

# Pursuing Change in Caring for Patients with Chronic Illness

The Report of the Minnesota Medical Association's  
Chronic Care Task Force



January 2005

## Acknowledgments

The Minnesota Medical Association wishes to thank the members of the Chronic Care Task Force for their commitment of time and expertise. Although this report accurately reflects the discussions and recommendations of the task force, it is a product of the Minnesota Medical Association and, as such, may not represent the views of all task force members.

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## Introduction

The Minnesota Medical Association (MMA) House of Delegates adopted a resolution that called on the MMA to “study and respond to the issue of inadequate reimbursement of outpatient care for individuals with complex medical illnesses.” In response, the MMA Medical Practice and Planning Committee recommended that the MMA “authorize the establishment of a planning task force to explore the development of new models for the delivery of and payment for care to chronically ill individuals.” The MMA Board of Trustees created the Chronic Care Task Force in July 2002. This report represents the findings and final recommendations of the task force.

The mission of the task force was to highlight the problems inherent in the current health care delivery system in paying for and managing chronic and complex illnesses and to facilitate an exploration of alternative delivery models. To guide its work, the task force adopted a set of working principles, which are as follows:

- The health care system in Minnesota, and throughout the United States, emphasizes acute care at the expense of adequately and appropriately addressing the needs of patients who require care for chronic medical problems.
- Health care resources are limited and should be used as efficiently as possible.
- Provision of care for chronic illnesses is as important as the provision of acute, episodic care.
- Gaps and disparities in current chronic care provision and reimbursement should be eliminated.
- Access to chronic care services should be assured and barriers to appropriate care should be eliminated.
- Changes in the financing and payment systems that improve the provision of chronic care and thus lower overall health care costs should be pursued.
- Payments for chronic care should be based on sound financial principles that take into consideration the finances available for both short- and long-term care.
- New chronic care delivery models should be evidence-based whenever possible.
- New chronic care delivery models should be innovative, integrated, and coordinated.
- Chronic care should emphasize patient self-direction and self-management to the greatest extent possible.
- The problems in the financing of chronic care should be addressed in Minnesota and at the federal level.
- Many organizations will need to work together to overcome problems in the provision of, and reimbursement for, chronic care.
- Optimal chronic care models need to involve a variety of other health care professionals as well as physicians.

## Chronic Illness and Chronic Care: Current Challenges

A chronic illness generally is defined to mean a health condition that requires ongoing care for more than one year and may limit a person’s activities. It is estimated that nearly half of all Americans have one or more chronic illnesses, and providing care to these individuals accounts for 78 percent of all health care spending.<sup>1</sup>

Despite the prevalence and the financial impact of chronic illnesses, the task force unanimously agreed that the current health care system is designed for and rewards acute care over chronic, complex care. Much of this is historical. Only recently has the health care system begun to manage chronic medical problems effectively over many years, yet neither the dominant practice models nor the primary payment systems have caught up. Even the education and research efforts still focus more on acute than on chronic care. However, as noted above, the bulk of health care spending is devoted to the treatment of chronic disease, whether maintenance treatment or treatment of acute exacerbations, instead of truly acute care. New technological advances, together with an expected rise in the number of people living with chronic illness (from the current 125 million to more than 155 million by 2020), help to explain the expected increases in spending attributable to chronic disease care that is expected over the next few years.<sup>2</sup> These facts should provide the necessary incentives to change the way we practice, teach, do research, and pay for chronic care.

The task force agreed that current payment and financial incentives in the system provide real barriers to improving care for the chronically ill. There are few, if any, incentives for physicians to reduce costs and improve care. In a fee-for-service system, physicians are “rewarded” the sicker the patient is, because there is an incentive for increasing the volume of services delivered. In a managed care or capitated setting, physicians can be “penalized” for spending too much time with a patient and there are perverse incentives that generate dollars for physicians and other providers if less (not necessarily better) care is provided. Although capitated arrangements were once envisioned as a remedy, adverse selection, imprecise risk adjustment mechanisms, and patients’ unwillingness to have limited access led to its demise.

Effective care for chronic and complex medical problems must be delivered differently than care for acute problems. Taking care of a patient with diabetes is very different than taking care of a patient with acute appendicitis. The task force agreed that, in the future, more of the care of chronic and complex problems will be done by patients, families, and non-physician health care providers; this is in contrast to the care of acute problems. Team care, with the physician as team leader, needs to replace the notion of the physician as the primary provider of care. Good team care can not be created if payers only pay for face-to-face patient visits with a physician or mid-level provider. Changes in payment systems are necessary so that good care is paid for appropriately. For example, non-visit care needs to be paid for, patient and family education needs to be paid for, and physicians shouldn’t be paid substantially more for seeing four people for ten minutes each, than for seeing one complex patient for forty minutes.

