



## Comprehensive Payment to Support Comprehensive Care

By Bruce Nash, MD, MBA, Senior Vice President, Medical Affairs and Chief Medical Officer, Capital District Physicians' Health Plan, Inc.

**O**n a late fall evening in November 2007, the 15-member board of directors for the Capital District Physicians' Health Plan, Inc. (CDPHP®), a not-for-profit, physician-founded and guided health plan based in Albany, N.Y., met with the sole purpose of strategizing a solution to the mounting primary care crisis.

The CDPHP board, comprising eight community physicians and seven business leaders, had much at stake. The primary care physicians on the board were acutely aware of the issues facing their specialty. They also had the strong support of the board's specialists, who knew that their own practices and the care of their patients would be adversely affected should the existing decline in primary care physicians continue.

Discussion ensued, and it was unanimously agreed that significant, timely action was needed to avert a severe shortage of primary care physicians in Upstate New York. Bruce Nash, MD, MBA, the plan's chief medical officer, was tasked with designing and developing an initiative that would essentially "save primary care."

### Major Issues at Hand

The overwhelming consensus was that primary care did not offer sufficient earning potential to attract the attention of graduating medical students. After extensive dialogue within the physician community, it was concluded that if a primary care physician had the potential to earn an extra \$85K, which in the Albany marketplace would place his/her compensation in the \$235K to \$285K range, it might be enough to recruit the next generation of physicians struggling to afford the ever-increasing cost of a medical education.

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## Projections of Medical Home Savings in West VA

By Dave Bond, F.S.A., M.A.A.A., Managing Partner of CCRC Actuaries, and Perry Bryant, Executive Director, West Virginians for Affordable Health Care

**I**n an actuarial project that was jointly sponsored by the West Virginia Health Care Authority ("WVHCA") and West Virginians for Affordable Health Care ("WVAHC"), an actuarial model was developed of the West Virginia health care financing system. The project received tremendous cooperation from both commercial and governmental payors in the state, both of which were critical to the development of a successful analysis. Detailed medical and pharmaceutical data was collected for over 800,000 individuals of the state, representing approximately 45% of the total state population of 1.8 million.

The actuarial model incorporated financial, health care utilization, and demographic information germane to projecting future health care expenditures through the various health care financial systems currently available to West Virginians, or alternatively, which could become available under health care reform. These systems include commercial and federal and state organizations, including the Public Employees Insurance Agency (PEIA), which provides health care coverage to both actives and retirees for state employees, Medicaid and Medicare. The project began in 2007. The final report, "Health Care Financing in the State of West Virginia - An Analysis and Projection of the Current System and Potential Transformations," was issued in August 2009. The entire report can be read at [www.wvahc.org](http://www.wvahc.org).

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# Patient Activation: Key to the Patient-Centered Medical Home

By Chris Delaney, CEO, Insignia Health

**E**xpectations are high that the patient-centered medical home will improve care and help control medical spending. Medical home initiatives typically center upon improving communication and coordination between health care providers, increase the use of data systems and electronic health records, and provide support for patient self-care.

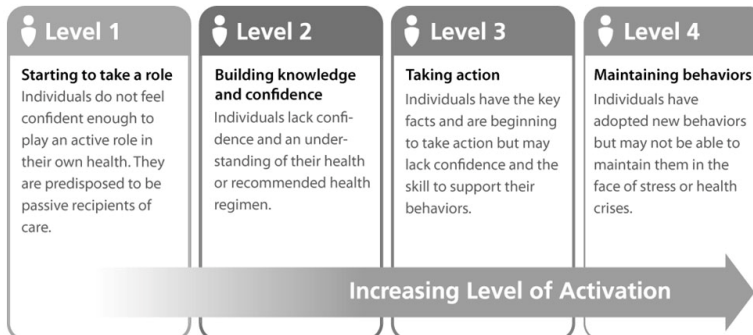
However, improving the support for patient self-management often does not receive the same level of attention as the other elements of the medical home. The current NCQA criteria for certifying the medical home illustrates this point. Patient self-management support represents 9 points within a 100-point certification program. This allocation clearly downplays the importance of the patient role in determining quality and outcomes. Yet research suggests that self-management accounts for 70% to 80% of the health outcomes. So why this disconnect? Have we lost confidence in the patient's ability to be an effective partner in care? Or are we overly focused on the power of technology to cure what ails the healthcare system? Whatever the case, effective patient self-management support is essential to the success of the medical home model.

The Chronic Care Model assumes that quality occurs when a prepared care team collaborates with activated patients (Von Korff et al 1997). We know that being an engaged and active participant in one's own care is linked to better health outcomes (Von Korff et al. 1997, Lorig et al. 1999; Von Korff et al. 1998, Bodenheimer et al 2002) and measurable cost savings (Glasgow et al. 2002). It comes as no surprise then, that there is a growing consensus that activating and engaging consumers is an essential component to health care reform in the United States.

