

## Ohio Health Quality Improvement Summit Planning Committee Improving Chronic Disease Management

**Caveats:**

**Suggested tactics and metrics for each strategy are examples only, derived from a general literature review and survey of other states’ initiatives and policy brainstorming. Further work is needed to (1) determine the extent to which these tactics and metrics are already under development or being used in Ohio, (2) probe the merit and viability of these tactics and determine whether there are better tactics for achieving the desired goals, (3) assess which mix of tactics would work best for Ohio, and (4) determine appropriate timeframes and targets for achieving the indicated metrics.**

**Additionally, our committee wishes to emphasize the importance of the seven cross-cutting “areas” reflected in the fourth column. In many ways, each of the seven topics in this column could form its own “strategy,” and it is our hope that when the work of the November conference is done, the tactics in all 7 areas can be mapped and tracked across all four focus areas of the conference (cost and efficiency, patient safety, chronic disease management, and prevention).**

**Finally, not all committee members supported every strategy or tactic and indeed, some members opposed certain strategies and tactics. Also, not every strategy or tactic currently being supported or pursued by each of our committee members is listed in this chart. Nonetheless, the strategies and tactics listed in this chart had sufficiently broad support among our committee’s members to warrant further consideration at the November summit.**

Proposed strategy	Rationale (with citations, and estimated return on investment)	Supporting tactics (general) <sup>1</sup>	Supporting tactics in the areas of (1) health information technology; (2) payment reform; (3) addressing and reducing disparities <sup>2</sup> ; and (4) workforce development <sup>3</sup>	Metrics for measuring progress
<b>1. Develop an infrastructure that supports coordinated care and the Chronic Care Model.</b>	The United States cannot effectively address escalating health care costs without addressing the problem of chronic diseases. People with chronic conditions are the most frequent users of health care in the U.S., accounting for 81% of hospital admissions; 91% of all prescriptions filled; and 76% of all physician visits. <sup>4</sup>  Over 6.7 million cases of seven common	a. Support and reward the use of evidence-based guidelines and organized approaches to assure that all consumers receive recommended care. Examples include: <ul style="list-style-type: none"> <li>▪ Health coaches (nurse/patient educator) who take responsibility for ongoing care.</li> </ul>	a. <b>Payment Reform.</b> Restructure the reimbursement system to reward care that produces good outcomes.  Funding mechanisms must be transparent, provide services for coordination of care, improve access and care management, reward providers for improving health outcomes and quality and	Care coordination cost vs. time & effort.  Patient satisfaction.  Compliance with care plans.  Hospital admission and readmissions, including

