

Chronic Illness and Health Care Payment: A Springboard to Sustainable Change

*A Report on the 2003
New England Regional Conference*

**Realigning Payment Policies and Incentives for
High Quality Diabetes Care**

**May 13, 2003
Manchester, New Hampshire**

Sponsored by the U.S. Department of Health and Human Services Region 1 Office (New England), the Vermont Program for Quality in Health Care, and the New England Public Health and Managed Care Collaborative

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One hundred million Americans have at least one chronic illness. Half have more than one. Yet most patients with chronic illnesses “are inadequately treated,” and today “chronic illness accounts for three quarters of total national health care expenditures,” declared an article in the October 9, 2002 issue of the *Journal of the American Medical Association*, co-authored by Edward H. Wagner, MD.

To close what they and others, including the Institute of Medicine, are calling the “quality chasm between current practices and optimal standards,” as the *JAMA* article put it, Dr. Wagner and his research associates have been involved with the development, testing, and promotion of a newly integrated approach called the Chronic Care Model. Already field-tested in hundreds of practice settings around the country, this approach appears to work, to produce better quality of care at lower costs. Perhaps the most challenging question is: Can the health care payment system be remade to pay for this, or for any similar approach to chronic care that centers, not on responding to acute health issues and crises, but on prevention, information, coordination, and continuing case management?

That was the issue that delegations from all six New England states met to explore in Manchester, NH on May 13, 2003.

Titled “Realigning Health Care Payment Policies and Incentives for High Quality Diabetes Care,” the conference was sponsored by the U.S. Department of Health and Human Services Region 1 Office (New England), the Vermont Program for Quality in Health Care, and the New England Public Health and Managed Care Collaborative. Participants included private insurers, health care purchasers, provider organizations, state officials, federal officials, and other health-related organizations. The meeting was made possible by the support of the Division of Diabetes Translation, Centers for Disease Control and Prevention, U.S. Department of Health and Human Services.

Though the conferees said more than once that a single, well-integrated, comprehensive approach to chronic care can be applied to virtually all such conditions, the day’s planners chose to focus on diabetes as a representative condition. The fifth-leading cause of death in the United States, diabetes and its associated health problems — heart disease, kidney failure, and other chronic conditions — cost this country an estimated \$132 billion during 2002 in medical expenses and lost productivity, according to the journal *Diabetes Care*.

Listening, Talk & Action

With this as their focus, the conferees gathered for a full day of presentations, discussions, “brainstorming,” and planning for action. As Betsy Rosenfeld, acting regional health administrator of DHHS’s Region I (New England) Office, said in opening the program, the participants were “a very varied and multisectoral group.

“We’re looking forward to concrete activities issuing forth from this discussion,” Ms. Rosenfeld said. “Today is the day to think ‘outside the box’ of the regional health care delivery system as we know it.”

What follows is a series of brief reports on the day's proceedings and discussions as they unfolded. Presented as much as possible in the participants' own words, this report seeks both to summarize the results of this conference and to contribute to the forward momentum — the sharing of ideas, useful information, and strategies — that this day generated.

The morning's program began, as the following article describes, with a keynote address by Ed Wagner. Dr. Wagner is director of the W.A. MacColl Institute for Healthcare Innovation, Center for Health Studies, Group Health Cooperative of Puget Sound, Washington, and director of the Improving Chronic Illness Program, a national initiative of the Robert Wood Johnson Foundation.

The Keynote Speaker: “There Is Hope Out There”

If realigning payment policies and incentives for the care of chronic illness is the means to an end, keynote speaker Ed Wagner, M.D. began with the end: much more effective treatment of a typical patient he called “Mrs. G.”

Mrs. G. is a 67-year-old widow with insurance coverage and a history of type-2 diabetes and moderate obesity. The regular care she has been receiving from an internist, Dr. Wagner said, “is characterized by seeing her doctor when she's having trouble.”

