

NEWTALK HIGHLIGHTS:

Chronic care: do we need an entirely new model of delivery?

- **FRAMING THE PROBLEM** – What are the dimensions of the chronic care crisis?
- **THE NEW MODELS** – Reviews of demonstration projects and proposed models.
- **PREVENTION** – Can we better involve patients in maintaining their own health?
- **HEALTHCARE IT** – The road to efficiency is paved with shared digital information.
- **LEGAL REFORMS** – How do we prevent regulations from stifling innovation?
- **SOLUTION SUMMARIES** – Lists of next steps.

FRAMING THE PROBLEM:

David B. Kendall: *(Moderator) Senior Fellow, Health Policy, Progressive Policy Institute*

Chronic illnesses such as diabetes and heart disease are vastly under-treated—resulting in premature disability and death and in dramatically higher health care costs. Chronic illnesses, by some estimates, account for upwards of three-quarters of total health care costs. Improving chronic care could be a huge benefit to everyone, and relieve much of the cost pressure that leaves so many millions uninsured. Amputating the leg of a patient with diabetes is a lot less humane and more expensive than monitoring her insulin level.

Timothy S. Jost: *Professor of Law, Washington and Lee University School of Law*

It is perhaps not surprising that we spend so much on chronic care, as care for chronic illness assists 133 million Americans to lead more productive and satisfying lives. Much of the value of our health care system is found here. Intuitively, however, it would seem that our balkanized fee-for-procedure-based health care system would not provide optimal care for chronic illness. Better coordination of care seems an obvious solution. Both presidential candidates seem to believe this to be true. But what works better? Medicare chronic care-oriented demonstration projects, to date, have failed to demonstrate dramatic cost-savings and only marginal patient care improvement. Also, most Americans are privately insured. If we knew how to deliver chronic care more effectively, how would we change private insurance payment to encourage it?

John E. Wennberg: *Director Emeritus, Dartmouth Institute for Health Policy & Clinical Practice*

While death from chronic illness might be pushed back in time by better prevention or tighter management of, say, diabetes, progression to death from one or more chronic illnesses is the fate most Americans inevitably face; most of Medicare's dollars go for managing really sick patients that are approaching this point. In the absence of some radical change in either technology or ethics, this can't be changed without reform of the way care is managed toward the end of life, no matter what the specific chronic illness. Thus, how to manage really sick patients needs to be a focus for reform. The evidence today is that in most parts of the country we have way over-invested in the acute care hospital sector because the major resource for managing patients with chronic disease-costs are higher, while outcomes are worse.

NEW MODELS OF CARE

Peggy O’Kane: *President, National Committee for Quality Assurance*

We actually have a number of models to manage chronic illness.

—Disease Management—developed by "accountable health plans," and now also deployed by independent vendors who contract with plans, employers and the public sector.

Performance of plans is widely reported and results have improved dramatically over time for many chronic illnesses, but this is largely on HMO plans to date.

—Physician-level recognition programs and reporting initiatives, often coupled with pay-for-performance

—Medicare group practice demonstration - heavily focused on chronic illness, with gain-sharing to reward efficient, high-quality care.

There is good evidence that all these approaches improve quality, the problem is deployment has not been broad enough.

Troy Brennan: *Senior Vice President and Chief Medical Officer, Aetna Inc.*

I think it is important to note that there are incentives to address the quality and costs of chronic care today. Certainly health plans have those incentives for their fully insured customers, and so do self-insured employers. As well the federal government in the Medicare program and the states in Medicaid face the same challenges. Yet for all the reasons suggested by others, their efforts in this regard have been stunted.

That is beginning to change, as a result of several factors. First the cost of care continues to rise, and it is increasingly clear this is due in large part to the costs of chronic care. Second, it is clear from years of health services research that costs can be reduced by improving quality of care—estimates range from 20-40% of today's care is waste in the form of errors, re-work, or ineffective care. Third, the promise of information technology is finally becoming clear in terms of programs that can overcome some of the miscommunication and lack of continuity that characterize today's health care system.

