



PRESCRIPTION FOR PENNSYLVANIA

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STRATEGIC PLAN

FEBRUARY 2008

Chronic Care Management, Reimbursement and Cost Reduction Commission

**THE PENNSYLVANIA CHRONIC CARE MANAGEMENT, REIMBURSEMENT
AND COST REDUCTION STRATEGIC PLAN**

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Executive Summary

The present system of providing health care was designed to treat acute illness, not control chronic diseases. In the face of rising levels of chronic disease and spiraling health care costs, governments, businesses, insurance companies and Pennsylvania families have, out of necessity, chosen to limit health care services, benefits and visits as ways of fighting expenses.

Evidence is mounting around the country that exactly the opposite approach to chronic disease is more successful. Early, consistent and persistent health care intervention for those with chronic disease will likely be more cost-effective and will dramatically improve the quality of life for anyone with chronic disease.

In May 2007 the **Pennsylvania Chronic Care Management, Reimbursement and Cost Reduction Commission** was created and its first requirement was to develop a strategic plan for a Chronic Care Model to improve the quality of care while reducing avoidable illnesses and their attendant costs. This report is part of that requirement.

About half of all Pennsylvanians have a chronic disease, including diabetes, asthma, pulmonary disease, heart conditions and others. These chronic disease conditions are exacerbated in Pennsylvania by obesity, an older population, smoking and other factors that are hardly unique to the state but statistically more prevalent.

Chronic diseases are the leading cause of death and disability in the Commonwealth.

Chronic disease patients account for 80% of all health care costs and hospitalizations, 76% of all physician visits and 91% of all filled prescriptions.

Much of the hospital and emergency room costs for patients with chronic conditions would be unnecessary if patients simply received evidence-based care in a setting where multiple practitioners and health educators can easily communicate and collaborate.

Only 56% of patients with chronic disease receive that kind of recommended care. Those patients with complex conditions receive even less of the recommended care. In Pennsylvania, chronic conditions often become neglected conditions which become crisis conditions, with predictable increase in expense, lost productivity, pain and suffering.

For 2007, it is projected that avoidable hospital admissions by chronic disease patients will top \$4 billion in hospital charges not counting emergency room visits. Pennsylvanians with heart disease are admitted unnecessarily to hospitals more than two-and-a-half times as much as the best performing states,

approximately three times as often for asthma and more than four times as much for diabetes.¹

In Pennsylvania, one in five citizens is over the age of 60 and those over 85 are the fastest growing population segment. Pennsylvania rates for obesity, alcohol abuse, smoking and sedentary habits are all higher than the median for other states.

The issues lie with how patients respond to their illness as well as with how medicine is practiced by most primary care clinicians in Pennsylvania. Primary care practices are often poorly compensated by insurers, third party administrators and government under existing reimbursement models and not currently organized to deliver coordinated care, forcing them to see too many patients out of financial considerations.

Consequently, chronic disease patients who have not learned to manage their own diseases wait until a crisis develops and need to be rushed to, or referred to, the hospital emergency room.

It is a system that is frustrating for providers, increases suffering for patients and one that is ripe for change in the form of the Chronic Care Model, which was developed by Edward H. Wagner, MD, MPH, of the MacColl Institute for Healthcare Innovation.

The six key components include:

- **Self-Management Support:** Patient assistance in managing chronic disease and setting health improvement goals.
- **Delivery System Design:** Transformation from a reactive physician model to a proactive model using multidisciplinary care teams.
- **Decision Support:** Care based on evidence-based care guidelines.
- **Clinical Information Systems:** Better tracking and monitoring of chronic disease patients across disciplines and timeframes.
- **Community:** Partnerships with community resources that encourage healthy living.
- **Health Systems:** Incentives for quality improvement among care givers.

One of the largest and most successful examples of implementation of the Chronic Care Model is the Veterans' Affairs Health Care System (VA). Early in the 1990s, the VA was deeply troubled by complaints regarding the quality of its care for the 5.2 million people it serves.

¹ Agency for Healthcare Research and Quality, 2005 Annual State Comparison of Health Quality.

After adopting the six elements of the Chronic Care Model, the VA steadily improved perceptions to the point where it regularly outscores private sector providers *while also reducing per patient health care costs by 25%.*

In other states, like Vermont and Washington, where the Chronic Care Model has been adopted, there have been significant reductions in emergency room visits and other positive results.

According to the American Medical Association, the health process/outcomes for chronic care patients improved in 82% of the studies published so far, while cost savings were achieved in 67% of studies.

These cost savings are for health care costs only and do not factor in benefits regarding productivity and attendant financial benefits to citizens who currently pay higher insurance premiums and taxes to support an ineffective system of primary care for chronic disease.

The Commission established four Strategic Goals designed to change the paradigm for the receipt of medical care by persons with chronic diseases, as well as their ability to obtain support in self-management of their conditions.

The Strategic Goals are:

- **The widespread use of a new primary care reimbursement model;**
- **Broad dissemination of the Chronic Care Model to primary care practices across Pennsylvania;**
- **Achievement of tangible and measurable improvement in the quality of care for chronically ill patients; and**
- **Reduction in the cost of providing chronic care and mechanisms to ensure that savings are realized by those paying for health care.**

As determined by the Commission, the statewide chronic care strategic plan has five core elements to be implemented region-by-region over a multi-year period. They include:

- **The establishment of primary care learning collaboratives and disease registries, as well as practice redesign and support.**
- **Insurer-provider incentives aligned with the Commission's parameters.**
- **Insurer-consumer incentive alignment with Commission parameters.**
- **Community support resources.**
- **Measurement and evaluation.**

Detailed planning initiatives are more fully described throughout the following report and financial benefits that have been achieved by other entities adopting a Chronic Care Model are well documented herein.

The report also makes clear that there would be significant impetus for adoption of the Chronic Care Model if its *only* likely achievement was a dramatic improvement in the quality of life of Pennsylvanians with chronic diseases. That it both improves the health of chronically ill Pennsylvanians while simultaneously reducing the cost of their care makes this issue an urgent priority.

In a state and region where much of the best of American medicine was born and flourished over the decades, the implementation of a chronic care program will reenergize both the people who practice medicine and a patient population who will be given the resources and information to manage their own well being.

Introduction

Today, we face a compelling problem with health care in the Commonwealth. **We have a system in Pennsylvania that derives its success from measurements of illness rather than health.** Because of this yardstick, healthcare in our Commonwealth focuses too heavily on cures and emergencies, rather than on management and maintenance toward a healthy life, despite the predominant health care problem – chronic disease. The results of this misalignment are spiraling healthcare costs and an increasingly ill population.

The challenge, therefore, is to transform the current primary care system from one that reacts once a patient becomes acutely ill to one that provides proactive, comprehensive and coordinated care to keep our residents from suffering acute, chronic or terminal illness.² Nowhere is this opportunity more compelling than among the chronically ill, who unfortunately make up nearly half of Pennsylvania's population³ and whose ranks are growing at an alarming rate.

On May 21, 2007, Governor Ed Rendell issued Executive Order 2007-05, creating the Pennsylvania Chronic Care Management, Reimbursement and Cost Reduction Commission ("the Commission"). The Commission has been charged with recommending a strategic plan outlining the major changes needed to transform Pennsylvania's health care system into one that is collaborative and proactive in an approach focused on the needs of patients. The goals of that transformation are to improve patients' quality of life, clinical outcomes and to reduce costs.

The Executive Order required that the strategic plan be presented to the Governor, the President Pro Tempore of the Senate and the Speaker of the House of Representatives 90 days following the Commission's first meeting. This report has been developed to meet that requirement and contains the Commission's recommendations to the Governor.

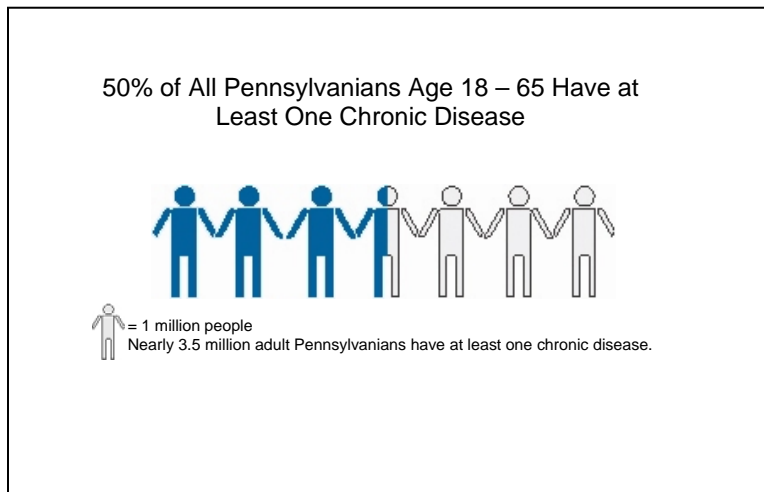
² E.H. Wagner, B.T. Austin and M. Von Korff, "Organizing care for patients with chronic illness", *Milbank Quarterly* 74: 511-544, 1996.

³ Although almost half of all adults have a chronic illness, 20% of all patients who have chronic disease account for over 75% of all health care costs.

Chronic Disease in Pennsylvania

Chronic diseases are life-long, persistent illnesses that are often not easily managed or quickly resolved. If left untreated, chronic diseases can lead to the need for emergency care, hospitalization and/or death. They include, among others, diabetes, asthma, congestive heart failure, and chronic obstructive pulmonary disease. In Pennsylvania, 69.5% of all deaths are caused by chronic disease.⁴

Chronic disease is the single most significant threat to the health of Pennsylvania residents. It is the leading cause of illness, disability and death in the Commonwealth. Approximately 50% of adult Pennsylvanians have at least one chronic disease.



Failure to treat persons with chronic disease properly and help them manage their conditions adds billions of unnecessary dollars to health care costs annually in Pennsylvania and causes needless suffering, disability and death for patients. There is an urgent need to transform Pennsylvania's health care system to contain costs and reduce the human burden for sufferers from chronic diseases.

⁴Chronic Disease Prevention, National Conference of State Legislatures, August 2003.

Pennsylvania's Poor Treatment Record for Chronic Illness

Compared with other states, Pennsylvania has a poor track record of managing chronic disease and its related costs.

The Commonwealth Fund Commission on a High Performance Health System ranked states based on avoidable hospital use and cost. Pennsylvania ranked 36th with only 14 other states showing a worse performance. Pennsylvania ranked 30th for hospitalizations for children with asthma and 41st for hospitalizations for all conditions that could be avoided with outpatient treatment.⁵

AHRQ (the Agency for Healthcare Research and Quality), the federal agency charged with improving health care quality reported that for 2005:

- The top 10% of states have 244 per 100,000 hospital admissions for chronic heart disease for which no procedure is done. Pennsylvania's admission rates are nearly three times higher than the national average at 612 per 100,000. This accounts for 15,000 avoidable hospitalizations each year.
- Pennsylvania had admission rates for asthma three times that of the best states with over 19,000 avoidable hospitalizations each year.
- For diabetes, Pennsylvania (at 24.4 per 1,000 admissions) had four times the rate of hospital admissions as the best-performing states. This compares to 5.8 per 1,000 hospital admissions for diabetes in the top performing states. This means that Pennsylvania had 14,000 avoidable hospitalizations.

