# Joint Commission on Health Care

## Staff Report: Opportunities for Early Identification and Preventive Care of Chronic Diseases (SJR 325 – 2009)

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## SJ 325 Study Mandate

- SJ 325 directs the JCHC to:
  i. "Examine clinical and other studies concerning the manner in which early identification and preventive care can be utilized to halt or slow the evolution of such conditions as diabetes, hypertension, kidney disease, obesity, and pneumonia into chronic and terminal conditions;
  ii. assess the means by which Virginia can address fragmentation of services across the health delivery system and the patient's community in order to enhance early identification and preventive care and care management for chronic disease, and to identify opportunities for providing more coordinated care management for individuals with multiple chronic diseases; and,
  iii. estimate the fiscal impact on the Commonwealth and private payers from such strategies."

## Chronic Disease

- Refers to a persistent and long-lasting medical condition that does not resolve on its own and requires ongoing care.
- Is rarely curable, but related complications can be managed to improve health.
- Has many preventable risk factors.
- Examples include: heart disease, diabetes, asthma, chronic obstructive pulmonary disease (COPD), and kidney disease.



## 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. Virginia-specific chronic disease data for 2003 revealed:
  - Cardiovascular disease continued to be the leading cause of death for men and women.
    - 93,661 hospital stays; total cost of $2.4 billion.
    - 34.5% of all deaths.
  - Hypertension (high blood pressure) affected 1/4th of adults.
    - Increases risk of stroke, heart attacks, kidney failure and congestive heart failure.
    - Hypertension, including hypertensive renal disease, was the primary cause of death of 473 Virginians.
  - Diabetes was suffered by 7.2% of Virginians, almost twice the prevalence rate of 3.8% in 1995.
    - People with diabetes are 2-4 times more likely to have a heart attack or stroke.
    - An estimated 10% of deaths attributed to cardiovascular disease, had "a contributing diagnosis of diabetes."
    - 11,231 diabetes-related hospitalizations resulted; at a total cost of $165.8 million.
  - Asthma affected 7.2% of adults; the mortality rate has declined from 5.0 per 100,000 in 1995 to 3.8 per 100,000 in 2003.
    - 10,498 hospitalizations; total cost of $93.4 million.

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)
- Many programs concentrate on eliminating the preventable risk factors that lead to chronic disease; many go further and focus on wellness as a precursor to prevention.
  - 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)



## Prevention of Chronic Disease

- 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)
- The CDC reports:
  - Of 50 million adults with high blood pressure, 70% do not have it under control; Uncontrolled hypertension leads to strokes, heart attacks, renal damage, and retinopathy, and is the primary antecedent to heart failure.
  - Hypertension can be controlled through improvements in diet and physical activity, and medication.
  - Regular eye exams and timely treatment could prevent up to 90% of diabetes-related blindness
  - Regular foot examinations and timely treatment could prevent up to 85% of diabetes-related amputations.

## Prevention of Chronic Disease

- Most of the precursors of chronic disease are lifestyle issues which can be altered.
  - The CDC estimates that eliminating 3 risk factors -poor diet, inactivity, and smoking- would reduce 80% of heart disease and stroke and 30% of Type 2 diabetes.
    - 2 of 3 adults are overweight
    - 1 of 4 adults smoke
    - 1 of 3 adults has high blood pressure
    - 1 of 3 has high cholesterol
    - 3 of 4 adults fail to get enough exercise
    - 4 of 5 adults need to improve their diet.



## Addressing Chronic Disease through Care Coordination Approaches

- Disease Management
- Integrated Care Model: Kidney Disease
- Chronic Care Management Models
- Patient Centered Medical Home
- On-Site Medical Clinics
- Wellness Programs

## Disease Management Programs

- Designed to:
  - Coordinate the delivery of care to patients,
  - Improve clinical outcomes, and
  - Reduce costs for participants living with specific chronic conditions that have high prevalence rates and/or expensive treatment costs.
- Used by almost all health insurers, employers and a majority of states to manage chronic diseases.
- Typically involve combinations of enhanced screening, monitoring, self-management and education, and the coordination of care among providers.