And there, essentially, is the trouble: Mrs. G's care, though well-meaning, lacks systematic coordination, communication, and case management.

When she is hospitalized with congestive heart failure, it becomes clear that Mrs. G is confused about her diabetes care. Discharged, she takes home six prescriptions that together cost almost her whole Social Security check, so she parcels them out — and lands back in the hospital. Back home she has a drawer full of diabetes diet sheets she has received and intermittently tried over the years. Her internist is unaware she's been in the hospital; and with two admissions that more systematic care could have avoided, the costs of her care are far higher than should have been necessary.

The U.S. health care system can do much better, Dr. Wagner said. It can hardly afford not to.

“Mrs. G is part of an accelerating national epidemic of chronic disease,” he explained. Like most patients with type 2 diabetes, she actually has several chronic disease problems, in her case including hypertension, congestive heart failure, and coronary artery disease. And although increasingly effective treatments are available for chronic conditions, Dr. Wagner said, less than half of today's patients are receiving them.

Like all patients with chronic disease, he said, Mrs. G “needs a continuous healing relationship — and that means somebody in charge of her care. Somebody who will proactively make sure that the benefits of modern care reach her in a systematic way.”

“The blame lies not with Mrs. G., and probably not with her doctors,” Dr. Wagner said. “It's the system in which they are coming together ... Trying harder will not work. Changing the system will.”

“What Works” to Transform Outcomes

After a decade of studying diabetes-care interventions, Dr. Wagner and his associates have found that the more domains of intervention are part of a patient's treatment, the more positive the outcomes will be.

“We found,” he said, “that practice enhancements fall into the same four categories for various chronic illnesses”:

- self-management support,
- delivery system design,
- decision support, and
- clinical information systems.

Self-management support is, Dr. Wagner said, different from older-style patient education, which tended to be didactic, were modeled after medical school, and didn’t change beliefs and outcomes.

What works, he observed, is when patients are made to feel in charge of managing their illness and their health; when they are routinely assessed; when they are given advice based on evidence, delivered as information not scolding; and when there is long-term follow up.

An electronic medical registry would be helpful, Dr. Wagner said, but it’s not essential. “I’m not railing against paperless care, I just don’t want Mrs. G to have to wait for it.”

Other key features of an effective system, he added, include visible, committed leadership, incentives, and community resources. Strong leadership is a powerful predictor of success. Incentives cannot create motivation; “but if systems really want to do better, incentives will really help.” And community-based programs, support groups, and other resources and organizations are especially vital to smaller practices.

Proving the Model in Practice

All these are key elements of the Chronic Care Model that Dr. Wagner has been closely involved in testing and promoting. With these elements, he said, Mrs. G’s care would not have fallen through the cracks. But can changes outlined in the Chronic Care Model be implemented “by busy practices in the real world”?

“We have now done these with about 1,000 different organizations,” Dr. Wagner said. He pointed in particular to the diabetes-care improvement project in Washington State, which in five years has carried out three successive collaborations that, altogether, have engaged all the state’s health plans and over 60 medical practices. Roughly two-thirds to three-quarters of the involved teams showed measurable improvements in the quality of their care; and the outcomes keep improving as the collaborators learn more.

“What I’d like to leave you with is that there is hope out there,” Dr. Wagner concluded. “There is good evidence that medical practices can do this job. It needs a realigning of incentives, it needs strong leadership, and it needs an incentive structure that will sustain it.