While it can be fairly stated that Pennsylvania's demographics result in more people with chronic conditions, demographics do not cause hospitalizations that could be avoided with appropriate primary care.

⁵ J. C. Cantor, C. Schoen, D. Belloff, S. K. H. How, and D. McCarthy, "Aiming Higher: Results from a State Scorecard on Health System Performance", The Commonwealth Fund Commission on a High Performance Health System, June 2007.

Chronic Illness Is Growing at an Alarming Rate in the U.S. and Pennsylvania

The prevalence of certain chronic illnesses is growing nationally and in Pennsylvania, which will compound the problem of inadequate treatment in the Commonwealth.

- Asthma incidence grew over 75% nationally between 1982 and 1996.⁶
- Diabetes incidence grew nationally over 30% between 1994 and 2004.⁷

Furthermore, lifestyle factors contribute to the growth of chronic illness.

- Obesity: Overweight and obesity incidence increased nationally from 46% to 65% over a recent 20-year time period.⁸
- Obesity in children: The percentage of overweight children has more than tripled since 1980.
- Physical inactivity.
- Aging population: One in five Pennsylvanians is over the age of 60, with those 85 years or older representing the fastest growing segment of the population.

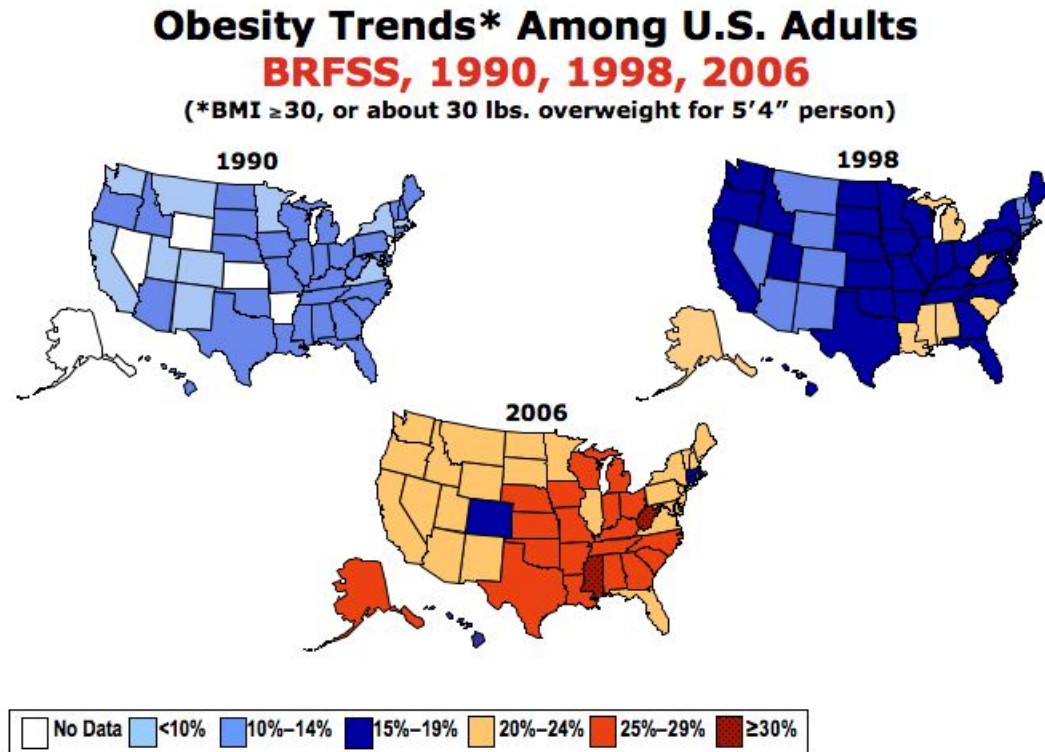
⁶ Sophia Chang. "The Challenge: Chronic Disease Care and the Promise of HIT", Conference Presentation, November 18, 2004, San Francisco, CA.

⁷ Ibid.

⁸ Centers for Disease Control, National Center for Health Statistics, National Health and Nutrition Examination Survey, 2002; Flegal et. al. *JAMA*, 288:1, 723-7, 2002; and National Institutes of Health, National Heart, Lung, and Blood Institute, Clinical Guidelines on the Identification, Evaluation and Treatment of Overweight and Obesity in Adults, 1998.

Obesity

Unhealthy nutritional behaviors also contribute to growing numbers of Pennsylvanians with chronic conditions.



As illustrated above, the percentage of the Pennsylvania population that is obese almost doubled in under 20 years (increasing from 12.5% to 24%) consistent with the national trend.⁹ This increase has been linked with growing rates of diabetes and other chronic conditions.

Obesity not only contributes to the growing rate of diabetes, but also to the onset of other chronic diseases that often afflicts diabetics. One-third of total direct health care costs in the United States are related to 15 diseases associated with diabetes. For 1996-1998, the CDC found that Pennsylvania had medical expenditures of \$4.1B attributable to diabetes.

⁹ America's Health Rankings 2007, United Health Foundation.

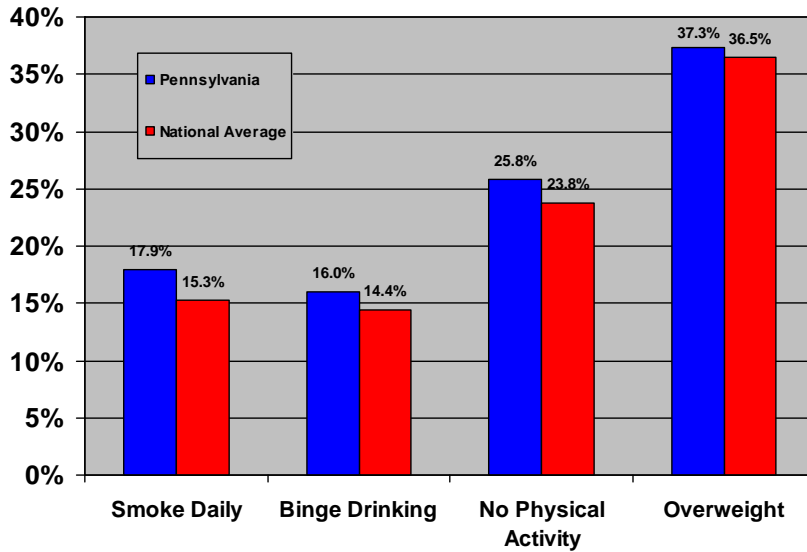
Other Unhealthy Behavior

Unhealthy eating habits, physical inactivity and obesity can cause or aggravate many chronic diseases and conditions, including type 2 diabetes, hypertension, heart disease, stroke, and some cancers.

On the United Health Foundation's list that ranks percentage of population that smokes, from best to worst, Pennsylvania has a poor showing. It ranks 32nd.

Pennsylvania's performance on other measures of lifestyle risk factors that lead to chronic conditions also needs improvement.

Prevalence of Health Indicator Behaviors in Pennsylvania in 2005 and 2006

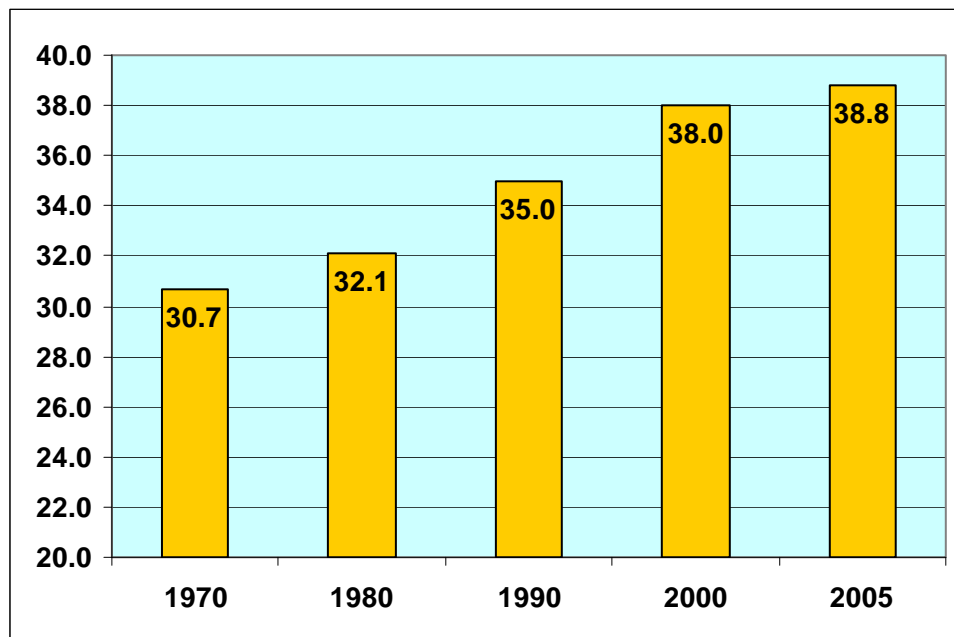


Demographics

Pennsylvania's demographics will lead to a further increase in the prevalence of chronic diseases.

Chronic disease is more prevalent in older persons, with many having multiple chronic diseases. Eighty percent of those age 65 years or older have at least one chronic disease.¹⁰

Median Age of Pennsylvania Population, 1970-2005



- Pennsylvania ranks third in the nation in the percentage of people age 65 and older (15%).
- Pennsylvania ranks fourth among states in residents aged 85 and older, a number that is projected to increase by more than 40% by 2020.
- By 2020, the number of Pennsylvanians age 65+ will equal the number of children under age 15.

¹⁰ Senior Citizen Longevity Statistics, *Senior Journal*, July 5, 2002.

A recent study found that older U.S. adults are twice as likely as older European adults to have chronic disease, many of which are related to obesity and smoking. Researchers from the Rollins School of Public Health at Emory University examined information from 2004 on the treatment of chronic diseases among adults ages 50 and older in the U.S. and 10 European nations – Austria, Denmark, France, Germany, Greece, Italy, the Netherlands, Spain, Sweden and Switzerland – and found the following.

- Older U.S. adults were twice as likely as older European adults to have heart disease.
- Older U.S. adults were more than twice as likely as older European adults to have arthritis.
- 12.2% of older U.S. adults had cancer, compared with 5.4% of older European adults.
- 16% of older U.S. adults had diabetes, compared with 11% of older European adults.
- 33.1% of older U.S. adults were classified as obese, compared with 17.1% of older European adults.
- 53% of older U.S. adults were active or former smokers, compared with 43% of older European adults.

