Joint Commission on Health Care

Interim Staff Report: Chronic Health Care Homes (HJR 82 – 2010)

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HJ 82 Study Mandate

- HJ 82 (Delegate Hope) directs the JCHC to review programs in other states and to develop recommendations related to:

(i) standards for chronic health care homes which emphasize

(a) the use of a range of primary care practitioners and other professionals including care coordinators to provide high quality, patient-centered care, including development of individualized comprehensive patient care plans, use of patient decision-making aids that provide patients with information about treatment options and associated benefits, consistent contacts between patients and care teams, and systematic patient follow-up,

(b) the use of health information technology,

(c) the use of evidence-based health care practices, and

(d) incorporate quality outcome, and cost-of-care measures;

HJ 82 Study Mandate (Cont.)

- (ii) standards for certification of health care facilities as chronic health care homes including ongoing reporting requirements for chronic health care homes;
- (iii) development of a chronic health care home collaborative to provide opportunities for chronic health care homes and state agencies to exchange information related to quality improvement and best practices;
- (iv) enrollment of state medical assistance recipients with chronic health problems in chronic health care home programs; and
- (v) costs associated with implementing a successful demonstration program to test whether chronic health care homes can improve health care quality and patient outcomes, and reduce costs associated with chronic health problems.

The Joint Commission on Health Care shall complete its meetings for the *first year* by November 30, 2010, and for the *second year* by November 30, 2011.

Chronic Disease Statistics

- Chronic diseases are a leading cause of adult disability and death in the US.
  - Account for 70% of all deaths in the U.S. (approximately 1.7 million each year). http://www.cdc.gov/nccdphp/
- More than 70 million (4 out of 5 of those 50 and older) have at least one chronic illness; 11 million have more than one.
  - By 2020, the number of Americans with one or more chronic disease is expected to be 157 million, and 81 million will have multiple chronic conditions. (Robert L. Mollica and Jennifer Gillespie. "Care Coordination for People with Chronic Conditions," Partnership for Solutions, Johns Hopkins University. January 2003.)

Costs of Chronic Disease

- Expenses for chronic diseases are typically driven by the reoccurrence of acute events, such as emergency room visits, hospitalizations, or costly inpatient and outpatient treatment plans.
- The medical care costs for people with chronic diseases account for more than 75% of the nation's $2 trillion in medical care costs. By 2020, that is expected to rise to 80% of overall health spending.
  www.cdc.gov/nccdphp/overview.htm
- People with chronic conditions account for 88% of all prescriptions filled, 72% of all physician visits, and 76% of all inpatient stays.
- In the U.S., the Centers for Disease Control (CDC) reports the direct and indirect costs annually of:
  - Heart disease and stroke to be approximately $448 billion,
  - Smoking estimated to exceed $193 billion, and
  - Diabetes to be approximately $174 billion.

Costs of Chronic Disease in Virginia

- The Virginia Department of Health's 2006 report on chronic disease indicated approximately 2.2 million Virginians are living with a chronic disease at an estimated cost of $24.6 billion in health care.

Source: Virginia Department of Health, Division of Chronic Disease, Prevention and Control, "Chronic Disease in Virginia: A Comprehensive Data Report" (2006 addition).

Fragmentation

- People with multiple chronic conditions typically receive health and home care services from different systems, often from multiple providers within each system. As a result, the health care delivery system for those with chronic conditions is complex and confusing, and care is often fragmented, less effective and more costly.
- People who receive care from numerous providers often lack the ability to monitor, coordinate or carry out their own treatment plans.
  - Often have multiple health care providers (HCPs), treatment plans and prescriptions written by different physicians who may be unaware of the other providers treating the individual; resulting in unnecessary ER and hospital admissions.
  - About 25% of those with chronic conditions face limitations with activities of daily living such as walking, dressing and bathing.

Source: Robert L. Mollica and Jennifer Gillespie. "Care Coordination for People with Chronic Conditions," Partnership for Solutions, Johns Hopkins University. January 2003.

Fragmentation

- "Physician groups, hospitals, and other health care organizations operate as silos, often providing care without the benefit of complete information about the patient's conditions, medical history, services provided in other settings, or medications prescribed by other clinicians." Ernest Clevenger, "How Primary Care, America's Best-Kept Secret, Can Reduce Health Care Costs for Self-Funded Employers" HealthWatch, September 2008.
- A new study from the Center for Studying Health System Change revealed:
  - "widespread acknowledgement that most provider payment methods don't encourage efficient or effective delivery of chronic disease care."
  - And, "optimal care for people with chronic disease involves coordinated, continuous treatment by a multidisciplinary team."

Prevention of Chronic Disease

- There is a growing body of evidence that earlier identification of chronic diseases coupled with preventive care can halt or slow the progression of chronic diseases, thereby improving patient health and well-being while reducing medical costs. (www.aha.org)
- Chronic diseases are the most prevalent, most costly and most preventable of illnesses.
  - Prevention includes interventions such as risk screenings, vaccinations, education on behavior, primary care, disease detection, monitoring and treatment.
    - These activities can significantly reduce disease, disability and death. (www.aha.org)
  - Transforming the system from one that reacts when a person is sick, to one that is proactive and focused on keeping a person as healthy as possible. (www.improvingchroniccare.org)

Primary Care Systems

- Evidence suggests that strong primary care systems lead to better health outcomes at lower cost. However, the US health system is facing a crisis in primary care.
  - An estimated 65 million Americans live in officially designated primary care shortage areas.
  - The US spends more on specialist care and has more specialists per capita than any other leading industrialized country.
  - The number of medical students entering adult primary care careers in general internal medicine and family medicine is steadily declining.

