



**2009 ISSUE BRIEF**  
**CARE COORDINATION**  
**CORE COMPONENT OF THE MEDICAL HOME**

**Background**

The costs for treating chronically ill patients are astronomical. It's been estimated that almost all Medicare dollars and about 80 percent of Medicaid spending is for people with chronic conditions.<sup>1</sup> Of course, as the population ages, further financial stress will be placed on national and state governments.

Patients with chronic illnesses typically see multiple physicians and are prescribed multiple medications. Due largely to the complexity of treating these beneficiaries, health care for patients with chronic illnesses is often fragmented and poorly coordinated across providers and practice settings.

This lack of coordinated care has negative ramifications. According to a recent study, patients who reported seeing four 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 four 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.<sup>2</sup>

**The Medical Home**

The medical home has been suggested by many as an alternative mechanism for coordinating care, especially for the chronically ill. Some of the key principals of the medical home include: Care that is coordinated across all elements of the health care system (e.g., between primary and specialty care physicians and between hospitals, nursing homes, home health agencies, etc). Care that is facilitated by information technology such as registries and health information exchange, with safety ensured through use of evidence-based medicine. Importantly, patients would have a relationship with their personal physicians.<sup>3</sup>

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<sup>1</sup> Page 22 , *Chronic Conditions: Making the Case for Ongoing Care*, Gerard Anderson, Ph.D., Professor, Johns Hopkins Bloomberg School of Public Health, November 2007  
[http://www.fightchronicdisease.com/news/pfcd/documents/ChronicCareChartbook\\_FINAL.pdf](http://www.fightchronicdisease.com/news/pfcd/documents/ChronicCareChartbook_FINAL.pdf)

<sup>2</sup> Cathy Schoen et. al., *Taking the Pulse of Health Care Systems: Experiences of Patients with Health Problems in Six Countries*, (Bethesda, MD: Health Affairs, 2005).

<sup>3</sup> ACP Issue Brief on the Patient-Centered Medical Home



## **Tiered Payments for the Medical Home**

AMGA supports the fundamental principles of the medical home. We recognize that without incentives to coordinate care, there will be little reform to the current fragmented and uncoordinated system of care and even less positive effect on the chronically ill.

However, it may be difficult for many physician practices to serve as a medical home. To reflect varying levels of “medical home” capability and, importantly, to stimulate acquisition, promulgation, and furthering of those capabilities, we believe Congress should offer a tiered approach to incentivizing the medical home. This would allow many physician practices to participate as medical homes; would provide incentives for their growth and evolution in care coordination capabilities and competencies; and would also recognize and reward large medical groups which have already invested in the means and methods of care coordination. This is an approach that would traverse the diverse needs and capabilities of all models of medical care delivery, irrespective of size.

Possible tiers might be these:

1. *Basic Medical Home*: Use of health risk assessment tools. Use of medication reconciliation and adherence monitoring. Employment of electronic scheduling and reminder systems (patient “call back” systems). Evidence-based care guidelines. Patient Registries. Use of patient education materials and resources.
2. *Intermediate Medical Home*: All of the above plus use of individualized care plans. Coordination across and among specialties, home health, social services, inpatient and outpatient services. Electronic or telephonic patient communication.
3. *Advanced Medical Home*: All of the above and use of a care team that includes dedicated care managers to coordinate social services, nutritionists, physical therapy, pharmacists, etc. Plus use of a fully integrated electronic infrastructure that allows sharing of patient specific information across all care settings, based on a “need to know”. Appropriate home health monitoring with information flow back to care team. Demonstrated reduction in hospitalizations, readmissions, emergency room visits, nursing home admissions. Incorporating use of clinical decision support tools.

## **Conclusion**

Federal health care programs should take the lead in advancing good public policy by offering a system of tiered incentives to stimulate adoption of the infrastructure and mechanisms of the medical home. This would enable its chief delivery advantage, the true coordination of patients’ medical care. This policy objective could be advanced through provision of a tiered reimbursement system that would compensate practices for varying levels of procedural and structural accomplishments. Those with limited capabilities would be paid accordingly and those with advanced structures and processes in place would be paid more. *A staged approach would stimulate both entry into the realm of care coordination and evolution to more advanced levels.*



## Care Coordination Hierarchy Based on Patient Complexity

<i>Level of Care Coordination</i>	<i>Intensity of Patient Need</i>	<i>Priority Concerns Addressed</i>
<p><i>Basic Care Coordination - Components Include:</i></p> <ul style="list-style-type: none"> <li>▪ Health Risk Assessment tools</li> <li>▪ Medication reconciliation and adherence monitoring</li> <li>▪ Electronic scheduling and reminder systems</li> <li>▪ Evidence-based care guidelines</li> <li>▪ Patient registries</li> <li>▪ Patient education materials and resources</li> </ul>	<p>At low risk for decline in the presence of stable chronic disease. Generally “normal” functional abilities</p>	<ol style="list-style-type: none"> <li>1. Limiting disease progression</li> <li>2. Improving longevity</li> <li>3. Preventive services</li> <li>4. Self management and health promotion</li> </ol>
<p><i>Intermediate Care Coordination – Components Include all of the above plus:</i></p> <ul style="list-style-type: none"> <li>▪ Individualized care plan</li> <li>▪ Coordination across and among specialties, home health, social services, inpatient and outpatient services</li> <li>▪ Electronic or telephonic patient communication</li> </ul>	<p>At risk for decline in the presence of one or more chronic conditions. Relatively stable medical or mental disability. Functional abilities slightly compromised</p>	<ol style="list-style-type: none"> <li>1. Limiting disease progression</li> <li>2. Promoting autonomy</li> <li>3. Accommodating environment</li> <li>4. Preventive services</li> <li>5. Community services and support</li> </ol>
<p><i>Advanced Care Coordination – Components Include all of the above plus:</i></p> <ul style="list-style-type: none"> <li>▪ Care team that includes care managers to coordinate social services, dietitians, physician therapy, pharmacist, etc, assigned to each patient</li> <li>▪ Fully integrated electronic infrastructure (e.g., EMR system) that allows sharing of patient specific information across all care settings (based on “need to know”)</li> <li>▪ Home health monitoring with information flow back to care team</li> <li>▪ Demonstrated reduction in hospitalizations, readmissions, ER visits, nursing home admissions</li> <li>▪ Clinical decision support tools.</li> </ul>	<p>Declining or frail health with multiple medical/social/functional problems. At high risk for hospital admission or emergency care, or recent hospitalization for acute exacerbation of condition</p> <p>Capable of addressing all levels of chronic care and intensity of need. Plus added efficiency of care and accountability.</p>	<ol style="list-style-type: none"> <li>1. Injury prevention</li> <li>2. Close monitoring of health status including depression screening</li> <li>3. Nutritional monitoring or assistance</li> <li>4. Community services and support</li> </ol>