The study found that if the U.S. were able to reduce chronic diseases for their older adults to the rate of older Europeans, U.S. health care costs would decrease by \$100 billion to \$150 billion annually.¹¹

Another demographic factor impacting the growth of chronic illness is that minorities face a higher burden of chronic disease. For instance African Americans are significantly more likely to have diabetes, asthma and high blood pressure.¹² Minority populations are growing fastest, which will lead to greater growth in chronic disease unless action is taken to eliminate these disparities.¹³

Two-thirds of the increase in health care spending is due to the increased prevalence of treated chronic disease.¹⁴ Pennsylvanians need to become aware of the impact of chronic care on their health and their wallet.

¹¹ "Chronic Diseases Twice as Likely in U.S. as Europe," *California Healthline*, October 2, 2007.

¹² In 2005, hospital admissions for uncontrolled diabetes per 10,000 were 5.5 for whites and 23.8 for African Americans. Asthma admissions were more than double those for whites for both Hispanic and African Americans. PA Department of Health, Health Equity Fact Sheet.

¹³ Between 1990-2004, in Pennsylvania, the Hispanic population doubled, the Asian/Pacific Islander population grew 77%, and the African Americans by 19.4%. PA Department of Health, Population Fact Sheet.

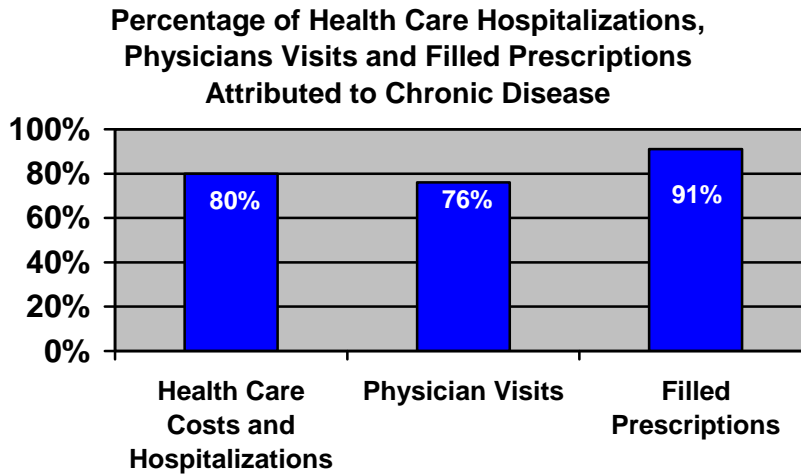
¹⁴ "Six Unhealthy Truths Tell the Story of the Rise of Chronic Disease and Its Impact on Health Care in the U.S.," Partnership to Fight Chronic Disease.

It is clear that the financial and human burden of chronic disease will only increase in Pennsylvania unless aggressive action is taken now to support change in the delivery of health care. Such changes will include providing the informational, technological and reimbursement infrastructure needed to implement the proven Chronic Care Model and to support widespread dissemination, adaptation and implementation thereof.

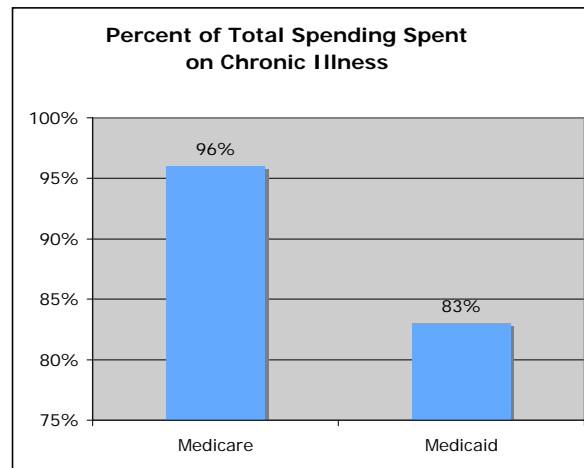
The Financial Consequences of Not Properly Treating Chronic Illness in Pennsylvania

In addition to the immense personal toll of chronic illness, there is also a staggering financial consequence with chronic disease which accounts for:

- 80% of all health care costs and hospitalizations;
- 76% of all physician visits; and
- 91% of all filled prescriptions.



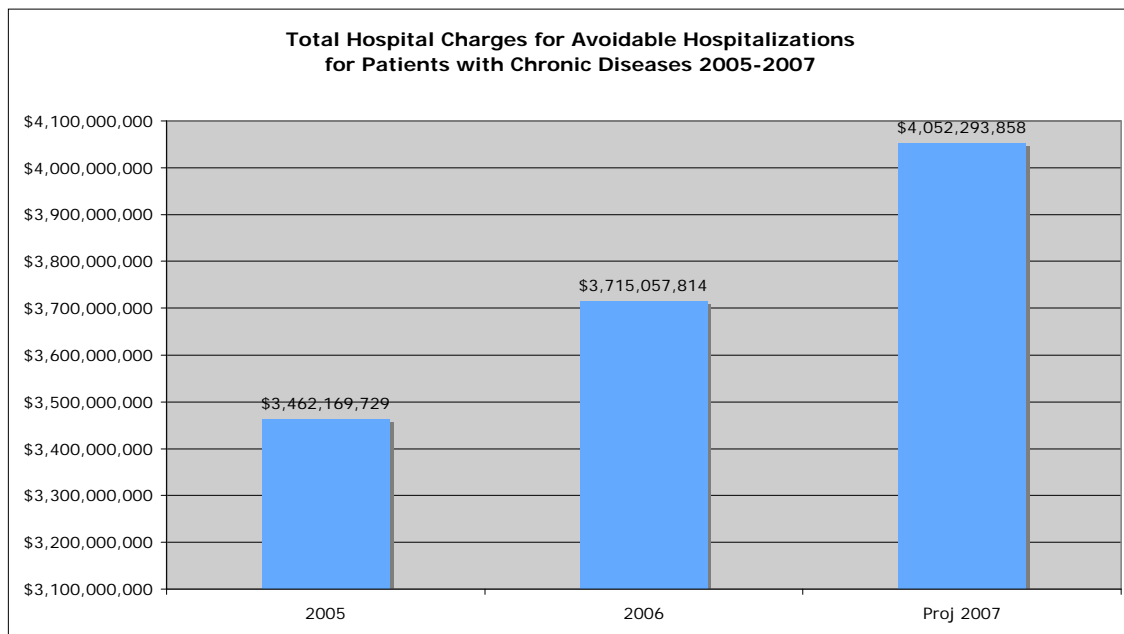
In public programs, chronic care accounts for an even larger percent of public spending.¹⁵



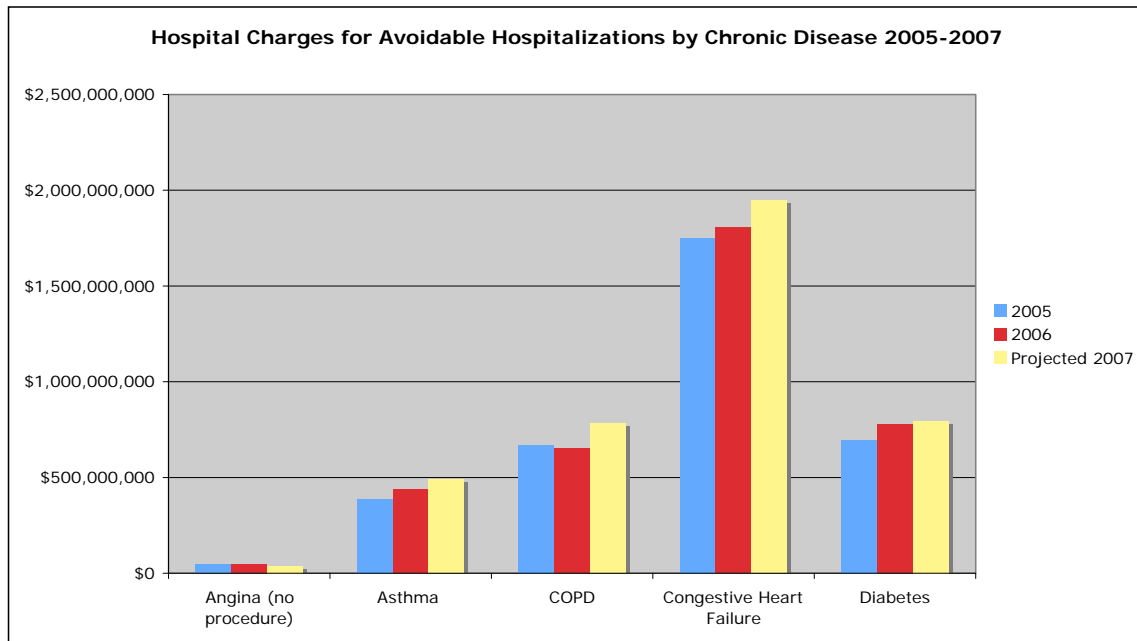
¹⁵ Ibid.

Much of the hospital and emergency room costs for persons with chronic conditions are avoidable and would be made unnecessary if patients received regular recommended primary care that research has conclusively demonstrated to be effective.

Yet, patients with chronic disease receive only 56% of the care they need to minimize the adverse consequences of their disease and prevent complications that chronic illnesses too often cause. As a result, far too many end up in Pennsylvania hospitals for preventable life-threatening complications. These hospitalizations result in significant health care costs, which grow unabated each year.



Charges for avoidable hospitalizations are reported to the Pennsylvania Health Care Cost Containment Council by all hospitals in Pennsylvania. For 2007, these charges are expected to top \$4 billion for Pennsylvanians with chronic conditions.¹⁶ This does not include charges for avoidable emergency room visits.



¹⁶ Only the first 2 quarters of data were available from PHC4. This projection was done by doubling the hospital charges for the first two quarters of 2007 to obtain the projected hospital charges for 2007. Note that hospitals report charges, not costs or payments to PHC4. Typically most insurers reimburse at rates that are less than charges, but charges are the only complete data set that is available.

Infrastructure Issues Must be Addressed to Reduce Chronic Care Costs and Improve Care in Pennsylvania

Despite the growing prevalence of chronic illness and the serious health and economic consequences of these diseases, the primary care system is insufficiently oriented toward the management and maintenance of the chronically ill. Today's health care is focused on curing illnesses and responding to acute health problems, which makes the primary care system ill equipped to deal with chronic illness.

As a result, we see the following trends:

- rushed clinicians that do not have full information about their patients when they see them;
- inability to obtain appointments or phone/e-mail consultation when health problems develop, resulting in unnecessary referrals to the ER;
- a lack of care coordination;
- a lack of active follow-up to ensure the best outcomes; and
- patients inadequately trained to manage their illnesses.¹⁷

In addition, the current payment system provides little or no reimbursement for more basic and less costly monitoring and education of patients with chronic diseases.