## Department of Medical Assistance Services (DMAS) Directed to Implement Disease Management Programs

- DMAS was directed in the 2005 Appropriations Act "to update on its efforts to contract for and implement disease management programs into the Medicaid program."
  - DMAS review found that "Virginia's health data reflects national trends for chronic illness."
  - In FY2005, DMAS spent approximately $825 million on health care expenses related to chronic illnesses.

Report of the Department of Medical Assistance Services, "Disease Management and Virginia's Medicaid Program." HD 90 2005.

## Virginia Medicaid Healthy Returns Disease Management Program (DM Program)

- Implemented January 13, 2006 for Medicaid fee-for-service patients with:
  - asthma,
  - congestive heart failure,
  - coronary artery disease,
  - diabetes, and
  - chronic obstructive pulmonary disease (COPD); added in May 2007.
- Designed to help patients better understand and manage their disease through prevention, education, lifestyle changes, and adherence to prescribed plans of care.
- Addresses participants' primary conditions, as well as any other chronic conditions they may have.



## Healthy Returns DM Program

- Voluntary (opt-in) program.
- Includes all Medicaid and FAMIS enrollees except:
  - Individuals enrolled in Medicaid/FAMIS MCOs
  - Individuals enrolled in Medicare (dual eligibles)
  - Individuals who live in institutional settings such as nursing facilities
  - Individuals who have 3rd party insurance
- Provides outreach and education, initial assessments, counseling, regularly scheduled follow-up assessments, and a 24 hour toll-free nurse call line.
- Monitors clinical health outcome measures and tracks changes in Virginia's Medicaid and FAMIS expenditures.

## Integrated Care Model: Chronic Kidney Disease

- Chronic kidney disease (CKD), a precursor to kidney failure, is a growing epidemic in the US, with almost two-thirds of CKD patients also having diabetes, hypertension or both.
- Cost of caring for patients with CKD is high, and the majority of costs result from hospitalizations that are most frequent and costly in the 6 months prior to initiating dialysis.
- According to the Centers for Medicare and Medicaid Service (CMS), estimated annual health care costs per patient for CKD is $28,000 and for end stage renal disease (ESRD) is $65,000-$85,000.
  - In comparison, annual costs for patients with diabetes is $10,000 per patient and $5,000 per patient for congestive heart failure.
  - CKD is not included in Virginia's Healthy Returns DM Program.



## Current Fragmented System Not Delivering Integrated Care

**Gaps In Preventive Care**

- < 50% vaccinated for pneumonia

**Inadequate Access to Expertise**

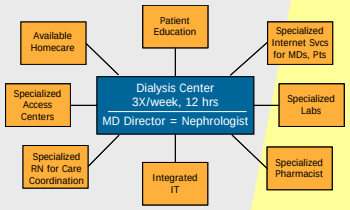
- ~8 meds, 3-5 MDs, but little guidance
- Too many appts; transport issues

**Avoidable Hospital Admits**

- Catheter infection → hospital
- Diet → excess fluid → hospital
- Foot ulcer → amputation

Source: DaVita 2009

# ICM Improves Kidney Patient Care




- **Integrated care plan/coordination of care with case managers, nurses, PCPs, nephrologists, and other specialists**
- **Identification and management of risk factors and co-morbid conditions**
- **Proactive 1:1 health coaching**
- **24/7 access to RN**
- **Customized patient/family education**
- **Medication reviews and management by trained pharmacists**
- **Diet consultation and nutritional supplements**
- **Arranged transportation**
- **Social work counseling**
- **Hospital discharge support**
- **Online info & community**