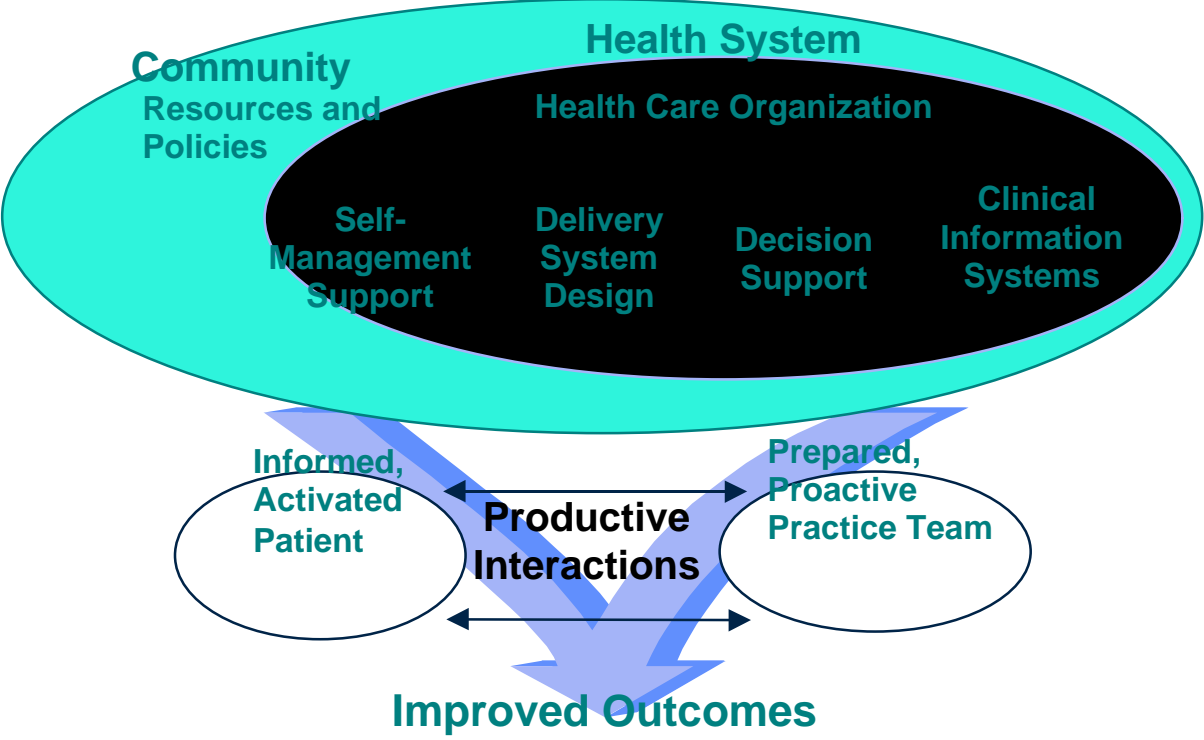
“With your help, maybe we can do it in New England.”

What people like Ms. G with chronic diseases need

- A “continuous healing relationship”
- Effective clinical management
- Information and ongoing support for self-management
- Regular assessments of how they are doing
- Shared care plan
- Active, sustained follow-up



Chronic Care Model



Representing CMS: “There Might Be Opportunities”

Medicare has 40 million beneficiaries and processes over a billion claims each day — yet it has “no system of producing and rewarding performance improvement on a large scale,” said second speaker David Kreiss, special assistant to the administrator of the Centers for Medicare & Medicaid Services, or CMS. “Fee-for-service does not distinguish any quality of performance.”

In looking to make change that can improve quality, Kreiss told the conference, “the real issue is: We need to find a business model that we can fund, and that meets the needs of how CMS does its contracting.

“Maybe population-based contracting is a way to think about it,” he suggested. “There might be a way to work with vendors, to work within that model and to bring the Chronic Care Model to a much broader scale.”

There is much support in Congress, he cautioned, for protecting how traditional Medicare works. And the administration does not favor creating a new fee scale, “enabling physicians to bill for new things, without having the systems in place to monitor performance.”

However, the leadership of the U.S. Department of Health and Human Services has made a “significant” commitment to quality improvement initiatives, Kreiss said. “I think you’re seeing both an emphasis on reporting on performance, and experimenting with different payment models to get at rewarding performance. We are aggressively moving in that domain.