## Activation Starts with Measurement

Measurement provides an important starting point for stimulating patient activation. With valid measurement we can gain insight into patient behavior, understand health risks, establish benchmarks, and learn how best to engage patients. Measurement can also be used to know which strategies are working and when progress is occurring and when it is not. Measurement tools commonly used either delve into a particular behavior (locus of control, self-efficacy, readiness to change) or assess deficits more broadly – what is it that a patient does not do well as reported through a health risk assessment or clinical insight. Self-care support and information is then provided to encourage recommended behavior, using a mostly one size fits all manner. The problem is, much of what is being encouraged is well beyond what many patients are capable of taking on. The medical home and care transition programs have much to gain through a better understanding of an individual's ability to adopt and maintain specific behaviors. The Patient Activation Measure takes a different approach. This measure is a global measure assessing the degree to which an individual understands their role in maintaining health, and feels they are up to the job.

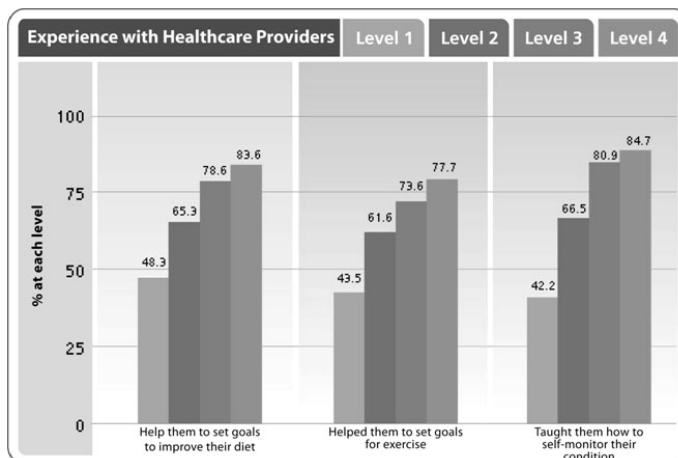
The Patient Activation Measure® (PAM) evaluates three key domains - knowledge, skills, and confidence for self-care that work together to determine an individual's self-management competency. In effect, the PAM provides a window into an individual's sense of being 'in charge' of their own health. Four levels of activation emerge that people go through in the process of becoming fully competent managers of their own health.



## An Important Vital Sign

A patient's ability to participate in his or her own care is a vital piece of insight for health care providers. Lower-activation patients are poor self-managers and have less skill in getting what they need from the healthcare system.

The low activated – levels 1 and 2 -- account for 40% to 45% of a typical Medicare population, and around 30% in commercial groups. The impact of this group on utilization, however, is much larger. Research has shown the low activated to be significantly more likely to be re-admitted to a hospital within 30 days of discharge<sup>1</sup>, to be half as adherent to medications as the high activated, and to find less value in the interactions with healthcare providers<sup>2</sup>.



Source: Center For Studying Health System Change 2007 Household Tracking Study  
Differences between level 4 and other levels significant at p<.05

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## Patient Activation & the Medical Home...continued

### Tailoring Support to Activation Levels Improves Outcomes

Knowing a patient's level of activation can help healthcare providers tailor support to strengthen understanding of treatment plans and options and help patients become more active members of their healthcare team. The behaviors encouraged for each activation level are based on empirical data indicating what is realistic at a particular level.

Research in a real-life setting demonstrates the merit of this approach<sup>3</sup>. Patients who received coaching tailored to their level of activation showed greater improvement in their biometrics and in their adherence to recommended regimens, and showed greater reductions in hospitalizations and in emergency department use than did patients coached in the usual way. Coaches in both control and intervention study groups used Motivational Interviewing (MI) technique.

### Application in a Care Support Setting

Tailoring support to levels of activation is being deployed in a variety of care transition and medical home programs. A program in Whatcom County, Washington, one of the 14 CMS care transition programs, demonstrates the application of PAM-based patient coaching with the aim of reducing unnecessary readmissions at St. Joseph Hospital. This program is built around the Care Transition Intervention (CTI), a model that identifies dozens of important tasks that must be communicated to a patient, and understood by the patient, prior to discharge. This approach, without tailoring support to levels, presents a set of tasks that can overwhelm the low activated with a predictable response – they shut down. For the low activated, who have poorly developed self-management skills and are much more likely to be readmitted, dealing with all these tasks is most often beyond their abilities. To address this challenge, CTI coaches at St. Joseph administer the PAM to consenting patients upon admission. Transition support is then tailored to levels of activation. For the low activated only a few key aspects of the care transition are developed in detail. For CHF patients as an example, understanding the importance of weight monitoring and how to respond to changes in weight changes takes on greater focus, as does the proper use of medications.

While the low activated need greater attention and help achieving focus on a select number of tasks, the high activated are good self-managers and capable of understanding their tasks and solving problems as they arise. It is this dichotomy that allows coaches to shift time from the high activated to support those in greater need at the lower levels of activation. The impact of this work on patient health and readmissions will be closely assessed over the next six months.

Supporting patients based upon their self-management abilities offers a promising approach to not only reducing readmission, but to helping patients become better self-managers well beyond 30 days after discharge. The medical home offers an ideal setting in which health care providers can tailor support and help patients on this journey.

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- 1 *Beyond 50.59: Chronic Care: A Call to Action for Health Reform*. AARP Public Policy Institute, March 2009
- 2 *Is Patient Activation Associated With Outcomes of Care for Adults With Chronic Conditions?* Journal of Ambulatory Care Management, Jan-Mar 2007
- 3 *Improving the Outcomes of Disease-Management by Tailoring Care to the Patient's Level of Activation*. American Journal of Managed Care. June 2009

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