Public and private insurers typically pay far more for surgeries and treatment procedures than for prevention counseling and self-management support in a primary care office. **The current payment system fails to support or reward primary care practices for effective control of chronic conditions, care coordination and office systems that have demonstrated effective prevention of hospitalizations and ER visits.**

The result of the current system is fragmented, suboptimal care that leaves patients inadequately supported, and primary care practitioners frustrated. It is a system that too often waits for patients to become seriously ill, and only then applies its full attention and resources to patient care.

The challenge, therefore, is to transform the current primary care system from one that reacts once someone gets very sick to one that provides *proactive* comprehensive and coordinated care to keep the person with chronic illness as healthy as possible.¹⁸

No less important is the challenge to prevent chronic disease from developing. Much of chronic disease is preventable. Research shows that there are three

¹⁷ The Chronic Care Model, Improving Chronic Illness Care.

¹⁸ E.H. Wagner, B.T. Austin and M. Von Korff, "Organizing care for patients with chronic illness", *Milbank Quarterly* 74: 511-544, 1996.

major causes of chronic disease that are avoidable: tobacco use; poor diet; and inactive lifestyle.

A plan to address these three causes would prevent:

- 80% of heart disease;
- 80% of type 2 diabetes; and
- 40% of cancer cases.¹⁹

A plan to prevent and minimize the onset of chronic illness in Pennsylvania has been developed for diabetes by the Diabetes Stakeholder Group and is being implemented by the Pennsylvania Department of Health. The Consumer Engagement Committee of the Commission is recommending a communication plan to help Pennsylvanians understand the importance of taking action to avoid chronic illness.

While both prevention and management of chronic illness are essential, the Commission acted in accord with the Governor's Executive Order and focused most of its efforts on methods to improve management of chronic illness.

¹⁹ Dr. Lee Jong-Wook, "Preventing Chronic Disease in the United States and Abroad," December 2006.

Efforts Elsewhere to Implement the Chronic Care Model

Several large-scale applications of the Chronic Care Model have preceded Pennsylvania's initiative. The federal government has the clearest economic case for investing in chronic care as the largest payer of health care in our country.

Veterans Affairs Health Care

The largest use of the Chronic Care Model is in the Veterans' Affairs Health Care System (VA). The VA provides medical care to 5.2 million patients, making it the largest single provider of health care in the world.

In the early 1990s, the Veterans' Administration health care had no reputation for quality, suffered from poor patient satisfaction and was the subject of numerous scandals. Beginning in 1995, the VA reinvented itself with a total redesign of how health care is delivered. Today, the VA's quality of care exceeds that of much of private care. In a study of diabetic patients, the VA's patients had better quality outcomes than diabetics in commercial health plans and were "statistically significantly more likely to receive all recommended processes of care than patients in managed care."²⁰

Based on the American Customer Satisfaction Index, the VA outscored the private sector mean score of 68 out of 100 with 80% for ambulatory care and 81% for inpatient care.

A critical component in the turnaround of the VA was adoption of the 6 elements of the Chronic Care Model. With patient-centered care coordination, patients who were formerly dissatisfied are now very satisfied. Patients are informed about their conditions and actively engaged in managing their condition and lifestyle issues that impact it. When a patient visits the VA for an appointment, it is a planned encounter that ensures that the patient is receiving all the care which research indicates will deliver healthy outcomes and receives supportive patient education. The VA has been able to improve significantly on 18 individual quality measures while reducing health care costs by 25% per patient. The VA was able to accomplish this with a strategic plan which put all key components in place simultaneously.²¹

Federally Qualified Health Centers

Federally Qualified Health Centers (FQHCs) provide health care to all persons regardless of ability to pay, and charge for services on a sliding-fee scale that is

²⁰ Eve A. Kerr, MD, MPH, "Diabetes Quality of Care in Veterans Affairs Health Care Systems and Commercial Managed Care : The TRIAD Study," *Annals of Internal Medicine*, August 17, 2004.

²¹ Jonathan B. Perlin, MD, PhD, MSHA; Robert M. Kolodner, MD; and Robert H. Roswell, MD, "The Veterans Health Administration: Quality, Value, Accountability, and Information as Transforming Strategies for Patient-Centered Care," *The American Journal of Managed Care*, November 2004.

based on patients' family income and size. In 2006, FQHCs served over 15 million patients nationally. FQHCs are federally funded through the Health Research Services Administration (HRSA).

In 1998, HRSA created a national effort to implement the Chronic Care Model – the Health Disparities Collaboratives – for FQHCs. By 2006, over 800 FQHCs were participating, initially focused on diabetes. Since that time, other areas of focus have included asthma, depression, cardiovascular disease, cancer screening/planned care, prevention, diabetes prevention, perinatal/patient safety and oral health. This widespread adoption of the Chronic Care Model by health centers serving similar populations has allowed comparisons in outcomes between those centers that utilized the Chronic Care Model and those that did not. The outcomes are very dramatic.²²

- Patients with diabetes receiving care from health centers using the Chronic Care Model saw a systematic decrease in their average blood sugar levels, which indicates better management of their illness and less threat of complications.
- A comparison of South Carolina's CareSouth FQHC to all providers and specialists in the service area showed the following:

	CareSouth	All Providers & Specialists
Office visits per patient	3.27	3.12
Percentage of patients hospitalized	2.08%	9.52%
Average payment per hospitalization	\$3,545	\$12,025
Average length of hospital stay	3 days	5 days
Average total cost per patient	\$343	\$1,883

- South Carolina's FQHCs' average annual emergency room payments for diabetics using the Chronic Care Model was \$172 compared to \$634 for patients treated at centers that were not using the model. The return on investment for the additional costs of implementing the model was \$3.84 saved for every dollar invested.
- The Maine Primary Care Association testified at the State Appropriations and Financial Affairs Committee that health centers that used the Chronic Care Model had a 48% drop in hospitalizations associated with diabetes as compared to a 14% drop for the rest of the state. Hospitalizations for depression also dropped 25%.

²² Leaders Guide: Developing the Business Case for Planned Care, Health Disparities Collaboratives, April 2006.

Washington

Washington State's Department of Health is in the process of implementing the Chronic Care Model statewide. Primary care practices are participating in a number of learning collaboratives with an initial focus on diabetes. Washington provides free electronic registry software, statewide benchmarking information and some financial assistance to practices in systems redesign.

Vermont

The Vermont Blueprint for Health is a major component of the state's health reform efforts, and involves statewide implementation of the Chronic Care Model. Provider training and program implementation is phased in by community, using community hospitals as leaders. This effort began in 2005, initially focusing on diabetes. State law requires all private insurers, Medicaid and the state health insurance program to follow the Blueprint model and requires all insurers to follow the same clinical guidelines.

Vermont has just implemented statewide a Chronic Care Information System that:

- guides clinical care for individual patients based on evidence-based guidelines;
- provides reminders for needed patient visits;
- provides timely specialist and laboratory information; and
- permits emergency rooms to have immediate access to a patient's medications list.

Use of the Chronic Care Model resulted in significantly decreased visits to emergency rooms and non-routine health care provider visits 6 and 12 months after implementation. Additionally, after 12 months, patients report that their condition no longer interferes with their daily social and household activities.²³

There are also a number of regional collaboratives that are using the Chronic Care Model. For instance, the Robert Wood Johnson Foundation is funding work in Colorado and North Carolina; however, dissemination of the model for statewide use is only in the beginning stages.

²³ Sharon Moffatt, Vermont Blueprint for Health Presentation, August 2007.

The Chronic Care Model

The most recognized approach for improving care while reducing costs is the Chronic Care Model. The Chronic Care Model is based on research and evidence for delivery of effective chronic illness care. The model was designed and tested by Edward H. Wagner, MD, MPH, and his colleagues at the MacColl Institute for Healthcare Innovation.

The model recognizes that formal health care settings are only a part of what is needed to improve chronic care. Patient self-management, information systems, decision support and community resources are all critical components. The Chronic Care Model is a comprehensive approach to improving the management of chronic illness. Its elements touch the provider practice, insurers, state agencies, employers, communities and community organizations, and, of course, consumers. A brief description of the Chronic Care Model's six elements follows.

The Chronic Care Model's Six Elements

Self-management support. Involve the patient in lifestyle changes and the development of illness management skills using education, goal setting, action planning, problem solving and follow-up. Consumers are supported in achieving the health improvement goals they have set for themselves. Knowledgeable, involved and motivated patients are much better able to make informed healthcare and lifestyle choices, stay healthy and seek services when they need them.

Delivery system design. Transform community practices from a reactive physician model to a *proactive* model that uses multidisciplinary care teams to provide planned care at each appointment, including use of group appointments, and telephone and e-mail consultations.

Decision support. Base care on effective evidence-based care guidelines and use systems to inform and prompt providers and patients about care needs.

Clinical information systems. Use of relatively simple systems to identify and track patient information can improve diabetic care outcomes.²⁴ For example, registries can provide patient-specific and population-based support to care teams, reminders, data and analysis and provider feedback. With the correct tools, clinical practices can analyze **all** of their chronically ill patients, call up recent lab work, identify prescriptions filled, and assess which evidenced-based care is needed for each or for all patients in a category.

Community. Identify or develop resources and programs in the community to support healthy lifestyles and provide information to patients on these resources. Primary care practices do not have the resources necessary to provide all the support patients with chronic conditions need to be healthy. It is critical to establish partnerships with community resources to support those with chronic illness.

Health systems. Create a quality-oriented culture for providers through leadership commitment, incentives for continuous quality improvement and strategies to align reimbursement with desired care.

²⁴ Improving Outcomes for High-Risk Diabetics Using Information Systems, Medscape.

The Chronic Care Model calls for all six elements to be in place simultaneously to achieve improved health outcomes. There are, however, multiple possible approaches to addressing the elements.

A primary care office that has transformed itself consistent with the Chronic Care Model will have some or all of the following characteristics:²⁵

- agreements with community services agencies;
- referrals to community services agencies;
- assessment of how well the patient self-manages their condition;
- self-management programs;
- integration of preventative guidelines into care;
- integration of specialists into care;
- utilization of planned visits;
- support for patients to see multiple providers in one visit;
- employment of case managers within the practice;
- written feedback to primary care team members;
- internet communication between the primary care team and patients;
- open access scheduling so that patients can get same-day appointments if needed.

²⁵ Adapted from Julie Schmittiel, Stephen M. Shortell, and Thomas Rundall. "The Effect of Primary Health Care Orientation on Chronic Illness Care Management," presentation to AcademyHealth Annual Research Meeting, June 7, 2004.

Chronic Care Model Research Findings

In addition to the findings cited above involving the large-scale applications of the Chronic Care Model, the Robert Wood Johnson Foundation funded a rigorous independent evaluation of the collaborative improvement process and the implementation of the Chronic Care Model. In 1999, a multidisciplinary research team from the RAND Institute and the University of California at Berkeley undertook the evaluation work.