“... We’re really looking at working to enhance the existing capitated system ... working on tweaks and modifying the capitated systems to see if that can produce better results for folks with chronic illnesses ... and then shifting to population-based contracting.

“I’m not trying to say that CMS doesn’t need change,” he added — but “moving our ship isn’t easy. We need to find models to begin with that can work within where we are now, and begin to transform it.

“... The opportunity I see is an opportunity within the traditional Medicare program. I think there are ways to create that ‘tipping point’... I think population-based contracting is a way to get the agency to begin to change, in the way that it interacts with its contractors. I think it’s a potentially important first step.

“Thinking about a population base,” Kreiss said later in the day, during the panel discussion, “enables a payer to transform itself into an insurer, and start thinking about where it might want to concentrate its resources.”

“Start Thinking About Creating Partnerships”

Population-based contracting is not necessarily a default to traditional vendors, Kreiss said. If an entity can come forward to assume responsibility for improving outcomes with specified chronic-disease populations, “I think there is an opportunity to do business with CMS.”

Kreiss advised that any demonstration project offer guidance on self-care to targeted beneficiaries, and be designed to help patients manage multiple chronic conditions. Accountability is key, he said. It’s also important that any demonstration project involve an entity substantial enough to work with CMS, with strong experience in the chosen field, and with a defined target population that is large enough to generate outcomes and savings that can make an impression on the Congressional Budget Office.

“So I think it’s critical for people to start thinking about coming together and creating partnerships — because that’s what we can accommodate,” Kreiss concluded. “If there are enough innovative entrepreneurs out there, and folks willing to create consortia, there might be opportunities to work with CMS now.”

The Lahey Clinic’s Fee-for-Service Incentives

A CMS demonstration project for physician group practices is using financial incentives to improve chronic care in a systematic way within the fee-for-service system. In fact, the program has saved \$390-\$520 per patient over two years while markedly decreasing hospital stays and improving health outcomes, Robert Schreiber, M.D., of the Lahey Clinic told the conference in the morning’s third presentation.

“These programs can in fact be applied to fee-for-service Medicare, if the incentives are there,” said Dr. Schreiber, medical director of geriatric services at the Massachusetts-based clinic.

Under Lahey’s patient management program for seniors, participating physician groups within the multispecialty practice set annual performance and quality targets, then receive bonuses if they achieve cost savings through more effective and efficient care.

Overall, the program’s approach — one that Dr. Schreiber said is evolving widely through the 478-physician Lahey Clinic — is to place patients at the center of their health care planning and decision-making. Staff care is coordinated and information exchanged through a team approach before, during, and after hospitalization, with a focus on improving the transitions through that continuum. After their hospital stays, patients continue to play an active role.

“We really work with patients on taking control of their rehab,” he said.

The project has reduced patients’ average hospital stays by about three days. Satisfaction rates among affected patients have stayed high, and readmission rates to hospitals from nursing facilities have declined from about 20% four years ago to an average of 10-15% today.

“They’re getting out sooner, they’re functioning better, and they’re just as satisfied,” Dr. Schreiber summed up.

Though the fee-for-service system does not now pay for many of the services provided in Lahey’s coordinated-care project, Dr. Schreiber said it could. He urged that successful projects be cross-linked to share effective strategies, and that both providers and payers look beyond the approach that places each disease condition into a separate “basket,” instead seeing the interconnections that typify both chronic conditions and their most effective care.

“When you’re caring for this population, it’s multi-disciplinary,” he concluded. “It’s not one doctor or one nurse, it’s everybody working together. And the patient has got to be at the center of it all.”

Compensation for Quality In “Bridges to Excellence”

“We know there are pockets of excellence” in health care quality, said Francois de Brantes of GE as he began the morning’s final presentation. “The problem for purchasers is, we don’t know where to find them.”