Now is the time to demonstrate these programs can make a difference, and many companies, large and small, are taking advantage of quite innovative ideas to do so. So we do hold out some hope that the market incentives represented by this burden of illness can call forth interesting and timely solutions.

John E. Wennberg:

Brent James should chime in because Intermountain Healthcare has done more than any other place I know of to rationalize the clinical pathways for managing chronic illness—for example, the relationships and roles of specialists versus generalist in managing diabetes over time. Mayo Clinic is beginning to work on the same issues, but we need a lot more focus on this aspect of the “comparative effectiveness” agenda before we can even begin to talk about cost-effective management of chronically ill populations. In the meantime, how do we control excess capacity and the damage it appears to be doing to the Medicare budget and the lives of patients?

Brent James: *Chief Quality Officer and Executive Director, Intermountain Healthcare*

Intermountain has had some real success in managing chronic diseases. Several of the earlier comments mentioned some of what we have come to believe are critical points: specifically, successful management appears to require (1) good data systems (2) embedded in an organizational structure.

The Dartmouth Atlas analyses identified Intermountain as one of the (relatively) most efficient care delivery systems in the country (along with Mayo Clinic). They estimated that, if other care delivery regions showed similar performance, the cost of Medicare around chronic disease would fall by more than 30%—I recall that that's around \$150 billion per year—while quality measures would improve. We think that our chronic disease management contributes to that.

Finally, we're not the only group showing these kinds of improvement results. Depending upon the particular clinical topic, many other practices are matching or exceeding Intermountain's performance.

Peggy O’Kane:

It's also worth mentioning that there's a model of care for chronic conditions that has been so widely accepted in the health care system that it's simply referred to as the Chronic Care Model. It was developed by Dr. Ed Wagner of the MacColl Institute. The model clearly defines a system for chronic illness management: patients are placed in charge of managing their health with the support of an interdisciplinary care team, decision support and clinical information tools, and resources in the community.

The principles of the Chronic Care Model – promoting evidence-based decision making, using clinical information to proactively manage care, and recognizing that a lot of health care happens outside the clinical setting – also resonates with other models of care such as the Patient-Centered Medical Home.

Nancy Johnson: *Senior Public Policy Advisor, Baker Donelson*

Dr. Wagner's model and others developed by integrated care systems are making tremendous progress. But we know a lot less about care coordination in fee-for-service medicine. Some of the demos have taught us a lot about what does and does not work, as have some of the group practice demos. The difference between clinical care coordination and the chronic care support systems necessary to achieve the care improvement and cost savings possible is also becoming clearer. I think we need to understand these differences, focus greater attention on how to get patients actively involved, and promote a variety of solutions to be able to create a delivery system that can both prevent and minimize the medical and cost consequences of chronic illness, and support patients through better informed and more rational end of life decision making.

John Rother: *Group Executive Officer of Policy and Strategy, AARP*

I agree with Peggy that the Ed Wagner chronic care model is widely accepted, but it's not widely implemented. Another important element of the model is patient and family engagement, supported by nurse calls and patient support groups. After all, behavior change is one of the most difficult elements of chronic care management.

Patient engagement may be one of the critical missing elements in most medical care today. I'd be interested in successful examples of programs that have managed to achieve behavioral change among those with chronic diagnoses or those at risk.

All of this points to the need to change reimbursement incentives and flexibility. Without such change, I wonder whether it's possible to truly reorient our medical system from one based on acute episodes to one that can coordinate and manage chronic conditions.

Lawrence Casalino: *Physician & Health Services Researcher, Univ. of Chicago*

I believe that all Accountable Care Organizations would have the characteristics of medical

homes, but not all medical homes would be part of Accountable Care Organizations – the latter would range from large to very large; a medical home might be a very small physician practice. I think it is critical that patients not be forced into choosing a medical home or an ACO, or staying in one once chosen, or required to access services only through their medical home or ACO. The system could function well without that. Health plans, Medicare, and Medicaid could do much to educate people about the advantages of having a medical home and/or being a patient of an ACO; the proof, over time, would be in the pudding.

