorie Saint-Laurent at 845-896-9301 x3129 or msaintlaurent@taconicipa.com.

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Taking coordinated care to the next level:

TIPA launches embedded case manager pilot

by A. John Blair III, MD, FACS, president of TIPA



For the last several months, TIPA has been developing a care coordination project. Now, we're ready to unveil it.

As you know, our medical home transformation work has been an essential building block for care coordination. Now, we are taking it a step further: We have launched a new division initially focused on helping organizations enhance care coordination efforts and better manage care transitions.

Starting this month—July—TIPA is embarking on an 18-month pilot project with embedded case managers in advanced medical homes. Our goal: Demonstrate that patient-centered care coordination services as part of an advanced primary care model *in an open community of care* can deliver safe, effective and efficient care to achieve the Institute for Healthcare Improvement's Triple Aim. The Triple Aim is to improve the health of the population; enhance the patient experience of care; and reduce, or at least control, the per capita cost of care.

We selected the seven pilot sites based on their commitment to continue to advance the effectiveness of the primary care transformation that started with achieving NCQA Level 3 PPC-PCMH medical home recognition in 2009. As was the case with the medical home project, these practices are varied: They include large multi-specialty practices as well as mid-size and small primary care practices.

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The pilot focuses on adults with chronic, complex medical conditions who are likely to benefit from care coordination by an experienced RN case manager working as part of a collaborative team in primary care practices. The case managers will work with patients and use standardized protocols and processes designed by TIPA. We anticipate each case manager will actively manage 125 patients; actual caseloads may vary based on factors such as severity, intensity and case mix.

This is truly a cooperative effort. Geisinger is providing consulting and training services, and a THINC-managed research component of the project will measure outcomes in collaboration with researchers from Weill Cornell Medical College and RAND Public Policy Research.

The case manager

The embedded case manager is an experienced registered nurse who has met rigorous selection criteria. She will conduct the full range of case management responsibilities, including comprehensive patient assessments, patient education, development of individualized care plans, facilitation of care across different care settings, and data gathering for ongoing research and analysis of the pilot results.

TIPA has developed an extensive training program for the case managers; they have now undergone 10 weeks of training, including a four-week training program at Geisinger sites.

We've adapted elements from Geisinger ProvenHealth Navigator®. It's worth noting that our project will be the first time ProvenHealth is being widely utilized outside the Geisinger system, and notably in a community made up of small, mid-size and large independent practices.

Our pilot, however, is *not* a replica of the Geisinger model. We are also including effective practices and protocols from other programs, incorporating elements of Johns Hopkins Guided Care Nursing, the Massachusetts General Hospital Medicare Demonstration Project for Care Management and the Wagner Chronic Care Model.

A coordinated approach to care

One challenge of implementing care coordination is that traditional payment structures don't pay for these additional services within the primary care practice. We've been able to secure funding from the payer community, many of whom will be part of testing this innovative approach. THINC will manage the evaluation and reimbursement aspects of the pilot. TIPA is working with practices on engagement, workflow changes necessary to fully deploy the embedded case managers,

facilitating data collection for evaluation, and providing collaborative oversight of embedded case managers as they manage their caseloads and other components to fully support the program.

Beyond the Hudson Valley

We plan to expand this project, and I know many of you will want to participate. But the Hudson Valley is just the beginning: We intend to also show scalability and the ability to replicate the pilot in other communities that desire to follow in our footsteps and transform care in their own communities. If we are successful, we can build on our successes here in the Hudson Valley to help fix a broken system—and make the Triple Aim a reality.

NEWS TO KNOW

HVI announces three new issue briefs, all focused on the Direct Project

The Hudson Valley Initiative has released three new issue briefs, all dealing with aspects of the Direct Project and its impact on care coordination.

- ▶ In *Beyond Babel: MedAllies Direct brings a provider-driven, collaborative solution to the challenge of interoperability*, A. John Blair III, MD, MedAllies CEO and TIPA president, offers an overview of the project. He explains how it enhances care coordination and supports the advanced primary care medical home and accountable care models, and health care delivery for everyone.
- ▶ Holly Miller, MD, MBA, FHIMSS, MedAllies chief medical officer, focuses on the clinical implications of MedAllies Direct in *Essential information, available immediately, in the right dose: MedAllies Direct delivers on the promise of quality patient care*.
- ▶ In *Not So Elusive: MedAllies Direct advances interoperability, allowing clinicians to share data across systems, across providers, across the country*, MedAllies CIO Leroy "Lee" Jones addresses the health IT issues, including implications for providers, vendors and HIEs. All of the Hudson Valley Initiative Issue briefs are available for download at www.hudsonvalleyinitiative.com/press-kit.html.