Finding and rewarding high-quality providers in a way that helps them build toward still-better patient outcomes is the aim of the new Bridges to Excellence collaboration, launched this April by a coalition of physicians, health plans, and large employers, led by GE. “It’s our belief that this approach to physician compensation will improve the quality of care that patients receive and will, ultimately, lower overall costs of care,” said de Brantes, program leader for GE’s Health Care Initiative, in the media announcement of the national project.

The Bridges to Excellence (BTE) approach in Massachusetts has two parts: a Diabetes Care Link based on the NCQA Diabetes Provider Recognition Program certification process, and a Physician Office Link (POL) quality incentive program that was developed by the BTE team. The POL model creates three levels of quality standards across three dimensions of care processes: Clinical Information Systems, Patient Education and Support, and Disease Management. POL offers physicians annual per-patient incentive payments, and these bonus payments are structured to reward providers to continuously improving quality of care.

In describing the BTE diabetes care initiative at the conference, de Brantes was joined by Thomas H. Lee, M.D., chief medical officer for Partners Community HealthCare, Inc., the integrated delivery system founded by Brigham and Women’s Hospital and Massachusetts General Hospital.

Dr. Lee is co-chair of the Committee for Performance Measures of the National Committee for Quality Assurance — and NCQA has co-developed the Bridges to Excellence performance measures.

“In essence, we tried to look at how do we standardize measures of care,” said de Brantes, who highlighted the lack of consistent quality measures as a key issue for employers seeking to find and reward providers for effective, well-coordinated, patient-centered care.

“We’re trying to keep it very simple,” de Brantes explained. “If you meet the performance measures, you get the money.” Providers who don’t qualify are told what they need to improve. The idea is to create a fee base for continuous quality improvements.

“We need you to continue to reinvest in these systems,” de Brantes said of providers. “That’s where we get a very big yield.” The Bridges program couples its provider incentives with support tools designed to engage and inform patients.

For the physicians involved in Bridges to Excellence, working with purchasers has been new and refreshing, Dr. Lee said. It has also broken down barriers in the effort to create shared solutions.

“The process forces all the parties out of defending their interests,” Dr. Lee said. “This was a fresh idea at a time when the health care system really needs one.”

Broadening the Discussion: A Panel's Perspectives

The afternoon's panel discussion featured representatives of health care purchasers, small and large physician practices, state Medicaid programs, consumers, and CMS. Here are some excerpted highlights:

What is the most important single step that needs to be taken to better align incentives to the Chronic Care Model?

Karen Bell, MD, Anthem Blue Cross Blue Shield in Maine: To have a collaborative atmosphere among the stakeholders, in whatever area you represent. To have a meeting of the minds, among the plans, among the key employers, the provider groups, and some consumers, is absolutely critical.

Raymond Maxim, MD, University Medical Group, RI: Speaking from the small-practice perspective, the country as a whole needs to finally decide what it wants in the medical community. Do we want acute, episodic chronic care, or do we want chronic care? It affects every part of the system.

Ellen Gagnon, Dartmouth Hitchcock Medical Center: From the large-provider organization perspective, the most important thing is a reimbursement mechanism to pay for the structure, the infrastructure that supports exactly what we're trying to accomplish. Group visits, e-visits, disease management programs, case managers ... how do we build those things? Recognizing that CMS is not interested in paying for these on a line-by-line basis, there's got to be a funding mechanism to pay for that as a structure, so we can provide that kind of care.

John Young, RI Dept. of Human Services Medicaid Program: I think you need to broaden the base of the discussion. You've got to get the community organizations into the conversation, along with all the public entities that pay into these systems, to find out what they're funding and how they're touching the same people that you're trying to treat. That's where you're going to find the money to create incentives in the first place.

Doug Libby, Maine Health Management Coalition: I think what purchasers, i.e. employers, really need is to show measured performance of the Chronic Care Model in a way that demonstrates return on investment to employers. To convince the CFO or the human resource manager that they should actively start to implement significant differentials, there needs to be something that's clearly understandable.