HEALTH CARE IT

Nancy Johnson:

I think it is important to remember that all the advances in developing care management models have come from the business-driven market, not from government-run health care plans because the silo payment structure of Medicare and Medicaid prevents such developments. Interesting that the Community Health Centers with their very different payment system have been leaders in Electronic Health Records (EHR) adoption, preventative care support systems, and outreach. A home care provider I am acquainted with provides a post-episode care package that is saving people from E.R. and hospital readmissions. I think our goal is to require private systems to compete on quality, efficiency, and outcomes and, using health IT, to enable government and other entities to do the appropriate oversight to assure that individuals are getting the care they need. It is all so possible now.

Carol Raphael: *President and CEO, Visiting Nurse Service of New York*

One practical approach is to unleash the power of health information technology (HIT) as a "virtual integrator." HIT can help to facilitate information-sharing across disciplines, providers and settings, as well as communication with patients and their families. HIT can also assist care providers with decision-making at the point of care and reducing errors. While at the federal level, there is some movement to create standards and interoperable health information systems, much of the work on the ground is being done at the state level, with maturity of systems varying by state.

Brent James:

Good chronic care delivery requires good information systems, in order to move from episodic to continuous care. The key issue around health IT is not funding—properly implemented (now there's a loaded term!) a good EMR can be a real money-saver even for small practices. The key is interoperability. Tommy Thompson established a series of committees that identified information standards for all of the major subsets of practice where an ability to easily share data are key. Mike Leavitt's AHIC work, and the continued efforts of ONCHIT, have kept that moving ahead. We still need, though, a mechanism for software vendors to generate standards; and an independent body to certify software as meeting those standards.

PREVENTION

Susan Dentzer: *Editor-In-Chief, Health Affairs*

We must not omit the fact that a "new model" of chronic care delivery must incorporate serious efforts at secondary and tertiary prevention, in addition to care and treatment. This of course raises all the conventional payment issues – e.g., incentivizing providers to engage in these sorts of activities as much as in delivering treatments.

In the interests of containing costs – and possibly improving effectiveness – it's also worth stressing the importance of team-based approaches to delivering this broad spectrum of care. "Task-shifting" and use of non-physician personnel may also be critical. My understanding is that Kaiser Permanente is exploring ways to deliver as much timely and cost-effective care to patients as possible – and at the same time, keep them away from physicians until they really need to be seen by one! Other systems, too, are exploring ways to have all non-physician health care personnel work up to their very maximum in terms of scope of practice. Why couldn't a well-trained "community health worker" be put in charge of helping heart attack victims in a given neighborhood comply with medication, undertake changes in diet and exercise and engage in other steps necessary to avoid a second event?

Lawrence Casalino:

I couldn't agree more, Susan. As a naive young family physician in private practice years ago, it became clear to me that most of what my patients needed, in terms of acute, chronic, and preventive care, could be very effectively handled by my nurse and me over the phone (this was pre-e-mail and pre-the chronic care model). The patients loved it, as well, because they didn't have to leave work, get a baby sitter, lug the kids along, wait for a half hour in our waiting room, or pay babysitters. It might be a good idea to start with a clean slate and ask: We have highly trained and motivated individuals—physicians. What is the best way for them to spend their time? It probably is not rushing from patient to patient as fast as possible.

LEGAL REFORM

Timothy S. Jost:

Susan raises an important point that health care reform to address chronic illness requires not only reform of our health care financing system, but also of our legal regulatory system (specifically, she mentions scope of practice laws). Ezekiel Emanuel and I published an [article](#) in the June 4 issue of JAMA identifying a number of legal and regulatory barriers to health care delivery reform (including the anti-kickback, self-referral, antitrust, tax exempt organization, certificate of need, and incentive-to-reduce-services laws).

We proposed the establishment of a commission to waive compliance with laws on a health care system by health care system demonstration project basis to establish an evidence base for further legal reform. Whether or not this is the right approach, some approach short of wholesale repeal of all laws regulating health care needs to be found to allow delivery system innovation.

Philip Howard: *(Moderator) Founder and Chair, Common Good*

Finally, Tim Jost has touched on a part of this that is near and dear to my heart—legal constraints. Can we all agree that coming up with new models or frameworks for chronic care requires a clean legal slate? Trying to design a system that can grind through all the requirements of the Rube Goldberg regulatory structure is almost certainly hopeless.