During the following four years, the evaluation team conducted in-depth assessments across 51 participating sites in four collaboratives involving almost 4,000 patients with diabetes, congestive heart failure, asthma and depression. More than 15 papers have been published detailing what was learned from the evaluation, and a summary of each can be found at RAND's web site.²⁶

Highlights of the findings include:

- patients with diabetes had significant decreases to their risk of cardiovascular disease;
- chronic heart failure pilot patients who were more knowledgeable and relied more often on recommended therapy had 35% fewer hospital days than patients not involved in the Chronic Care Model practices; and
- asthma and diabetes pilot patients were more likely to receive appropriate therapy than were other patients.²⁷

When contacted a year later, the care teams reported that involvement in the collaboratives was rewarding. Over that year, 82% of sites had sustained the changes and 79% of sites had extended change to other places or diseases.

A 2005 meta-analysis combined results of 112 studies.²⁸ The analysis concluded that:

- interventions that contain one or more elements of the Chronic Care Model improve clinical outcomes and processes for patients with chronic illness;
- cost-effectiveness study results are generally positive, but a little mixed, according to a review of 27 controlled trials studying interventions related to the Chronic Care Model;²⁹ and
- alignment of incentives for providers and strong provider leadership heavily influence the business case for the Chronic Care Model.

²⁶ See www.improvingchroniccare.org/index.php?p=The_RAND_Evaluation&s=32.

²⁷ See www.rand.org/health/projects/icice/findings.html

²⁸ Tasi et. al. "A Meta-Analysis of Interventions to Improve Chronic Illness Care" *American Journal of Managed Care*, 11: 478-88, 2005.

²⁹ T. Bodenheimer, E. Wagner and Grumbach. "Improving Primary Care for Patients with Chronic Illness: The Chronic Care Model, Part 2", *JAMA*, 288:15, 1909-1914, October 16, 2002.

The Journal of the American Medical Association reported that health process/outcomes improved in 82% of studies of practices using the Chronic Care Model and reduced costs/lower use of health services were found in 67% of studies.³⁰

Studies in Western Pennsylvania demonstrated that use of the Chronic Care Model improved diabetic practice and outcomes in a large health system, the community and a rural health practice.³¹

³⁰ Ibid..

³¹ Piatt G, Orchard T, Emerson S, Siminerio L, Simmons D, Korytkowski M, Ahmad U, Songer T, Zgibor J. "Translating the Chronic Care Model into the community: A randomized controlled trial of a multifaceted diabetes education intervention." *Diabetes Care*, 29(4):811-817, 2006; Siminerio L, Piatt G, Emerson S, Ruppert K, Saul M, Solano F, Stewart A, Zgibor J. "Deploying the Chronic Care Model to implement and sustain diabetes self-management training programs," *The Diabetes Educator*, 32(2): 2006; Siminerio L, Piatt G, Zgibor J. "Implementing the Chronic Care Model in a rural practice," *The Diabetes Educator*, 31(2):225-234, 2005; Siminerio L, Zgibor J, Solano FX. "Implementing the Chronic Care Model for improvements in diabetes practice and outcomes in primary care: The University of Pittsburgh Medical Center experience," *Clinical Diabetes*, 22(2):54-58, 2004.

Relationship to the Medical Home

Separate and apart from the growing interest in and implementation of the Chronic Care Model, interest has been growing in what is referred to as the Medical Home or Advanced Medical Home. At its essence, the Medical Home concept is an approach to providing comprehensive primary care. A Medical Home is defined as primary care that is accessible, continuous, comprehensive, family centered, coordinated, compassionate and culturally effective. A medical home addresses how a primary health care professional works in partnership with the family/patient to assure that all of the medical and non-medical needs of the patient are met.

The American College of Physicians (ACP)³², the American Academy of Family Physicians (AAFP) and the American Academy of Pediatrics (AAP) have each called for significant practice redesign to improve patient-centered care in the form of a Medical Home. Seven major insurers have agreed to a demonstration with four medical societies (ACP, AAFP, AAP and American Osteopathic Association). These insurers include Aetna, the Blue Cross and Blue Shield Association, CIGNA, Humana, MVP Health Care, UnitedHealthcare and WellPoint.

In Pennsylvania, the Pennsylvania Chapter of the AAFP, the ACP, and the Pennsylvania Chapter of the AAP have been particularly active, having secured grant funding to help family practices redesign the manner in which they deliver primary care. In addition, Aetna and Independence Blue Cross have been working with AAFP, ACP, Blue Cross Blue Shield Association, National Committee for Quality Assurance and Philadelphia providers on the design of a demonstration.

³² "The Advanced Medical Home: A Patient-Centered, Physician-Guided Model of Health Care," American College of Physicians, 2006.

Proponents of the Medical Home concept cite the following:

- U.S. and international studies of the Medical Home model for children have indicated that a relationship with a Medical Home is associated with better health on the individual and population levels, with lower overall costs of care and with reductions in hospitalization and specialty referral disparities between socially disadvantaged and advantaged populations.³³
- A recent study estimated that if every American had a Medical Home, health care costs would likely decrease by 5.6 %, resulting in national savings of \$67 billion dollars per year, with an improvement in the quality of the health care provided.³⁴

The Medical Home and Advanced Medical Home models are rooted in the Chronic Care Model, and share much in common with the latter, including a population-based approach to care management, use of information technology to support care management, and proactive care management. They do, however, differ from the Chronic Care Model in three ways:

- The Medical Home and Advanced Medical Home focus primarily on the primary care practice and how it is paid. They do not address community resources and programs to support healthy lifestyles to the same degree that the Chronic Care Model does.
- The Medical Home and Advanced Medical Home focus on redesigning the primary care practice for all patients.
- The Medical Home and Advanced Medical Home are specific to physician practices and do not extend to advance practice nurse primary care practices.

The Chronic Care Model and the Medical Home concepts both improve on insurer-based disease management programs that use nurse case managers who are external to the practice. Both models establish responsibility for managing chronic diseases with a primary care team and insist on coordinating care, communication and information sharing among all the physicians and non-physicians that a patient may see.

The differences between the Chronic Care Model and the Medical Home are far more limited than what the two programs have in common. This has enabled the Commission to pursue the implementation of the Chronic Care Model in partnership with the medical societies, and with national Medical Home-based

³³ B. Starfield and L. Shi "The medical home, access to care, and insurance: a review of evidence," *Pediatrics*, 113(5 Supplement):1493-8, May 2004.

³⁴ SJ Spann, for the members of Task Force 6 and The Executive Editorial Team. "Report on Financing the New Model of Family Medicine." *Annals of Family Medicine*, 2(suppl_3):S1-21, 2004.

initiatives such as the Patient Centered Primary Care Collaborative.³⁵ However, we must do so in a way that permits and encourages nurse-managed health care centers to be included and that they can be quickly credentialed by insurers. A critical component of the Governor's Prescription for Pennsylvania is ensuring that all health care providers can practice to the full extent of their training and can be a part of a comprehensive patient-centered primary care practice.

³⁵ New Physician Payment System to Support Higher Quality, Lower Cost Care, The ERISA Industry Committee, October 2007.

Pennsylvania Agency Action to Address Chronic Illness

The Department of Public Welfare has taken considerable action to improve chronic care for the Medical Assistance population, including separate efforts affecting the fee-for-service and capitated managed care subpopulations. Appendix E provides a brief summary of the Department's efforts to date. In addition, the Pennsylvania Employees Benefit Trust Fund, which provides benefits for state employees, has a Get Healthy Program, which provides reductions in employees' share of health care premiums for successful participation in the program.

Strategic Plan for Chronic Care Model Implementation in Pennsylvania

Vision

Pennsylvania residents should not be condemned to less than optimum health just because they have a chronic disease and lack access to comprehensive, patient-centered, coordinated culturally and linguistically competent primary care, which would provide improved health and quality of life throughout their years.

Likewise, employers and individuals should not be forced to pay higher premiums due to the costs of avoidable hospitalizations and emergency room use because persons with chronic conditions have been unable to obtain the recommended care that would avoid these costs.

To improve care and reduce health care costs, we must transform chronic care treatment in our Commonwealth, beginning with the nature and structure of primary care delivery, continuing with the provision of self-management support for patients with one or more chronic diseases and culminating with the alignment of incentives that motivate primary care teams and patients to improve management of chronic conditions.

The Commission expects, based on proven application of similar models, that the cost of Pennsylvania health care will progressively decline, even as we focus on enriching patient care.

Starting with Diabetes and Asthma

Diabetes

According to a recent report released by the American Diabetes Association, diabetes cost the United States \$174 billion in 2007 in both direct cost and productivity losses, an increase of \$132 billion over costs in the prior year. The report also found that:

- diabetes condition costs rival those associated with cancer care;
- the incidence of diabetes is growing rapidly, nearly doubling between 1995 and 2006 to 7.4% of the population;
- approximately half the people with diabetes are covered by publicly funded health care;
- inpatient care accounts for about half the costs for diabetes care;
- diabetes increases hospital stays for other conditions by almost 50%; and
- routine care for diabetes is relatively low cost, with most of the cost resulting from lack of management of the disease.³⁶

Due to human and financial impact of Diabetes in Pennsylvania and the momentum created by advance work done by the Pennsylvania Department of Health and the Pennsylvania Diabetes Action Partnership, the Commonwealth plans to focus first on diabetes and related co-morbidities for adults and asthma for children.

The Diabetes Stakeholder Group spent two years developing the Pennsylvania Diabetes Action Plan. This Plan represents the combined effort of more than 200 stakeholders, including federal, state, and local governmental agencies, health insurers, voluntary health organizations, academic institutions, health systems, professional associations, foundations, consumers, corporations, and communities with an interest in diabetes prevention and control. The Plan provides the blueprint for how efforts, resources and interests can be combined to strengthen the collective capacity in Pennsylvania to ultimately prevent diabetes whenever possible and to assist individuals with diabetes to live their best and healthiest lives.

The Burden of Diabetes in Pennsylvania 2007 report prepared by the Pennsylvania Department of Health contains information and data provided both to educate individuals and organizations on the burden of diabetes and to provide them with the tools necessary to plan effective interventions for all those affected by the disease.

³⁶ "Diabetes Cases, Costs Rising" Richmond Times-Dispatch, January 24, 2008.

Diabetes affected an estimated 8% of Pennsylvania's population, or 764,000 individuals, in 2005. The prevalence of diabetes increases dramatically with age and there is a higher prevalence of diabetes among African American adults in Pennsylvania when compared to white adults.³⁷

Older persons with diabetes often have other chronic conditions. A recent study of older diabetics found that of 92% had at least one other chronic disease in addition to diabetes, and half had three or more additional diseases.

The potential consequences of poor diabetes management are grave. Debilitating and costly complications affecting the eyes, feet, nerves, cardiovascular system and kidneys can develop, and the disease frequently results in premature mortality.

Asthma

The second chronic illness targeted by the Commission for use of the Chronic Care Model is asthma.