<p>chronic diseases – cancers, diabetes, heart disease, hypertension, stroke, mental disorders, and pulmonary conditions – were reported in Ohio in 2003. Ohio scores in the third quartile (out of four) in the State Chronic Disease Index – States in the top quartile have the lowest rates of seven common chronic diseases.<sup>5</sup></p> <p>The total cost of treating chronic conditions in Ohio totaled \$13.5 billion in 2003. The impact of lost workdays (absenteeism) and lower employee productivity (presenteeism) resulted in an annual economic loss in Ohio of \$43.4 billion in 2003.<sup>6</sup></p> <p>Americans receive only about half the recommended, evidence-based care they require when they see their doctor.<sup>7</sup></p> <p>Experts estimate that somewhere between 20% and 50% of all U.S. health care spending produces no benefit to the patient – and some of it produces clear harm.<sup>8</sup></p> <p>As spending for chronic illness goes up, value and quality go down.<sup>9</sup></p> <p>Fragmentation in the healthcare delivery system often leads to failures in transitional care, putting patients at risk for adverse outcomes that can lead to costly hospital readmissions.<sup>10</sup></p> <ul style="list-style-type: none"> <li>▪ An AHRQ study of patients admitted to hospitals with preventable admissions found 19.4% had at least one preventable readmission within six months. The cost of these admissions, which occurred in four states in 1999, was \$729 million, or \$7,400 per readmission.<sup>11</sup></li> </ul> <p>The reasons for early rehospitalization,</p>	<ul style="list-style-type: none"> <li>▪ Educational supports for practitioners, including, multidisciplinary health professions education; teaching of care coordination principles in academic settings; peer review; and development of care teams.</li> <li>▪ Patient-care focused and quality driven registries that include guidelines such as NCQA, AQA, CMS at the point-of-care.</li> </ul> <p>b. Use provider, patient, payer, and state and local government collaboratives to test and support coordination of care. Examples at:</p> <ul style="list-style-type: none"> <li>▪ Patient Centered Primary Care Collaborative, <a href="http://www.pcpcc.net/">http://www.pcpcc.net/</a></li> <li>▪ National Academy for State Health Policy, <a href="http://www.nashp.org/">http://www.nashp.org/</a></li> <li>▪ Commonwealth Fund, <a href="http://www.commonwealthfund.org/">http://www.commonwealthfund.org/</a> (Keyword: Care Coordination)</li> <li>▪ RWJF's Aligning Forces for Quality (Cleveland and Cincinnati), <a href="http://www.rwjf.org/qualityequality/af4q/">http://www.rwjf.org/qualityequality/af4q/</a></li> </ul> <p>c. Identify and mitigate real and perceived legal issues (e.g., HIPAA, anti-trust) that could impede coordination of care.</p> <p>d. Establish and/or support the use of performance assessments of specialists on quality and total</p>	<p>decreasing cost, and must support transitional and start-up cost associated with transformation, including investment in health information technology.</p> <p>Payment options could include:</p> <ul style="list-style-type: none"> <li>• Pay-for-performance and pay for process</li> <li>• Comprehensive prospective payments for providing coordinated care/ medical home services</li> <li>• Fee-for-service reimbursement for coordinated care/medical care services</li> <li>• One time grants and specific support for case management and disease management services</li> <li>• Changes to the tax code which accelerate depreciation for infrastructure improvements and quicken return on investment</li> </ul> <p>Promote alignment of performance incentive programs across payers.</p> <p><b>b. Health Information Technology.</b> Support use and acquisition of patient-centered electronic health records to ensure communications of treatment plans across providers and seamless transfer of health information during transition of care (i.e., hospitals, nursing homes, home health).</p> <p>A summary record should be</p>	<p>costs.</p> <p>Emergency room visits, including cost.</p> <p>Primary care staff satisfaction.</p> <p>Increase in primary care workforce by type (e.g., primary care physicians, geriatricians, nurse practitioners, health educators/coaches)</p> <p>Number of primary care practices using EHRs.</p> <p>Number of practices utilizing registries.</p>
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	<p>particularly during transition from one provider to another or from hospitals to rehabilitation centers, nursing facilities, or home, include defects in care, medication error, failure to plan for necessary equipment, and short comings in the preparation of the patient and family for his or her care outside the hospital.</p> <ul style="list-style-type: none"> <li>▪ A study based at the University of Colorado followed Medicare patients 30 days after hospital discharge and found about a quarter of patients did not progress smoothly on the road to recovery. These researchers identified 45 unique patterns of care, likely resulting in considerable confusion and error along these pathways.<sup>12</sup></li> <li>▪ A 2005 Commonwealth Fund survey found that at least a third of hospital patients did not receive instructions about what symptoms to watch for when discharged, did not know who to contact with questions, or were left without arrangements for follow-up care.