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AMGA CHRONIC CARE MODEL
A SYSTEM OF COORDINATED CARE FOR PATIENTS
WITH CHRONIC CONDITIONS
2008 ISSUE BRIEF

Absent in the Medicare program, and indeed in most “pay for performance” programs, are incentives for coordinated care. This lack of care coordination has negative ramifications. According to recent study, patients who reported seeing 4 or more physicians were three times as likely to report at least one type of adverse event (e.g., medicine, medication, or lab). Additionally, only 41 percent of U.S. patients who were taking more than 4 medications had a physician review their medication use during the past year, putting them at risk for adverse reactions. Not surprisingly, these complications increase the likelihood of hospital re-admissions, and additional office visits, and procedures. Further, lack of coordination among providers can lead to costly inefficiencies such as duplicative testing, and unnecessary or inappropriate treatment.

The American Medical Group Association (AMGA) supports a Chronic Care Model (Model) that provides the components for effective care coordination. AMGA calls on Congress and CMS to provide the financial incentives necessary to reward providers that coordinate effective care for patients with multiple chronic conditions.

The Model would encourage care coordination across practice settings and disease conditions. Importantly, the Model would focus on patient-centered care that includes: proactive monitoring of health status; reinforcement of self-care behaviors; early detection of problems and intervention; and coordination of and collaboration among health care disciplines. Treating the “whole” patient is most successful when supported by innovative technologies including electronic medical records, patient registries, and home monitoring or telephonic devices that allow the sharing of patient specific information when and where it is needed.

AMGA believes the Model will provide beneficiaries with the right care, at the right time in the most appropriate setting. Moreover, the Model could produce significant cost savings due to decreased utilization and duplication of services. In a Veterans’ Health Administration clinical demonstration project that targeted high cost/use veterans and utilized care coordinators and home monitoring devices, ER visits were reduced by 40%, hospital admissions were reduced by 63%, and hospital bed days of care (BDOC) were reduced by 60%. Nursing home admissions were reduced by 64% and nursing home BDOC were reduced by 88%. Most importantly, quality of life indicators, as measured by patient survey responses, were significantly improved for participating veterans.¹

¹ Meyer, Kobb, Ryan, Virtually Healthy: Chronic Disease Management in the Home: Disease Management, Volume 5, Number 2, 2002.

The first year results of Medicare's Physician Group Practice demonstration, released in early July, 2007, provided further confirmation of the promise of the Model. For year one, the demonstration focused on patients with diabetes mellitus and implemented performance measures developed from evidence-based guidelines to manage their disease. Through increased communication with patients, a focus on prevention, and services designed to address gaps in care, such as increased use of nursing staff and "health coaches," all of the group practice participants were able to improve the clinical management of diabetes patients and decrease hospitalizations in this patient population. Years two and three of the demonstration will implement performance measures for other chronic diseases such as hypertension and congestive heart failure.

AMGA recommends that Congress and CMS continue to provide incentives to encourage coordinated care in the Medicare program. Specifically, AMGA recommends incentives for providers that meet these performance measures:

- Structural Measures: EMR systems, electronic patient registries, home or telephonic health monitoring devices, professional care coordinator(s), integrated teams of primary and specialty care.
- Process Measures: Periodic monitoring, case management, medication management, written electronic feedback between primary and specialty physicians regarding treatment changes and referrals, multi-specialty treatment plans, patient self-management training.
- Outcomes Measures: Reduced hospitalizations, re-admissions, and BDOC, reduced nursing home admissions, re-admissions and BDOC, reduction in ER visits, patient satisfaction surveys, and savings compared to Medicare FFS baseline.

AMGA's Strategic Objectives

- Create incentives in the Medicare Program for fully coordinating the care of patients with chronic conditions