Medical schools and residencies also will need to modify curricula and schedules to make trainees more familiar with managing patients with chronic, complex problems, empha-

sizing team care in an outpatient setting. Clinical research will have to become less reductionist and focus on what leads to the best outcomes in people with more than one chronic health care problem.

## Chronic Care Strategies

### Disease Management

Among the most popular means of improving care and outcomes for patients with chronic illness is the application of disease management programs. The Disease Management Association of America (DMAA), a non-profit, voluntary membership organization, defines disease management as “a system of coordinated health care interventions and communications for populations with conditions in which patient self-care efforts are significant.” A report by the American Medical Association (AMA) describes the disease management process as follows:

“Various means, such as claims and pharmacy data reviews and patient questionnaires, are used to identify the chronically ill population. Computer programs sort through the plethora of personal and medical information that purchasers of DM [disease management] services store about their members’ age, prescription drug use, gender, family history, test results, and other medical information. Predictive modeling--the latest analytical tool of the DM industry--uses this information and technology to identify patients with chronic diseases as well as those at risk for developing chronic diseases.”<sup>3</sup>

Both nationally and in Minnesota, the recent trend is the implementation of disease and case management by outside vendors with whom payers contract, rather than implementation by the medical practices providing care to patients with complex and chronic problems.<sup>4</sup> The vendors have limited clinical information about the patients, certainly do not have the benefit of a full physician-patient relationship, and too often fail to engage sufficiently the patients’ primary medical team. Such attempts at disease and case management tend to confuse patients and alienate physicians, especially in those circumstances where patients receive conflicting recommendations or information not relevant to their conditions. The task force believes that the locus for case and disease management should be where the patient receives the majority of his/her care. This should be achieved easily in larger practices, but smaller practices may need to explore cooperative opportunities to hire the nurses and other professionals needed for case and disease management.

### Integration and Coordination of Care & Financing

Another approach to chronic care delivery that has its roots in Minnesota is care and financing integration and coordination. The Minnesota Medicaid program, Medical Assistance (M.A.), has been operating two such projects under federal waivers since 1997. The Minnesota Senior Health Options (MSHO) project and the Disability Health Options (MnDHO) project integrate primary and acute Medicare and Medicaid benefits, long-term care benefits, and service delivery. It

is a voluntary enrollment program and currently has about 5,300 enrollees in 10 Minnesota counties.<sup>5</sup> The health plans involved with the MSHO project are Medica, Metropolitan Health Plan and UCare Minnesota. UCare Minnesota is the only health plan currently involved with MnDHO.

The goals of the projects are to: 1) align fiscal incentives to support sound clinical practices and reduce cost shifting between acute and long term care providers and Medicare and Medicaid; 2) reorganize service delivery systems to reduce administrative duplication and provide a seamless point of access for enrollees; and, 3) create a single point of accountability for tracking total costs and outcomes of care across a full range of acute and long term care services.

Officials with the Medical Assistance program believe that the use of care coordinators is the key to the program’s success. Each MSHO member is assigned a care coordinator and the level of the coordinator’s involvement is based on frailty and patient preference. Care coordination services are not available routinely in traditional fee-for-service or in Medicaid or Medicare managed care (i.e., PMAP or Medicare+Choice).<sup>6</sup>

Results, to date, suggest that MSHO provides quicker access to home and community-based services than is available under fee-for-service, hospitalizations have been reduced, and there are shorter nursing facility stays. Additionally, there appears to be low disenrollment and high satisfaction among enrollees, providers, and plans. Challenges do exist, however, including difficulty quantifying clinical success; low enrollment across a broad network and, therefore, low physician awareness (lack of “critical mass”); and, limitations of risk adjustment.<sup>7</sup>

### Chronic Care Model

The other primary strategy to improve treatment for patients with chronic illness that the task force examined was the Chronic Care Model, which was developed by Ed Wagner, M.D. The Chronic Care Model involves the formation of collaboratives to bring together a provider “team” to develop protocols and systems that will result in optimal information-sharing and adherence to treatment standards in a particular care setting.<sup>8</sup>