Nine percent of Pennsylvania adults, 786,000 adults, report that they presently have asthma diagnosed by a clinician. Also, 9.8% of Pennsylvania school-aged children in grades K-12 have asthma. Between 2001-2003, 496 Pennsylvanians died of asthma.

Income has a significant impact on prevalence. Adults with annual incomes below \$15,000 reported an asthma incidence rate more than twice that of adults with income of \$25,000 and above. In addition, there is higher prevalence of asthma among African American and Hispanic adults in Pennsylvania when compared to white adults.³⁸

While there is no cure for asthma, attacks can be prevented by taking proper medication and avoiding asthma "triggers."

³⁷ 2001-2006 Behavioral Risk Factor Surveillance System Survey, Pennsylvania Department of Health.

³⁸ Pennsylvania Department of Health, Office of Health Equity.

Goals & Implementation Priorities for the Redesign of Chronic Care In Pennsylvania

The Commission established four Strategic Goals supported by seven Implementation Priorities designed to change the paradigm in Pennsylvania for the receipt of medical care by persons with chronic diseases, as well as for their ability to obtain support in self-management of their conditions.

A more detailed description of the plan components is contained in the Strategic Plan that follows.

Strategic Goals

Widespread use of a new primary care reimbursement model that rewards:

- use of the Chronic Care Model;
- primary care practice team collaboration;
- patient-centered care coordination;
- delivery of evidence-based, best practice chronic care to the vast majority of chronic care patients;
- assisting patients in setting and achieving self management goals for weight loss, smoking cessation, exercise, medication compliance, etc.;
- outcomes for quality care;
- ability to get a timely appointment or consult if problems develop;
- use of a patient registry to manage patients with chronic illness and to reach out to patients in need of evidenced-based care;
- consumers for completing self management courses; and
- culturally and linguistically competent care.

Broad dissemination of the Chronic Care Model to primary care practices across Pennsylvania, through regional chronic care learning collaboratives.

Achievement of tangible and measurable improvement in the following areas:

- chronic care patient satisfaction;
- chronic care patient access to services;
- chronic care patient health status and function, and quality of life;
- primary care provider satisfaction;
- health resources utilization; and
- improved quality of care for chronic care patients, as measured using process and clinical outcome measures.

Reduction in the cost of providing chronic care with the reduction of avoidable hospitalizations and emergency room visits and mechanisms to ensure that some of the savings are realized by all entities paying for health care.

Implementation Priorities

- **Make practice coaches available to primary care practices that want assistance with redesigning their practice.**
- **Establish regionalized, culturally sensitive and linguistically appropriate approaches to engaging consumers in self-management** of their chronic conditions and meeting goals for healthier lives.
- **Provide all primary care clinicians use of a free, secure, web-based patient registry** to support chronic disease prevention and treatment and for effective management of individual and population based care.
- **Develop a statewide, pooled claims database** across insurers accessible to primary care providers, insurers and the public to provide transparency on how we are doing as a state in improving chronic care.
- **Adopt a certification process** administered by an independent entity for use to determine if primary care practices qualify for enhanced reimbursement for transforming their primary care practice to the Chronic Care Model.
- **Increase understanding about how to best support those persons who are most severely, chronically ill**, while maintaining an approach that addresses the needs of all people with chronic illness.
- **Educate and inform consumers about Pennsylvania's Chronic Care Model and how to access it.**

Policy Principles

The Commission has adopted policy principles that create a framework for a successful multi-year implementation of the Chronic Care Model Strategic Plan.

These principles are as follows:

Primary care practices will be encouraged to develop the knowledge and tools to redesign their practices through participation in learning collaboratives organized within regional rollouts.

Initially, the learning collaboratives will focus on the application of practice redesign for:

- patients with diabetes, including those who have co-morbidities such as cardiovascular disease, depression, substance use disorders; and
- child patients with asthma, for pediatricians and family practitioners participating in the learning collaborative.

The Governor will request the Chairs of the relevant clinician licensing boards to allow continuing educational requirements to include courses on implementing the Chronic Care Model.

Each regional collaborative will be required to have the following elements in place before commencing its work:

- trained practice coaches;
- a critical mass of participating payers in each collaborative region;
- patient registries for use by participating practices;³⁹
- practices of various sizes willing to participate in the collaborative;
- culturally and linguistically appropriate training for consumers in self-management of chronic conditions;
- communication plan that encompasses consumers, practices, insurers and the public;
- reliable, valid and feasible performance measures as well as the ability to undertake data collection;
- staffing for the collaborative; and
- an evaluation plan in place, including a plan to share results publicly.⁴⁰

Incentives may be provided through increased per member per month payments, increased fee-for-service payments or through payments made from a pooled set of dollars from health plans for practices in the learning collaboratives.

³⁹ Initially registries will be populated by practices for their patients with chronic diseases. Thereafter, interfaces will be developed to allow inclusion of data from multiple plans.

⁴⁰ This will be phased in the first year, and more widely utilized thereafter.

The Chronic Care Model will be implemented using rapid learning cycles.

Certain approaches (e.g., provider incentive alignment) will be introduced, evaluated, and modified, as necessary, as the Commission's work proceeds. Critical to this effort will be a vigorous communication strategy to ensure that lessons are widely shared on a timely basis.

Practice coaches will have to be trained by qualified persons. In addition, the Commission will strive to ensure that trained practice coaches are resident within the largest provider organizations to provide ongoing support.

Empowered patients will participate as active members of a collaborative primary care team. To achieve this goal, patients will be able to access patient self-management training, member coaches, employer and community resources and providers who encourage patient self-management and that are culturally competent.

Payers participating in the regional rollouts must agree to align incentives for the provision of good chronic care by offering:

- payment enhancements for infrastructure and resources to support use of the Chronic Care Model;
- practice-level payments based on performance relative to specified evidence-based quality metrics, including those for incremental change; and
- incentives for participating consumers to use evidence-based services provided by their primary care practice team.

Eventually, provider incentives should use a common methodology across payers within each regional rollout. Avoidable emergency room and hospitalization data will be collected by practice and for the regional rollout, but will not be used as part of the initial payment redesign. The Commission will assess whether performance measures of avoidable emergency room and inpatient hospital services related to chronic conditions should be included in future incentive alignment methodologies.

Beginning in the first year of each regional rollout only aggregate performance data from the collaborative will be made public. Individual practice performance data will not be public. Participating practices, however, will share their data with other practices in the collaborative.

Insurer claims will be pooled in order that the combined data might be used for developing consolidated profiles of primary care team performance, and eventual integration of claims data with provider registry data and other clinical data (e.g., laboratory, EMR).

Beginning in the first year of Chronic Care Model implementation, **the Governor's Office of Health Care Reform will coordinate the regional rollouts** and work with the Pennsylvania Departments of Health, Welfare, Aging and Insurance to support the regional rollouts.

Major Tasks and Timeline

Regional Rollouts: Five Core Elements

The Commission envisions a multi-year implementation of the Chronic Care Model across Pennsylvania. The Model shall be implemented using a regional rollout approach. Each regional rollout will have the following five core elements:

- a primary care learning collaborative, which will include the provision of a disease registry and practice redesign training and support;
- insurer-provider incentive alignment using the Commission's parameters;
- insurer-consumer incentive alignment using the Commission's parameters;⁴¹
- community consumer self-management support resources; and
- measurement and evaluation.

Participating insurers and providers will commit to participate in each regional rollout for three years. Each regional rollout will include the participation of at least two insurers.⁴²

As described further below, the rollout will commence in May 2008 in Philadelphia, with a preceding web-based provider presentation in March. The rollout will continue with expansion to additional regions in September 2008, with subsequent learning collaboratives added as quickly as possible thereafter.

Core Element #1: Learning Collaboratives

The principle vehicle to spread knowledge and practice will be the use of "learning collaboratives". These are intensive programs wherein primary care practice teams receive education and support in order to redesign and transform their practices. In order to be a part of a regional rollout and potentially receive enhanced payment, practices must be active participants in the regional rollout learning collaborative. Approximately 50 physicians or advance-practice nurses and their practice team colleagues will participate in each learning collaborative. The collaboratives will meet four times per year for a total of seven days. The first three meetings will involve training, sharing of experiences, data review and problem solving. The final meeting of the year will be for one day and will be focused on reviewing data to assess practice-level

⁴¹ This will be phased in the first year, and more widely utilized thereafter.

⁴² For purposes of this discussion, the Medical Assistance Program shall be considered to be an insurer when it is directly paying providers for service delivery to Medicaid beneficiaries.

impact. Following the first year, each learning collaborative will meet twice a year for a combined two days.

Learning collaboratives are currently scheduled into 2010. The Commission anticipates that it will never educate every primary care practitioner in the Commonwealth, but that the cumulative effect of its efforts will be to complete a transformation of primary care practice and support for chronically ill patients.

Curriculum

The learning collaboratives will teach primary care practice teams, including physicians, nurse practitioners, physician assistants, nurses, nutritionists, educators and any other members of a practice team how to redesign their practice in order to be more effective in caring for their chronically ill patients. A few of the core concepts include:

- practicing as a true team;
- using evidence-based care guidelines and data to inform care planning and management; and
- providing patient self-management education directly and/or through external professional and lay community resources that are culturally and linguistically appropriate.

While the initial learning collaboratives will focus upon the treatment of diabetes and associated co-morbidities and pediatric asthma, the effect of the practice redesign process will be to change how care is provided to all of a practice's patients, to the particular benefit of those with one or more chronic illnesses.

Disease Registry

Staff from the Governor's Office of Health Care Reform (GOHCR) will ensure that the participating practices have access to a patient registry to follow their patients with chronic illnesses, if they do not have access to one already. GOHCR is currently evaluating electronic registries that can be obtained and used by Pennsylvania primary care practices.

Disease registries can generate one-page clinical data sheets that document the patient's adherence to specified evidence-based guidelines for treatment and management of chronic illnesses. The database can also flag lab tests and services that are due or which generate values that are outside of expected or desired ranges. They can also produce graphical representations of changes in a patient's health status over time and assist in care planning activities. These stand-alone registries can be integrated with a primary care practice's electronic medical record system should the system not already be equipped with a registry.

Governor's Office of Health Care Reform will explore alternative longer-term registry strategies for use in future years.

Practice Coaching

Learning collaborative participants will also benefit from technical assistance made available by practice coaches. Governor's Office of Health Care Reform is working closely with the Pennsylvania Chapter of the American Academy of Family Physicians (AAFP) and the Primary Care Consortium to make available practice coaches who are being trained as part of a grant that the AAFP Pennsylvania Chapter received from the Robert Wood Johnson Foundation.⁴³ The AAFP is having its practice coaches trained by North Carolina IPIP participants; these coaches will serve as the initial coaches for the Chronic Care Model rollout.

Over time, the Commission will encourage large Pennsylvania primary care provider practices to have their internal staff become trained as coaches, as national experience has shown that internal coaches have greater effectiveness in supporting and sustaining practice change than do practice coaches who are external to the practice.