Source: DaVita 2009



# CMS Has Recognized the Integrated Care Model's Potential for Savings

Two CMS Demonstration Examples

- *DVA ESRD Demo* (CA)→ 400 enrolled, saves 6.5%, beats quality targets[1]
- *DVA CKD Demo* → 1,600 enrolled, reducing hospitalizations ~8%[1]

1 Source: DaVita analysis of claims costs vs. benchmark/control; not validated by CMS

## Chronic Care Management Models

- More comprehensive, community-based approach to address needs of patients with chronic disease.
- Focuses on needs of the whole person, rather than only the disease.
- Uses all community resources to address needs of patient.
  - Attention to the hierarchy of needs
  - Many persons with chronic conditions have other problems that prevent them from getting the help they need:
    - poverty, transportation, mental illness, child care, housing, etc.



## Components of Chronic Care Model

- Community:
  - form partnerships with community organizations to develop interventions that fill any gaps in services; avoid duplication of effort.
- Health system:
  - encourage open and systemic handling of errors/quality to improve care; provide incentives based on quality of care; and develop agreements that facilitate care coordination within and across organizations.
- Self-management support:
  - emphasize patient role in managing own health; use effective self-management support; include health literacy and cultural sensitivity.

## Chronic Care Model

- Decision support:
  - use evidence-based guidelines and share information with patients to encourage their participation; ongoing training for staff on latest clinical evidence; use of new models of provider education that improve upon traditional continuing medical education; and integration of specialty and primary care when more complex cases are presented.
- Clinical information system:
  - organize patient and population data to help ensure efficient care: timely reminders for services with summarized data to help track and plan patient care; at the population level, identify groups of patients needing additional care and facilitate performance monitoring and quality improvement efforts.



## Chronic Care Model

- Chronic Care illness collaboratives:
  - Use this model
  - RAND evaluated these collaboratives
    - Patients with diabetes had significant decreases to their risk of cardiovascular disease
    - Chronic heart failure pilot patients were more knowledgeable, relied more often on recommended therapy, and had 35% fewer hospital days than patients not involved
    - Asthma and diabetes pilot patients were more likely to receive appropriate therapy than were other patients.

## Chronic Care Model in Virginia

- As mandated by Health Resources and Services Administration (HRSA), Virginia's community health centers have been phasing the Chronic Care Model into their care practices.
- In 2007, the Virginia Association of Free Clinics received a grant from the Department of Health to identify risk factors among clinic patients and adopt best practices for prevention of chronic illnesses.
- The Medical Society of Virginia Foundation implemented "To Goal" and is supporting 94 family physicians in Southwest Virginia in implementing a chronic care management program.

Source: "Chronic Care Management, Summary of Research and Key Findings," Virginia Health Care Foundation, December 8, 2008.



## DMAS Issued Request-for-Proposals (RFPs) for a Care Management Program

- Released RFP in July 2008.
- Designed to focus on Medicaid and FAMIS fee-for-service recipients at highest risk for high utilization of services and cost of services.
- Withdrew RFP because too expensive and CMS would not approve certain elements.

## Patient Centered Medical Home (PCMH)

- Supported by American Academy of Pediatrics, American Academy of Family Physicians, American College of Physicians, American Osteopathic Association, Patient Centered Primary Care Collaborative.
- These groups and National Committee for Quality Assurance developed recognition process to ensure that qualifying practice meets PCMH model.
- 50 national demonstration projects.



## 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.
  - Are rewarded for managing patient care and for meeting or exceeding quality and performance standards, such as:
    - 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.



## Patient Centered Medical Home

- Congress passed Medicare Medical Home Demonstration Project in 2006.
  - Coordinated by American Medical Association, is 3-year demonstration project that will focus on rural, urban, and underserved areas in up to 8 states.
  - Will provide participating internists with care coordination fee for managing care of patients with multiple chronic conditions and allow physicians to share in cost savings, such as from reduced hospitalizations, that result from effective physician-directed care management.