The model consists of the following six components: community, health system, self-management support, delivery system design, decision support, and clinical information systems.<sup>9</sup>

#### 1. The Community – Resources and Policies: Mobilize Community Resources to Meet Needs of Patients

- Encourage patients to participate in effective community programs
- Form partnerships with community organizations to support and develop interventions that fill gaps in needed services
- Advocate for policies to improve patient care

**2. Health System – Organization of Health Care:** Create a culture, organization and mechanisms that promote safe, high quality care

- Visibly support improvement at all levels of the organization, beginning with the senior leader
- Promote effective improvement strategies aimed at comprehensive system change
- Encourage open and systematic handling of errors and quality problems to improve care
- Provide incentives based on quality of care
- Develop agreements that facilitate care coordination within and across organizations

**3. Self-Management Support:** Empower and prepare patients to manage their health and health care

- Emphasize the patient's central role in managing their health
- Use effective self-management support strategies that include assessment, goal-setting, action planning, problem-solving and follow-up
- Organize internal and community resources to provide ongoing self-management support to patients

**4. Delivery System Design:** Assure the delivery of effective, efficient clinical care and self-management support

- Define roles and distribute tasks among team members
- Use planned interactions to support evidence-based care
- Provide clinical case management services for complex patients
- Ensure regular follow-up by the care team
- Give care that patients understand and that fits with their cultural background

**5. Decision Support:** Promote clinical care that is consistent with scientific evidence and patient preferences.

- Embed evidence-based guidelines into daily clinical practice
- Share evidence-based guidelines and information with patients to encourage their participation
- Use proven provider education methods
- Integrate specialist expertise and primary care

**6. Clinical Information Systems:** Organize patient and population data to facilitate efficient and effective care

- Provide timely reminders for providers and patients
- Identify relevant subpopulations for proactive care
- Facilitate individual patient care planning
- Share information with patients and providers to coordinate care
- Monitor performance of practice team and care system

## Recommendations

Our current non-system for care of patients with chronic and complex illnesses costs both dollars and lives. It is these patients that are most vulnerable to medical errors because they

are often on several medications and are subjected to frequent procedures. The task force believes that to be effective, the care and payment systems, in particular, must change. The system needs to shift away from episodic-based models and truly transform how patients that consume the bulk of the health care dollars are served. Adding new billing codes alone will not solve the problems that are entrenched in the system. Improved care and payment for patients with chronic conditions, however, can reap significant benefits for both patients and the health care system.

The following recommendations, divided into four sections—practice, public and private sector advocacy, education, and research—were approved by the MMA Board of Trustees:

### Practice

- The MMA should explore the feasibility of creating a consortium of medical practices willing to provide disease management (paid for by health plans or employers) to patients with chronic, complex illnesses.
- The MMA should conduct a campaign to generate physician and payer enthusiasm for better chronic care delivery.
- The MMA should work to ensure that every patient with a chronic or complex illness has a medical home where much of that patient's care is provided and from which other care is arranged and coordinated. For patients with chronic conditions, the medical home generally will be a primary care practice, although there are certain conditions where a specialty practice may be better suited to provide the medical home.
- The MMA should endorse evidence-based guidelines (those developed by ICSI and others) that pertain to chronic illness.

### Public & Private Sector Advocacy

- The MMA should submit a request to the AMA CPT Editorial Panel for the development of CPT codes for group visit, inter-visit (including consultant codes), and other adaptive codes to support chronic care delivery models.
- The MMA should work with Minnesota public and private payers to obtain payment for non-visit care, such as telephone consultation and online E&M services (e.g., CPT code, 0074T).<sup>10</sup>
- The MMA should encourage the AMA to lobby Congress and the Centers for Medicare and Medicaid Services (CMS) to allow payment for the broader array of services that are critical to ideal chronic care delivery. Advocacy is vital to expand Medicare coverage from payment for individual face-to-face services, to payment for effective chronic care delivery such as group, internet, and inter-visit services.