And in terms of consumers, I think we just need to convince them — to make consumers aware of the perversity of the current reimbursement process.

David Kreiss, CMS: Finding an organization or entity that is willing to accept responsibility for improving clinical results, and also taking some responsibility that, in doing so, you're not going to increase that program's expenses, at least over the first five years.

Why aren't the quality improvement networks the ideal partner? QIOs are perfectly positioned to do ongoing performance evaluation, finding the providers, do everything that's required. My biggest fear is that only [for-profit care-management] vendors come to the table. What I'm trying to communicate is that I think there are other potential players in getting it done.

What can you do “by next Tuesday” — that is, quickly?

Dr. Maxim, Univ. Med. Group: Extend Dr. Wagner into places he has not been. People in financial and contracting departments tend to not know anything about him. The other place education needs to happen is in the medical schools. That's where physicians' practice habits become fixed.

Ellen Gagnon, Dartmouth Hitchcock: We could also start to lay the groundwork, which we've been doing gradually for a few years, about how we structure reimbursement that reflects this type of activity to maintain health.

John Young, RI Medicaid: Mine would be sort of a Biblical “next Tuesday” ... We've got to focus on public financing. We've got to make the changes that will make sense over a longer period of time.

Doug Libby, Maine Health Management Coalition: If we could take a single sheet of paper and, in CFO language, put down very simply the pathway of the usual care for a diabetic, then the Chronic Care Model, and beside that compare the costs over a number of years, the CFO could take that to the human resource manager's office and say: “This is what it's costing us now, and this is what we could be paying under the Chronic Care Model.”

David Kreiss, CMS: When we're talking about the traditional Medicare program, the first step is getting commitments from our systems folks to begin the process of enabling us to do the kinds of information transfer to our partners that would enable them to do population-based contracting. Without the data, it won't work.

What can each of you do to decrease the cacophony that's occurring in the physician's office?

Doug Libby, Maine Health Management Coalition: Support some sort of a national effort like the National Quality Forum, or a similar organization, to really standardize details about how quality is measured. Take that out into the medical community, so doctors and hospitals can know exactly what is going to be measured, how it is going to be measured, and that it isn't going to change over the next six to nine years.

John Young, RI Medicaid: I think the biggest threat to this kind of model is a lot of diverse approaches. The only way to stop that is to say, “We're going to take a common approach to solving a priority problem.” That means a number of people are going to step back from their own philosophical bent; they're going to have to say, “I'm willing to take a little bit less of what I wanted, to get at the solution.”

Dr. Maxim, University Medical Group: We need to pick one chronic care model, and choose it for everything. The other thing is to bring the care manager as close to the primary care office as possible.

Dr. Bell, Anthem: We could certainly make practice easier by eliminating a lot of duplication. Every health plan has to credential; there are huge amounts of duplication in the doctor's office that waste medical resources. There are multiple agencies out there that require a huge amount of resources.

How do we think about keeping some available savings as a result of initiatives in the system, for possible incentives, as opposed to translating those savings into lower premiums?

Ellen Gagnon, Dartmouth Hitchcock: How you pay for something, I've discovered in the insurer world, is almost as important as how much you pay. I think there is opportunity for us to think a little bit more creatively about how we pay for this — not just incentives for quality, but how we structure our payments. There has to be a balance, because the employer groups cannot maintain the kinds of increases they have been paying; but I also think that the opportunity is big enough to be shared [among incentives and lower premiums].

Doug Libby, Maine Health Management Coalition: I have one employer member who says that if there's a way to document the savings that he gets, he'll give a third to the provider, a third will be kept in the company, and a third will go to the patient, or employee.