<sup>13</sup></li> </ul> <p>The U.S. could face shortage of 44,000 primary care physicians by 2025. In Ohio, 35.4% of direct patient care physicians are Primary Care (General Internal Medicine, General Pediatrics, FP/GP) and 64.6% practice are in a subspecialty; the subspecialty physician population continues to grow faster than primary care.<sup>14</sup></p> <p>There is substantial evidence indicating that sufficient access to high quality primary care results in lower overall health care costs and lower use of higher cost services, such as specialists, emergency rooms and inpatient care.</p>	<p>cost of care, in order to concentrate referrals to those who perform well.</p> <p>e. Determine the best use of and fit for traditional chronic disease management programs (e.g., home monitoring, 24/7 call center), including establishing return on investment for these programs.</p> <p>f. Where available (e.g., Medicaid, Medicare) provide primary care providers with information that will help supports decision making and coordinated care, including:</p> <ul style="list-style-type: none"> <li>▪ Information about their individual patients' needs and utilization.</li> <li>▪ Information about their own performance, including comparisons to that of their peers or objectives benchmarks.</li> <li>▪ Information regarding best practices and continuing education.</li> </ul>	<p>portable and patients should have total access to their record to ensure continuity of care. Determine who should be the custodian and/or owner of the health record.</p> <p>Support and advocate for national data standards and ability to transmit health information across organizational, state and regional boundaries.</p> <p>Develop regional health information portals that enable providers to access patient information through a single point of access.</p> <p><b>c. Workforce Development.</b> Increase the number of primary care practitioners (e.g., family physicians, pediatricians, internists, obstetricians, geriatricians, dentists, certified nurse midwives, physician assistants, and certified registered nurse practitioners) by:</p> <ul style="list-style-type: none"> <li>▪ Targeting state and federally funded support of education in medical school and residency programs.</li> <li>▪ School and residency partnerships with safety net clinics.</li> <li>▪ Loan repayment (e.g., loan repayment if primary care Practitioner stays in Ohio at least 5 years post-residency)</li> <li>▪ Practice start up cost support.</li> <li>▪ Increase pay base (e.g., P4P, Care Management Fees).</li> <li>▪ Programs that increase</li> </ul>	
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			<p>minority and rural-born student participation in medical education.</p> <p><b>d. Value Purchasing.</b> Bulk purchase and provide practices with evidence-based treatments and supplies (e.g., vaccines).</p>	
<p><b>2. Promote use of and increase the number and distribution of evidence-based Patient Centered Medical/Health Care Homes in Ohio.</b></p>	<p>As a result of the business case presented in the rationale for Strategy #1, private and public payers have become increasingly interested in developing new models of service delivery that better supports patient-centered primary care, including the Patient-Centered Medical Home (PCMH) model.</p> <p>Currently there are more than 20 purchaser and multi-payer-based efforts to implement Patient-Centered Medical Homes across the U.S.</p> <p>Research is beginning to show that (PCMH) and related care coordination activities are improving health and reducing hospital admissions and costs, examples include:</p> <ul style="list-style-type: none"> <li>▪ The Medical Home initiative at the Geisinger Health Systems in Pennsylvania cut hospital admissions by 20% and costs by 7%.<sup>15</sup></li> <li>▪ The North Carolina Chronic Disease Management collaborative produced cost savings of \$957,493 for a sample of 2,745 patients through the use of chronic disease registries. The program also reduced costly complications, for example, average A1c levels decreased by an amount that is predicted to result in an 8% reduction in diabetes deaths, a 6%</li> </ul>	<p>This strategy will benefit from the supporting and cross-cutting tactics identified in Strategy #1. In addition, to support the implementation of the Patient Centered Medical/Health Care Home in Ohio, the following tactics should be pursued:</p> <p>a. Encourage and reward efforts to inform providers of the need for primary care reform and the characteristics of a Patient-Centered Medical/Health Care Home.</p> <p>b. Develop a standard definition of medical home and standard measures to determine whether providers meet this definition. This definition should be broad enough to allow innovation and encompass various models that provider medical/health care home services to their patients.</p> <ul style="list-style-type: none"> <li>▪ Discuss and determine where the Medical/Health Care Home for consumers with Serious Mental Illness (SMI) should be based (e.g., primary care physician,</li> </ul>	<p>This strategy will benefit from the supporting tactics identified in Strategy #1.</p>	<p>Number of patient centered medical homes in state.</p> <p>Annual cost/patient in medical homes vs. average annual cost in other settings.</p> <p>Various chronic disease indicators, medical home vs. state average in other settings.</p> <p>Patient satisfaction.</p> <p>Compliance with care plans.</p> <p>Hospital admission and readmissions, including costs.</p> <p>Emergency room visits, including cost.</p> <p>Primary care staff satisfaction.</p>