- The MMA should encourage Minnesota public and private payers to increase payment for clinical systems that utilize the Chronic Care Model.
- The MMA should work with Minnesota health plans/payers and employers/purchasers to encourage changes in the way in which disease management is conducted by exploring opportunities to pay physician practices directly for disease management services.
- The MMA should work with Minnesota public and private payers to obtain payment for specialized services delivered to patients with qualifying conditions that are provided by non-physician professionals (e.g., pharmacists, social workers) who are actively linked with physicians in co-managing patients' care.
- The MMA should explore opportunities to support the expansion of the electronic transfer of information across sites of care, including the use of public and private capital investments to stimulate the adoption of electronic medical record systems.
- The MMA should explore ways to improve communication between the providers of community-based services and the primary medical care team. (Note – this item is most immediately applicable to Medicaid and Elderly Waiver beneficiaries participating in the new statewide Minnesota Senior Health Options program and the new Minnesota Senior Care program [integrating PMAP and Elderly Waiver] in which health plans and care systems have extensive covered benefits and special flexibility in clinical delivery.)
- The MMA should seek opportunities to work with the Department of Human Services to conduct pilot projects of case and disease management (consistent with these recommendations) for public program enrollees with complex, chronic illnesses.

## Education

- The MMA should develop or sponsor opportunities for Minnesota physicians to learn how to improve knowledge of and skills in team management of chronic conditions and the working relationships among team members.
- The MMA should provide information to Minnesota physicians about local and state community resources that are available to assist patients with chronic conditions. This information should be community-specific.
- The MMA should develop or sponsor opportunities for Minnesota physicians to learn how to improve physician practices' ability to teach patients self-management skills.
- The MMA should develop or sponsor opportunities for

Minnesota physicians and patients to learn how patients and physicians can set priorities and focus resources for patients with chronic conditions.

- The MMA should encourage Minnesota medical schools and teaching programs to improve curricula on and give students and trainees increased opportunities for delivery of care to patients with chronic, complex illnesses.
- The MMA should help physicians increase their awareness of opportunities for grants or demonstration projects in treating patients with chronic conditions.

## Research

- To help overcome the lack of evidence regarding treatment for the “old-old” and for patients with multiple chronic conditions, the MMA should encourage research that will identify a stronger evidence base for the treatment of chronic conditions among those over 75 and those with several chronic conditions.
- The MMA should encourage public and private payers to coordinate data collection and pursue research that improves the quality of data available to those wishing to use clinical care data to determine best practices in patients with chronic and complex illnesses.

- 1 U.S. Centers for Disease Control and Prevention (CDC), *The Burden of Chronic Diseases and Their Risk Factors*, February 2002. And *The Council of State Governments, State Official's Guide to Chronic Illness*, 2003.
- 2 *The Council of State Governments, State Official's Guide to Chronic Illness*, 2003.
- 3 American Medical Association, *Private Sector Advocacy. Disease Management and Chronic Diseases*. November 2002.
- 4 The task force did hear a presentation from Victoria Champeau, R.N., Minnesota Healthcare Network (MHN), in which she described promising efforts by MHN (a financial management entity for 450 independent primary care physicians) to introduce disease management in its member-clinics.
- 5 There are about 5,100 enrollees in MSHO, which is for seniors over age 65; and about 240 enrollees in MnDHO, which is for individuals with physical disabilities between 18-64 years of age.
- 6 Task force members noted the important distinction between case management (used to ensure that people with serious and persistent health conditions receive needed medical services in a timely fashion), and care coordination (used to keep patients at home and healthy by coordinating social support and medical services across different entities). *The Council of State Governments, State Official's Guide to Chronic Illness*, 2003.
- 7 Source for MSHO and MnDHO information – presentation by Pam Parker, Minnesota Department of Human Services, October 22, 2003 task force meeting.
- 8 *The Council of State Governments, State Official's Guide to Chronic Illness*, 2003.
- 9 Wagner EH. *Chronic disease management: What will it take to improve care for chronic illness? Effective Clinical Practice*. 1998;1:2-4. (Improving Chronic Illness Care (ICIC) is a national program supported by The Robert Wood Johnson Foundation with direction and technical assistance provided by Group Health Cooperative's McColl Institute for Healthcare Innovation).
- 10 Note that this is a Category III CPT Code: 0074T- Online evaluation & management service, per encounter, provided by a physician, using the Internet or similar electronic communications network, in response to a patient's request, established patient.

**Online Medical Evaluation**

An online medical evaluation is a type of Evaluation and Management (E/M) service provided by a physician or qualified health care professional, to a patient using Internet resources, in response to the patient's online inquiry. Reportable services involve the physician's personal timely response to the patient's inquiry and must involve permanent storage (electronic or hard copy) of the encounter. This service should not be reported for patient contacts (egg, telephone calls) considered to be pre-service or post-service work for other E&M or non E&M services. A reportable service would encompass the sum of communication (e.g., related telephone calls, prescription provision, laboratory orders) pertaining to the online patient encounter or problem(s).