Core Element #2: Insurer-Provider Incentive Alignment

Those practices that choose to participate in a learning collaborative will be offered an array of financial incentives. Participating insurers will need to design their incentives within the Commission's guidelines, but will otherwise have the flexibility to use customized approaches.

These guidelines require:

- enhanced payments or infrastructure and resources to support use of the Chronic Care Model; and
- performance bonuses for providers who demonstrate the delivery of superior clinical care.

⁴³ The grant was for a program titled "Improving Performance in Practice (IPIP)." Two other states were previously awarded grants (Colorado and North Carolina.) Pennsylvania and Michigan were the third and fourth IPIP grantees.

With regard to the supplemental fee, it is likely that participating rollout region practices will need to demonstrate either:

- that they have affected specific Chronic Care Model-aligned practice changes prior to receiving payment enhancement; or
- that they have affected such practice changes following receipt of payment enhancement.

Regarding the former, the Commission has reviewed the National Committee for Quality Assurance's (NCQA) Physician Practice Connections (PPC) certification program as a potential basis for qualifying practices for payment enhancement. The American Academy of Family Physicians, the American Academy of Pediatrics, the American College of Physicians, and the American Osteopathic Medical Association, worked with NCQA to revise its 2006 Physician Practice Connections program to align with the professional societies' conception of a Primary Care Medical Home (PCMH). These national bodies have endorsed the new PPC-PCMH standards. However, this would need to be adapted to accommodate certification for nurse-managed centers.

Regarding standards for accountability, the Commission has studied new initiatives in Minnesota and Rhode Island that propose to make payment enhancements and then retrospectively audit practices to ensure that practice change has occurred consistent with expectation.

Finally, the Commission's Performance Measurement Subcommittee has identified a comprehensive set of draft measures for evaluating the Chronic Care Model rollout, which will be reviewed by the Commission at its February 2008 meeting. The Commission will recommend that a subset of these measures be used commonly across insurers and practices within a regional rollout in time, but will initially support insurer use of measures that are already deployed to facilitate the timeliness of the rollout. Commission research has found that Pennsylvania insurers use many similar, but not exactly aligned measures in their pay-for-performance initiatives.

Insurers will have sole discretion in determining the amount of money to make available to providers for incentives. The insurers will use common regional rollout performance data, however, to inform their internal decisions on incentive payment allocation whenever possible.

Core Element #3: Insurer-Consumer Incentive Alignment

The Commission has recognized that the important focus on insurer-provider incentive alignment must be balanced with motivational incentives to help patients with chronic illness effectively manage their conditions. The Commission's Consumer Engagement Subcommittee has recently developed a series of recommendations for consumer incentives. The Commission anticipates

that such incentives may be introduced in the second rollout scheduled in September, and will be in use more widely thereafter.

The Consumer Engagement Subcommittee is recommending the five incentives be adopted and implemented by insurers. The Commission will consider these recommendations during its February 2008 meeting.

These incentives were designed to complement and reinforce those developed by the Incentive Alignment Subcommittee for providers. The dollar value of the incentives and the operational processes to implement them would be determined by each individual insurer.

Core Element #4: Community Consumer Self-Management Support Resources

Chronic illness management and behavior change are difficult. The Commission notes the attention given in the Chronic Care Model to the identification and/or development of resources and programs to support healthy lifestyles, and to the need to make support resources available beyond those provided by the primary care team.

The Commission will help coordinate the identification of existing culturally appropriate self-management education resources, peer support and community-based public health initiatives to which primary care practices in the rollout regions can refer patients, and which insurers and state and local public health agencies and departments can publicize.

The Consumer Engagement Subcommittee is also in the early stages of identifying avenues to increase the availability of disease-neutral, self-management training programs. The Subcommittee is considering both the development of peer-led, self-management programs based on the Kate Lorig⁴⁴ model out of Stanford University, and a self-management certification program for state-licensed clinicians.

The Governor's Office of Health Care Reform will work with insurers and provider organizations to identify and ensure financial support for resources in both clinical and non-clinical settings that will support patient self-management.

Core Element #5: Measurement and Evaluation

While the Chronic Care Model has been studied, evaluated and validated, and it has been implemented in many provider settings and by other states, never before has it been deployed as comprehensively as envisioned by the Commission. While Commission members are enthusiastic about its anticipated clinical and financial impact, they also feel a strong need to verify that it will actually have its desired effect. As a result, the Commission is recommending a

⁴⁴ For information on the Kate Lorig model, see <http://patienteducation.stanford.edu/training/>.

comprehensive set of evaluation activities for each regional rollout, and for all of the regional rollouts in combination.

The Commission has a high degree of confidence and support for the work that it and its representatives' organizations are undertaking. However, it believes that its efforts should discontinue in the event that evaluations of effectiveness indicate that the implementation of the Chronic Care Model has failed to improve quality of care and to decrease the rate of health care cost growth, if not the cost of health care altogether within three years.

Prior to the end of the three-year period for the regional rollouts commencing in September 2008, the Commonwealth will conduct an evaluation of the regional rollouts using a predefined set of performance measures that are being recommended by the Performance Measures Committee at the February 2008 Commission meeting.

Finally, anticipating that the initial regional rollouts will demonstrate positive impact, in 2008 the Commonwealth will begin to develop the capacity to support future systems improvement efforts by developing the means to pool claims data across providers for common profiling, and for integration with clinical information. In addition, it will evaluate the effectiveness of its efforts on an ongoing basis in order to make continuing refinements and to add to the body of knowledge regarding how best to support patients with chronic illness.

This report makes clear that there would be significant impetus for adoption of the Chronic Care Model even if its *only* likely achievement was a dramatic improvement in the quality of life of Pennsylvanians with chronic diseases. That it both improves the health of chronically Pennsylvanians while simultaneously reducing the cost of their care makes this issue an urgent priority.

In a state and region where much of the best of American medicine was born and flourished over the decades, the implementation of the Chronic Care Model will reenergize both the people who practice medicine and a patient population who will be given the resources and information to manage their own well-being.

Addendum

The Commission recommends that implementation of the Chronic Care Model begin in 2008 and organize around the following major areas of activity, subject to approval by the Governor.

Major Areas of Activity

Implementation of regional rollouts

- Begin implementation in Spring 2008.
- Start with one Philadelphia rollout in May 2008 consisting of practices of various sizes and models. Aetna, Independence Blue Cross and Keystone Mercy Health Plan have expressed interest in participating, and primary care practices from multiple health systems have also expressed interest.
- Continue implementation in September 2008 with regional rollouts in the remainder of the Commonwealth.
- Thereafter, introduce new learning collaboratives as quickly as possible in other regions.
- Explore making CME credits and other incentives available to encourage practice participation.

Selection and provision of primary care practice access to a patient registry

Alignment of incentives for primary care practices

- Finalize incentive alignment guidelines for May 2008 regional rollout.
- Assess and revise guidelines prior to the start of the September 2008 regional rollouts.

Alignment of incentives for patients

- Establish incentive alignment guidelines prior to the start of the May 2008 regional rollout.
- Identify culturally appropriate self-management education resources and launch them in time for the May 2008 regional rollout.
- Assess and revise guidelines prior to the start of the September 2008 regional rollouts.
- Implement a consumer education plan in September 2008.

Pooled claims database

- Convene a new committee for the express purpose of developing plans for pooling claims data in April 2008.
- Provide recommendations to the Commission in October 2008.
- Commence construction of the database in January 2009.

Measurement and evaluation

- Establish recommended evaluation measures for the Commonwealth, and for each learning collaborative, by February 2008.
- Commence baseline measurement for the May 2008 regional rollout in March 2008 using Commonwealth staff.
- Refine measures by April 2008 for the second round of regional rollouts.
- Hire an evaluation contractor to assist with the conduct of future evaluation activity.

Appendix A

Existing Care Model vs. the New Chronic Care Model - A Case in Point

Meet May. She is a fictitious patient but her chronic condition and treatment circumstances are real for thousands of women and men across the Commonwealth of Pennsylvania.

Existing Treatment Scenario

May is a 52 year-old woman who was diagnosed with diabetes 10 years ago. She has required insulin for the past eight years and now gives herself insulin injections twice a day. She also has high blood pressure and high cholesterol, is overweight, and smokes 10-20 cigarettes a day.

May understands what can happen to a person with her health conditions and knows she needs to make some changes. Her mother also had diabetes and died in her early sixties of a heart attack, after one of her toes was amputated due to an infection. Before she died, May's mother also had problems with her vision. May knows she needs to eat better, exercise, see her doctor regularly and keep closer tabs on her blood sugars, but most of the time she feels as if she can barely make it through the day. She is divorced and works two jobs to try to support herself and her two teenage boys. She often feels depressed and overwhelmed.

May does have a primary care physician whom she sees every few months to check up on her diabetes and high blood pressure. She likes him but often forgets to ask him her questions once she is in the exam room for the 10-12 minutes he is with her. At most visits he tells her that she needs to stop smoking, exercise, and lose weight, but his advice is usually very general and she doesn't know how to begin. Mostly, she feels that nothing she does will make a difference anyway. Her doctor has also given her a referral to get her eyes examined, her feet examined by a podiatrist, and some blood work, but she hasn't had time to make the appointments to get any of that arranged and they are not near her home or near public transportation.

When May calls her doctor for an appointment, she is given an appointment 6-8 weeks later. On occasion, the doctor's office has not been able to give her an immediate appointment when she was feeling ill and instead told her to go to the emergency room. May has been to the emergency room twice and hospitalized once in the past 18 months for problems related to her diabetes. Unfortunately, after all three incidents, her primary care doctor didn't know the details of either the emergency room visits or the hospitalization for pneumonia, and May herself wasn't sure of the details. In fact, she didn't even see her doctor until several weeks after the hospitalization. Her medications, including her insulin dose, were changed during the hospitalization, and May isn't sure which of the many medicines she has been given she is supposed to be taking.

All in all, both May and her doctor are frustrated and feel that May is not getting the kind of ongoing care and support that she needs to manage her diabetes

and her other health concerns. In addition, since May is not getting the kind of support she needs, it is very likely that her utilization of the hospital and emergency room will escalate as her disease progresses.

Chronic Care Scenario


In the health care system designed around the Chronic Care Model, both May and her doctor are supported by a multidisciplinary team of health care professionals that take a proactive approach to helping May manage her diabetes, provide educational and emotional support to May so that she can better manage her disease, and help to keep both May and her physician on track with making sure that May gets the tests and other preventive services that she needs. In addition, May is able to get in touch with someone from the team after she is at work and on weekends so that she can get her questions answered, be seen when necessary, and have her problems taken care of before they escalate.