Primary Care Systems

- 27% of adults in the US can easily contact their primary care physicians by telephone, obtain care or advice after hours, and schedule timely office visits.
- 50% of patients do not understand what their primary care physicians told them because their office visits are too short
- The primary care system has been characterized as suffering from a fee-for-service reimbursement mechanism that rewards quantity over quality, declining numbers of providers, high and rising per-capita costs, and compromised quality.

Patient Centered Medical Home

- A number of experts believe that many of the problems identified with the US health system can be solved using the model of a health care home.
- A health care home, or patient centered medical home (PCMH), is an approach in which primary care providers, families and patients work in partnership to improve health outcomes and quality of life for individuals with chronic health conditions and disabilities.
- A major goal of PCMHs is to reduce costs by avoiding duplicate or unnecessary testing and services and result in better quality care at a more affordable cost.

Components of the Patient Centered Medical Home

- Team-based model of care led by personal physician who provides continuous and coordinated care throughout a patient's lifetime to maximize health outcomes.
- Components include:
  - Each patient receives care from personal physician who leads team of providers who are responsible for planning ongoing care;
  - personal physician responsible for "whole person";
  - patient care coordinated across health system and community;
  - enhanced access to care offered through open scheduling, expanded hours, and new care options such as group visits;
  - payment structure recognizes enhanced value provided to patients.

Patient Centered Medical Home

- Typically providers who adopt the medical home model receive additional compensation to reflect the change in the delivery of health care services. Some:
  - Receive fee-for-service payments for all services they provide plus additional payments to provide care coordination.
  - Receive additional payments for managing patient care and for meeting or exceeding such quality and performance standards by:
    - implementing electronic health records,
    - e-prescribing,
    - coordinating medication management with pharmacists,
    - tracking test and referrals,
    - providing telephone access after business hours, and the percentage of children who receive well-child visits.

Joint Principles

- In 2007, the American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, and the American Osteopathic Association came together to identify a set of joint principles for PCMHs at the request of health care purchasers.
- These principles emphasize:
  - Access to a personal physician who directs a medical team responsible for the patient's care.
  - Patient care that has a whole-person orientation, is coordinated across the health care system, and is focused on quality and safety, as well as enhanced access to care.
  - Payment should recognize the added value that physicians and other care providers add.

NCQA Standards

- Standards developed by the National Committee for Quality Assurance (NCQA) are most often used to identify which primary care practices have achieved designation as a medical home.
- The standards allow for recognition as a PCMH at 3 different levels and include 30 elements, of which 10 are considered mandatory or "must pass."
- Practices that achieve NCQA's PCMH Recognition are positioned to take advantage of financial incentives offered by health plans and employers, as well as of federal and state-sponsored pilot programs.
- NCQA is currently updating its standards and expects to publish new guidelines in January 2011.

PCMH Programs

- As of March, 2010 NCQA had reviewed and recognized approximately 450 practices in 24 states and the District of Columbia as medical homes.
- Studies have demonstrated that PCMHs improve access and reduce unnecessary medical costs. For example,
  - Pennsylvania's Geisinger Health System, medical home patients had a 14% reduction in hospital admissions; they also identified a trend toward a 9% reduction in medical costs after 2 years.
  - Group Health Cooperative of Puget sound experienced a 29% reduction in ER visits and an 11% reduction in ambulatory sensitive care admissions
  - The Genesee Health Plan HealthWorks model in Michigan reduced ER visits by 50% and inpatient hospitalizations by 15%.

Federal Health Reform

- The Patient Protection and Affordable Care Act (PPACA) creates the Center for Medicare and Medicaid Innovation within CMS. The Center, to be in place January 1, 2011:
  - Will test innovated payment and service delivery models to reduce the rate of growth of Medicare and Medicaid expenditures.
    - Among the models to be tested under the law are those that promote "broad payment and practice reform in primary care, including PCMH models for high need individuals, medical homes that address women's unique health care needs, and models that transition primary care practices away from fee-for-service based reimbursement and toward comprehensive payment or salary-based payment."
  - Preserve or enhance the quality of care.

Federal Health Reform

- The Department of Health and Human Services (HHS) has the authority to expand the use of PCMHs within Medicare or Medicaid if has been shown that these models reduce spending or the growth in spending without reducing quality, or can improve patient care without increasing spending.
- Additionally, federal stimulus funding provided under the American Recovery and Reinvestment Act includes incentives to invest in electronic health records (EHRs).
  - Beginning in 2011, hospitals and eligible professionals may be able to receive incentive payments under Medicare and Medicaid if they make "meaningful use" of EHRs.

Demonstration Projects

- PPACA authorizes the Department of Health and Human Services (HHS) to test medical homes.
  - The Department of Veterans Affairs, the nations largest health system, has begun shifting its clinics to the medical home model, with transition expected to be complete by 2015.
  - In June 2010, HHS invited states to apply for participation in the Multi-payer Advanced Primary Care Practice Demonstration (MAPCP), an initiative in which Medicare, Medicaid and private insurers will use the medical home model to assess improvements to the delivery of primary care and lowering health care costs.

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