	<p>reduction in heart attacks, a 5% reduction in stroke, a 17% reduction in amputations and a 10% reduction in renal failure.<sup>16</sup></p> <p>Research based on a sample of 291 medical groups of 20 or more physicians shows that adoption of medical home infrastructure is low, with large groups having the highest levels of adoption. In general, very large organizational size is strongly associated with greater PCMH structure. Ownership by a larger entity – a hospital or HMO – is associated with increased PCMH infrastructure compared with physician-owned groups.<sup>17</sup></p>	<p>psychiatrist).</p> <p>c. Coordinate lessons from current demonstrations of PCMH models in Ohio and across the U.S.</p> <p>d. Consider specific support for demonstration projects targeted at small practices and rural providers.</p> <p>e. Consider specific support for demonstration projects targeted at high need or vulnerable populations.</p> <p>f. Develop a sustainable financing model that supports implementation of Medical/Health Care Homes services. (see supporting and cross-cutting tactics in Strategy #1)</p> <p>g. Partner with other purchasers of health care to develop a uniform set of standards or common measures of clinical performance outcomes.</p> <p>h. Consider how best to provide adequate funding for technical support, education, and dissemination of best practices to support patient-centered primary care re-design.</p>		
<p><b>3. Expand the use of care management models (e.g., PACE,</b></p>	<p>Seventy-five percent of those age 65 and older have at least 1 chronic condition, and 50% have at least 2.<sup>18</sup></p> <p>This group has an average of 13 doctors and</p>	<p>a. Determine where care management models such as PACE, Managed Care Special Needs Plans and After Discharge Care Coordination fit into Ohio's</p>	<p>This strategy will benefit from the supporting and cross-cutting tactics identified in Strategy #1.</p> <p><b>a. Workforce Development:</b></p>	<p>Number of PACE sites in Ohio.</p> <p>Number of consumers being served by PACE</p>