Anthem Blue Cross in Maine: Creating a New Contracting System

In Maine, Anthem Blue Cross and Blue Shield has worked with physicians and employers to develop "quality-based contracting," its new working model for incenting improvements in care, said Karen M. Bell, MD, Anthem's medical director in Maine, in an afternoon presentation.

The system is a three-year commitment by Anthem and each contracting provider — and by the end of this year, Anthem expects 75% of Maine's primary care practices to have signed on. Key elements of the system are accountability, evidenced-based practices, and better communication.

"The system has to give the individual physician the ability to track and monitor what is going on with their patients in chronic care," Dr. Bell said. "And the payer has to realize that statistically, you're not going to get an improvement in clinical outcomes overnight. You have to develop a model that gives you time."

In the first year of each contract, Anthem rewards providers for implementing systems that can track and measure care processes.

"That can be whatever works for the practice," Dr. Bell said. "We give them a full year to do it.

"In year two, we support what we think to be the better care processes that you've all heard about this morning," she said. "We do reimbursements for practice-based care management, group visits. We waive copays for certain medications ... we do some things that go above and beyond the typical payment structure, so better care processes can be implemented.

"By year three, we believe we're going to be seeing demonstrable and sustainable care improvements," she said.

Already, late in its second year, 75-90% of diabetes patients have their disease in good control, compared to Anthem’s estimate of 45% in the general population.

“While it sounds wonderful, this has been a tremendous amount of work — and our partners helped us get there,” Dr. Bell said. “Employers have been very gracious and patient with us, to start to feel somewhat comfortable with our reward structure in year one. The clinicians felt very uncomfortable with the outcomes piece; but they’re more comfortable now. I’ve had actuaries go through Dr. Wagner’s articles with a fine-tooth comb, to believe there might actually be some cost savings from this.

“There is always a bias within a health plan that there’s a certain way of doing things, and it’s hard to change,” she concluded. “But if everyone is on board, knowing this is important and in the end this will help, it’s much easier to make changes within an organization.”

SEACHANGE IN DELIVERY

Past 2 MSYSTEM The present → future

	Episodic Care	Systemic Care
STRUCTURE	Patient initiates visits to physicians, or may telephone	All patients history of results available online with decision supports built in.
PROCESS	Physician reviews patient history and labs, advises patient during 15 minute visit or phone call.	Physician reviews patient population to see who needs care/follow-up. Patient contacted & engaged in visit, case management, self education programs.
OUTCOMES	45% diabetes in good control. 75% hypertension in poor control. 5% of patients on Coumadin will have stroke or bleed.	75 – 90% in good control 75% in good control <1% at risk for bleed or stroke.



What's Next? State Groups "Brainstorm" Strategies

After the panel discussion, the conferees from each New England state gathered into a group to discuss how their state might proceed, and what they can do, to implement the Chronic Care Model. Here in brief are the ideas each group then presented to the conference:

Connecticut

The most important steps we can take in our state toward better aligning incentives with the Chronic Care Model:

- Educate about the model; make the case to payers, patients, providers.
- Identify key stakeholders: state departments of Public Health, Public Services, Mental Health, consumer constituency groups, providers, Qualidigm consumers, Ct. Managed Care Association.

What are the strengths and weaknesses of state- vs. regional-scale interventions?

- Regional strengths: wider range of ideas and best practices, power in numbers, blend of rural/inner city environments, thinking across state lines. Weaknesses: too many payers, competing interests.
- State strengths: Most quality-improvement programs organized at state level; legislators respond better to local issues; ease of collaboration; implementation is local.

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Maine

Most important steps:

- Create statewide CMS demonstration project, involving Medicare and Medicaid, to realign financial policies. Build acceptance for that model as a coordinated approach.
- Write one-page summary of how a coordinated approach would work, clarifying expectations and outlining how a statewide demonstration project would work. Use that to build support in our organizations; focus on key players in state.