Since May has diabetes, her data is in a diabetic registry. This registry alerts her physician and his staff to keep track of May and to make sure that she gets her eye exams, foot exams, and blood work—as well as other general preventive services—when they are due. May herself is sent regular reminders to make appointments for check-ups. The care manager helps May to schedule these necessary tests and check-ups at locations near her home and schedules May to meet with the diabetic educator in her physician's office. The diabetic educator not only talks to May about how to manage her diabetes, the educator also works with May to improve her diet and coaches her regarding how to exercise, given May's complicated daily schedule. Perhaps most importantly, the care manager, the diabetic educator, the physician, and the rest of the team work together to make sure that all of May's health information is on her chart, that she understands and takes her medications properly, and her other health care needs are addressed fully and in a timely manner. For example, when May developed an upper respiratory infection, she was able to speak with the nurse and the diabetic educator regarding dietary, fluid, and insulin adjustments and thereby avoided a trip to the emergency room and a potential hospitalization. May has also been referred to a lay diabetes support group in her community. The group shares tips on nutrition, stress management and has fun together in the low impact aerobics work out sessions.

May now sees her doctor on a regular basis and works with the rest of the team to manage her diabetes. She is also able to get more focused help with smoking cessation, and as she loses weight, her hypertension is improving. May no longer feels hopeless about her health and is getting the support she needs to increasingly self-manage her diabetes and the factors that impact her health.

The money saved under the Chronic Care Model is substantial and yet, counter-intuitively, it is achieved by delivering enriched, multi-disciplinary care that improves a patient's quality of life immeasurably.

COMMONWEALTH OF PENNSYLVANIA
GOVERNOR'S OFFICE
EXECUTIVE ORDER

Subject:	CHRONIC CARE MANAGEMENT, REIMBURSEMENT AND COST REDUCTION COMMISSION	Number: 2007-05
Date: May 21, 2007	By Direction of:  Edward G. Rendell, Governor	

WHEREAS, chronic diseases are the biggest threat to the health of Pennsylvania's residents, and seventy-five percent (75%) of the cost of health care can be traced to twenty-five percent (25%) of patients who have chronic diseases; and

WHEREAS, Pennsylvania has some of the highest rates of any state for potentially avoidable hospitalizations because those with chronic diseases have not received the needed episodic evidence based care in the community resulting in \$1.7 billion in potentially avoidable hospital charges for Pennsylvanians with chronic disease in 2005; and

WHEREAS, there is a need to examine and change the covered benefits and methods of providing payments for chronic care in order for individuals to maintain a positive health status; and

WHEREAS, a nationally recognized Chronic Care Model is in use by the Veteran's Administration, federally qualified health centers and other locations in Pennsylvania and evaluations have demonstrated that the use of all of the components of this Chronic Care Model results in healthier patients, more satisfied providers and cost savings; and

WHEREAS, the components of this Chronic Care Model can be applied to a variety of chronic diseases in various health care settings.

NOW, THEREFORE, I, Edward G. Rendell, Governor of the Commonwealth of Pennsylvania, by the virtue of the authority vested in me by the Constitution of the Commonwealth of Pennsylvania and other laws of the Commonwealth, do hereby establish the **Governor's Chronic Care Management, Reimbursement and Cost Reduction Commission** (hereafter referred to as the "Commission") and order and direct as follows:

1. Purpose. The purpose of the Commission is to design the informational, technological and reimbursement infrastructure needed to implement and support widespread dissemination, adaptation and implementation of the components for chronic care in relevant health care sites throughout Pennsylvania, which result in quality outcomes and cost effective treatments for patients with chronic diseases.

2. Powers and Duties. The Commission shall have the following powers and duties:

a. Determine how to align and integrate these proven components for chronic care into the current health care system and into currently existing chronic care models throughout Pennsylvania. The components for chronic care include, but are not limited to, the following:

(1) providing patients with chronic conditions support and information so they can effectively manage their health;

(2) ensuring that treatment decisions by health care providers are based on evidence based medicine;

(3) ensuring that patients get the care they need by clarifying roles and tasks of health care providers and ensuring that all who take care of patients have centralized, up-to-date information about the patient and that follow-up care is provided as a standard procedure;

(4) tracking clinical information of individual patients and a population of patients to help guide the course of treatment, anticipate problems and track problems;

(5) engaging the entire organization in the chronic care improvement effort; and

(6) forming powerful alliances and partnerships with state, local, business, religious and other organizations to support or expand care for those with chronic disease.

b. Establish regional community learning collaboratives to educate providers, health care teams and consumers on the components for chronic care, evidence based treatment of chronic disease.

c. Identify and assess current efforts surrounding the implementation and maintenance of chronic care models across the Commonwealth and in each regional community learning collaborative, and develop guidelines to be used in the review of patient data by the Commission and those regional community learning collaboratives that maintain the level of confidentiality required by state and federal law.

d. Identify processes that assess positive and negative factors influencing the implementation of the components for chronic care in order to ensure the establishment of standards of care that comply with established practice guidelines.

e. Assess and potentially incorporate existing efforts dealing with chronic care being performed by Commonwealth agencies.

f. Develop a statewide chronic care information system, including rules for secure information sharing, which permits the exchange of information among the regional community learning collaboratives and the Department of Health.

g. Develop the infrastructure to make registries of patients with chronic conditions that include clinical data provided by the insurance company available for use by their primary care physicians.

h. Use outreach efforts to educate consumer groups and the provider community in order to engage individuals to take necessary steps to prevent chronic diseases and to better self-manage their chronic conditions with the support of a health care team.

i. Design and adopt the use of programs that utilize the proper personnel to support individuals in their efforts to self manage and live with chronic conditions, including use of community health worker programs.

j. Gather data that can be used by the Commission to construct robust measures of provider performance using a common set of chronic care measures.

k. Create evaluation processes and outcome measures to monitor implementation of the components for chronic care in different clinical settings.

l. Work with insurers and providers to examine current reimbursement systems and propose and develop new reimbursement models which will encourage, support and reward a provider team approach that uses all of the components for chronic care.

m. Oversee and assist workgroups consisting of representative stakeholders and state agency staff to advise the Commission on how best to meet its mission and goals.

n. Support widespread dissemination, adaptation and implementation of components for chronic care into practices and other chronic care models starting with patients with diabetes through collaboration with the Pennsylvania Diabetes Action Partnership, and identify strategic partners to include in cooperative efforts incorporating their work towards including other chronic conditions, such as, but not limited to, depression, asthma, chronic congestive heart disease, lung disease, etc. within this model.

o. Develop and ratify a strategic plan for the Commission that includes a blue print for evaluation within ninety (90) days of the first meeting of the Commission. After ratification, the Commission shall submit the strategic plan to the Governor, the President Pro Tempore of the Senate and the Speaker of the House of Representatives.

3. Composition. The Commission shall consist of the following members:

a. Five members of the Governor's Cabinet, or his or her respective designee, who shall serve *ex officio* and one of whom shall act as co-chair, as selected by the Governor, with the member selected under subparagraph b.

b. Individuals from each of the following categories appointed by the Governor, one who shall act as co-chair as selected by the Governor:

(1) a health insurer medical director;

- (2) a health insurance actuary;
- (3) a registered nurse, certified nurse practitioner, clinical nurse specialist, physician assistant and pharmacist that is currently practicing within the Commonwealth;
- (4) four primary care physicians who are members of the Pennsylvania Medical Society;
- (5) a specialty care physician in active practice;
- (6) an individual with a background in chronic care from an academic medical center;
- (7) a representative from a Pennsylvanian health care foundation;
- (8) a provider of home health care;
- (9) a health services researcher with expertise in chronic care;
- (10) an individual with a background in information technology and systems;
- (11) a representative from an organization that represents individuals with chronic conditions;
- (12) a consumer with a chronic condition or multiple chronic conditions;
- (13) a consumer with a chronic condition or multiple chronic conditions who is at least 65 years of age;
- (14) two individuals representing hospitals who are members of the Hospital and Health System Association of Pennsylvania; and
- (15) any other individual who can assist the Commission with the purposes outlined in this Executive Order.

c. The Executive Director of the Pennsylvania Employees Benefit Trust Fund or the Executive Director's designee, who shall serve *ex officio*.

4. Term and Composition. The members chosen under subparagraph 3b. shall each serve for a term of three years and continue to serve until their successor is appointed. Members shall serve without compensation except for payment of necessary and actual expenses incurred in attending meetings and in performing their duties and responsibilities as Commission members.

5. Relationship with other agencies. The Governor's Office of Health Care Reform, the Department of Health and the Department of Public Welfare shall provide staff and/or data support to the Commission. All Commonwealth agencies under the Governor's jurisdiction shall cooperate with, provide assistance to, and follow the direction of the Commission with respect to its purpose, powers and duties, as set forth in this Executive Order.

6. Effective date. This Executive Order shall take effect immediately.

7. Termination Date. This Executive Order shall remain in effect unless revised or rescinded by the Governor.

Appendix C

Pennsylvania Chronic Care Management, Reimbursement and Cost Reduction Commission

Commission Members

Joel Ario
PA Department of Insurance

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Philip Benditt, MD
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Robert Gabbay, MD
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Albert Black
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Rosemarie Greco
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Michael Dunn, MD, FACP
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American Diabetes Association

Kate Farley, ex officio
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Appendix D

Composition of Commission Subcommittees

Community Practice Redesign Committee

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Appendix D

Composition of Commission Subcommittees

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Appendix D

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Appendix D

Composition of Commission Subcommittees

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Appendix D

Composition of Commission Subcommittees

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Appendix D

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Appendix E

Pennsylvania Medical Assistance Initiatives Directed at Improved Chronic Care

FFS Programs

1. In 2005, the Department established a Hospital Quality Care Incentive Program that provides incentives to hospitals that demonstrate commitment to improved management of the healthcare needs of MA recipients. The Department intends to continue this Pay For Performance (P4P) program for future fiscal years as funding continues to be available. The Department will be assessing whether additional quality management incentives should be added. In FY 06-07, participating general acute care disproportionate share (DSH) hospitals earned \$1.75 million by meeting specific performance standards.
2. In addition, the Department operates a Hospital Investment Incentive Program that provides grants up to \$100,000 to DSH hospitals that have made investments in pharmacy error reduction, single medical records or other quality initiatives.
3. The Department created an incentive for the ACCESS Plus vendor to earn either a bonus or a penalty for effectively managing the cost of the disease management programs. A P4P Program has also been established in the ACCESS Plus Program which rewarded physicians for active engagement in DM programs. The Department saved \$27 million as a result of its ACCESS Plus Disease Management Program in FY 05-06.
4. MA Program nursing staff are available to provide medical case management for MA recipients with complex cases and certain chronic diseases. This group manages an average of over 800 complex cases monthly and over 1,300 high-risk OB cases per month.

Capitated Managed Care (HealthChoices)

1. Managed care plans can earn incentives for improving in 10 defined HEDIS measures focused on disease management. In FY 06-07 managed care organizations earned \$4.5 million by meeting targeted standards.
2. A Managed Care Provider P4P program was introduced for FY 07- 08. Plans must expand existing provider programs or initiate physician incentives for disease management programs.