## On-Site Medical Clinics

- Some employers are adding on-site medical clinics in an effort to save on health care costs and encourage employee wellness.
  - The greatest amount of avoidable health care spending comes from employees with chronic conditions.
    - 87.5% of health care claim costs are due to an individual's lifestyle, such as smoking and obesity.
- Clinics encourage and provide health risk assessments and preventive care, allow the medical provider to spend time with each patient to explain health improvement and wellness activities.



## Cost savings of On-Site Medical Clinics

- Reduce medical benefit costs
  - Exchange retail for wholesale on physician services, prescription drugs, and laboratory tests
- Increase productivity
  - Scheduled 20-minute appointment times that reduce time away from work
- Improve employee health
  - Encourage relationship with physician through free health care visits; it has been reported that it is this relationship that drives compliance and behavior change
  - Provide health care coaching, 24 hour nurse line,

## Wellness Programs

- Growing trend in private sector is to mandate health testing and wellness programs in order to improve employee health.
  - Well over half of big companies have launched such initiatives
  - One example is AmeriGas, based in Valley Forge, PA
    - Faced health expenses increases of 10% per year.
    - Self-insured health plan
    - Paid more than 2 dozen insurance claims in previous year for amounts greater than $100,000
    - Workers had high rates of diabetes and heart disease
    - People were not getting their required tests so decided to mandate.
    - Under the mandated wellness plan:
      - Checkups free
      - Plan doesn't charge for generic drugs for diabetes, blood pressure, asthma and cholesterol; Copayments reduced for brand-name medications for those conditions.
  - Since implementation, 90% have gotten required exams; use of needed drugs rose.
  - Anecdotal evidence of improved health
  - Health care costs were at least 3% higher in the first year given increased utilization.

Anna Wilde Mathews, "When All Else Fails: Forcing Workers into Healthy Habits," The Wall Street Journal. July 8, 2009.



## Virginia's Focus on Wellness

- Age-appropriate health screenings are provided at no cost to the employee under the State Employee Health Plan.
- COVA Connect was implemented in July 2009.
  - Pilot program for State employees in Hampton Roads area.
  - Administered by Optima Health.
  - Focus on wellness and preventive care to reduce on chronic conditions and control health costs.
  - Focus on convenience to encourage lifestyle change.
  - Provide health coaches, and personalized diet and exercise programs.
  - 2 year contract will cost the State $5 million in administrative costs and cover 17,000 State employees
  - Optima projects it has already saved 17% by identifying those at high risk for developing chronic diseases and enrolling them in health management programs.

## Policy Options

- Option 1: Take no action.
- Option 2: By letter of the Chairman, request that DMAS report to JCHC no later than August 2010, regarding recommended options for addressing the chronic care needs of Virginia's Medicaid and FAMIS enrollees. The options should consider at a minimum issues related to:
  - whether to retain a disease management program (perhaps incorporating additional diseases and an integrated care model for Chronic Kidney Disease),
  - whether to reissue a proposal for chronic care management services, and
  - whether to initiate one or more demonstration projects for a patient-centered medical home.



## Policy Options

- Option 3: By letter of the Chairman, request that the Department of Human Resource Management report to JCHC regarding the feasibility and advisability of initiating a pilot program with on-site medical clinics for state employees.
- Option 4: By letter of the Chairman, request that the Department of Human Resource Management report to JCHC regarding the costs and benefits of the recently implemented COVA Connect pilot program.

## Public Comments

- Written public comments on the proposed options may be submitted to JCHC by close of business on September 29, 2009.
- Comments may be submitted via:
  - E-mail: sreid@jchc.virginia.gov
  - Fax: 804-786-5538
  - Mail: Joint Commission on Health Care
    P.O. Box 1322
    Richmond, Virginia 23218
- Comments will be summarized and presented to JCHC during its October 7th meeting.



## Internet Address

Visit the Joint Commission on Health Care website:
http://jchc.state.va.us

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