State vs. regional:

- Start at state level to develop relationships and agreement on quality measures. Build on current initiatives, relationships, community partners.
- Think about "collaborative of collaboratives" among states, to learn from each other's efforts and use collective political clout.

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Massachusetts

Most important steps:

- Promote in our organizations the message that incenting providers toward adopting these systems is a good thing.
- Begin to build agreement on quality measures among physicians, employers, plans. Dept. of Public Health guidelines a good starting point.
- Process issue: how to bring different groups together in sustainable, effective way. Need incentives for involvement.

Regional vs. state interventions:

- The more complexity, the longer it takes; but beneficial to learn from programs developed elsewhere.
- Providers have stronger relationships within state; but health plans generally cross state lines.
- Interest in benchmarking against what other states are doing.

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New Hampshire

Most important steps:

- Look at reimbursement.
- Create a stronger public health infrastructure, starting at local and state levels.
- Identify key stakeholders; get employers involved.
- Survey care systems, information systems, and registries throughout the state.

State vs. regional:

- Felt strongly that state is the way to go.
- But sharing states' experiences, through a regional steering committee, would also make sense.

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Rhode Island

Most important steps:

- By summer, invite Anthem BCBS of Maine to present its strategy for quality-based contracting.
- By autumn, convene key players: Medicare, Medicaid, Rhode Island Foundation, medical and financial groups, state medical society, hospitals, universities, state departments, nursing and home care providers, other third parties, some consumers. Learn what they're working on. Find common interests.

State vs. regional:

- Regional: open, more neutral exchange of ideas, broad policy issues resources.
- State: RI can be a model pilot state. Various states have different payers.

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Vermont

Most important steps:

- Begin to educate on Chronic Care Model, with goal of building a plan and statewide agreement on implementing it.

State vs. regional:

- State strengths: VT is small; we tend to work collaboratively, with cohesive energy. A solid core of committed people working on quality issues.
- Regional strengths: Sharing, as in this conference; but more complex, harder to do.
- Suggest a hybrid model. Small portions of the work may best be done regionally, as each state moves forward on its own project.

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Closing Remarks: Time to Invest in Change

“This was a very exciting day for me,” Ed Wagner began his closing remarks. “I sensed a set of creative energy, ideas, and already action in this room that I haven’t seen in too many other places around the country.”

Summing up the day’s discussions, Dr. Wagner said “message one” was that “there is no health care system — so there’s no one in charge, and no one to be accountable.” CMS representative David Kreiss’s idea of population-based contracting “forces the system,” Dr. Wagner said. “What I don’t like is the [for-profit care-management] vendors ... I don’t want for-profit vendors organizing our health care system. But having them as a potential option I hope galvanizes people like you all to say, ‘All right: we’ll create a system that holds accountability for a population, a system that can organize quality improvement, a system that can help supplement the resources that small practices, especially, are going to need if we’re going to move into a real chronic disease improvement era.’

“Message two is that CMS — and now, I heard, health plans like Anthem, and purchasers like GE — are ready, if the configurations are right and if the incentives are aligned, to make an investment. I want them, and I think you do, to invest in our health care delivery system, not in for-profit end-rounds.”

All six states were talking, Dr. Wagner observed, about the imperatives of investing in information technology and in disease management, which must improve clinical management in some way.

“The last thing is, we must invest in aggressive, modern quality improvement — which seems to work best in this collaborative framework, and in our experience seems to work best at local levels, where people know each other and you can get the key people around the same table.”

As New Englanders experiment, Dr. Wagner urged them to find and try ways of locating care managers in communities, close to practices; to “think about how we populate registries with data, in a way that doesn’t violate anti-trust and is supportive of practices”; and to use tools and materials available through the Robert Wood Johnson Foundation to promote understanding of the chronic care model.

“In closing,” he said, “I want to reiterate my thanks for helping me clarify what a geographic area can do to create a system when one doesn’t exist ... Thanks for sharing the day with me. I hope it isn’t the last time.”

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