Nancy Johnson:

I don't think you can get a clean legal slate. We still have to get from here to there. All the providers are loaded with Medicare law, regulation, and all those letters changing terms and conditions of participation that move constantly from DC to hospitals, etc. I tried to modernize the cost reports, IG rules governing Stark issues, rules governing physician office audits so there would be some fairness as well as accountability. Very hard. Need more than this kind of dialogue to methodically identify changes in laws and regulations that we all agree need changing to allow the system to reorganize. Then there are those we don't agree on. But doing the former would be a great bipartisan contribution!

Timothy S. Jost:

I am, like Nancy, wary of trying for a "clean slate" in terms of regulation, and like Susan would favor greater flexibility and experimentation, trying to figure out what works before abandoning what we now have. I, in fact, believe that many of the laws we now have in place reflect important principles.

Wholesale abandonment of the anti-kickback and self-referral laws, for example, would in all likelihood lead to dramatic increases in utilization and cost, as well as unethical behavior and probably patient harm. The antitrust laws, though only weakly enforced, probably still discourage cartels that would drive up prices. The HIPAA regulations could be vastly improved, but patient confidentiality remains an important principle. Nevertheless, our existing set of regulations does complicate delivery system reform.

SOLUTION SUMMARIES:

Timothy S. Jost:

Philip and I would propose a synthesis of many of the ideas to emerge over the last three days as a way of moving forward. Congress and CMS should, within the Medicare program, create pilot programs to:

- 1) Support development and dissemination of Health IT to improve coordination of care for the chronically ill.
- 2) Create incentives for the creation of medical homes to improve continuity of care and optimize the use of the time of physicians and skills of other health professionals. Medical homes could take a variety of forms, and experimentation with different approaches should be encouraged.
- 3) Restructure provider payment systems to reward positive patient outcomes, patient satisfaction, and overall cost savings for Medicare (accountable care organizations could be a format for accomplishing this).
- 4) Authorize waivers of federal and preemption of state laws and regulations that would stand in the way of such projects for the duration of the project.
- 5) Waive requirements of short-term budget neutrality, recognizing that programs that save money in the long-term might cost more in the short-term.
- 6) Monitor results of pilot projects to develop an evidence base for further reform.

Peggy O’Kane:

I couldn’t agree more that real reform of the health care system needs to come with the full support of the federal government. The sheer size of our health care spend—2-plus trillion dollars a year—is a very powerful inertial force, as the article in the *Times* that Tim referenced earlier indicates.

As part of a workgroup known as the Quality Crossroads Group, we [proposed](#) five building blocks towards a high-performing health care system, which include:

- A national center for effectiveness research
- Models of accountable health care entities capable of providing integrated and coordinated care
- Payment reform to reward high-value care
- A national strategy for performance measurement
- A multi-stakeholder approach to improving population health

Implementing any one of the five above building blocks would require broad support from

health care thought leaders, bipartisan support in Congress, and the strong support of the next President.

David B. Kendall:

One definition of consensus is the absence of strenuous objections. Perhaps we have achieved such a consensus on this last day of the forum. Please let me exercise the moderator's prerogative and offer a simplified version of where consensus may lie on an agenda for chronic care:

1. Payments for chronic care. Instead of paying for health services and products separately, Medicare and other health insurance plans should pay health care professionals for coordinated services like medical homes (which, by the way, needs a more appealing name, perhaps a health care home base). These new kind of payments need to evolve with experience and research.
2. Electronic health record systems. Doctors who treat patients with chronic diseases need a common way to coordinate care, track patients' progress and check for gaps and problems. At a minimum, federal policy needs to make sure the EHR systems can all "talk the same language" and have a "phone line" that connects them.
3. A favorable regulatory and budgetary climate. Too many rules and budgetary controls can throttle innovation. Chronic care providers and patients need a federal process to review and remove barriers to improving chronic care.

Thank you to everyone who participated and for the public comment, too! The discussion clearly showed the desire and ability to come together around the common purpose of making health care better in our nation. Let's hope this spirit carries through the political debate as it moves to a new President and Congress!