<p><b>Medicare Special Needs Plans, After Discharge Care Management) that support the acute, chronic and long-term care needs and preferences of consumers, and facilitate transition between settings (e.g., hospital, home, long term care).</b></p>	<p>fill 50 prescriptions per year.<sup>19</sup></p> <p>Older adults receive the care that is recommended less than 50% of the time<sup>20</sup>:</p> <ul style="list-style-type: none"> <li>▪ End of Life Care (9%)</li> <li>▪ Falls (34%)</li> <li>▪ Dementia (35%)</li> <li>▪ Osteoarthritis (31%)</li> <li>▪ Depression (31%)</li> <li>▪ Pneumonia (49%)</li> <li>▪ Heart disease (55%)</li> </ul> <p>For frail elders with geriatric syndromes, e.g. falls, dementia, urinary incontinence, less than 30% receive best practice, evidence-based care.<sup>21</sup></p> <p>There are currently 7,128 certified geriatricians in the US -- one geriatrician for every 2,546 Americans 75 or older. Due to the projected increase in the number of older Americans, this ratio is expected to drop to one geriatrician for every 4,254 older Americans by 2030.<sup>22</sup></p> <p>It has been proven that interdisciplinary care management that integrates medical and social care improves elderly patients' overall health and well-being.</p>	<p>managed care and long-term care strategies.</p> <p>b. Implement the recommendations related to easing the transition from acute care to long-term care made by Ohio's Unified Long-term Care Budget Workgroup:</p> <ul style="list-style-type: none"> <li>• Leverage the existing long term care consultation program through the Area Agencies on Aging to encourage advance planning and meaningful choice prior to a consumer's transitioning from acute care to long-term care.</li> <li>▪ Regional long-term care collaborative should develop strategies to focus on "critical pathways" (hospital, skilled nursing facilities that provide short-term care) in a way that leverages existing relationships within each community.</li> <li>▪ Explore models such as Pennsylvania's fast track eligibility determination process and requirement that providers begin care within 24 hours of a referral.</li> <li>▪ Develop a mechanism between the managed care system and the long-term supports system to enhance coordination for</li> </ul>	<p>Support and implement provisions in the Caring for an Aging America Act of 2008 (S.2708/H.R.6337).</p> <ul style="list-style-type: none"> <li>• Build a cadre of health professionals trained in the care of older adults by linking educational loan repayment to a service commitment to the aging population.</li> <li>• Expand career advancement opportunities for direct care workers in long-term care settings.</li> </ul>	<p>sites.</p> <p>Number of hospitals that have after discharge care planning programs.</p> <p>Number of hospitals that engage in interdisciplinary care management.</p> <p>Number and persons covered under Managed Care Special Needs Plans.</p> <p>Number of Unified Long Term Care Budget Work Group Recommendations implemented.</p> <p>Annual cost/patient in medical homes vs. average annual cost in other settings.</p> <p>Various chronic disease indicators, medical home vs. state average in other settings.</p> <p>Patient satisfaction.</p> <p>Compliance with care plans</p> <p>Hospital admission and readmissions, including costs</p> <p>Emergency room visits, including cost.</p>
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		<p>consumers and efficiently manage cost of care.  <a href="http://goldenbuckeye.com/ultcb/">http://goldenbuckeye.com/ultcb/</a></p> <p>c. Encourage and reward use of care transitions tools and models, such as The Care Transitions Program<sup>SM 23</sup> and Summa Health System's Care Coordination Network.</p> <p><a href="http://www.caretransitions.org/">http://www.caretransitions.org/</a></p> <p><a href="http://www.commonwealthfund.org/innovations/innovations_show.htm?doc_id=520262">http://www.commonwealthfund.org/innovations/innovations_show.htm?doc_id=520262</a></p>		Primary Care Staff satisfaction.
<p><b>4. Improve and support the integration of inter-related specialties and therapies such as pain management, palliative care and mental health care into chronic care management.</b></p>	<p><b>Pain Management.</b> Untreated or undertreated pain is a growing public health problem and a leading cause of disability. Just over one-quarter of American adults – or, an estimated 76.5 million Americans – report that they have has a problem with pain that persisted for more than 24 hours in the past month. Notably, 57% of older adults who reported pain indicated that the pain lasted for more than one year.<sup>24</sup></p> <p>Chronic pain remains undertreated and poorly understood by physicians, even though recent healthcare policy has recognized pain as the fifth vital sign. Among the most common reasons why physicians are unwilling to treat patients with chronic pain are: fear of creating addiction, poor knowledge, service delivery constraints and concerns for patient motivation and adherence.</p> <p>Research shows that use of workshops that include didactic presentations and case-based learning at the physicians' office improved practitioners' ability to support the</p>	<p><b>Pain Management</b></p> <p>a. Require medical schools and others that train primary care practitioners to integrate pain management into their curriculums.</p> <p>b. Encourage professional medical /health care organizations to increase knowledge about pain management and provide primary care practitioners with necessary tools to appropriately prescribe pain medications, e.g., Case Western Reserve University's Practice Physicians Program for Chronic Pain (4PCP).</p> <p>c. Establish patient education programs that provide information, such as how to safely use medications, store medications to avoid unauthorized use by others,</p>	<p>This strategy will benefit from the supporting and cross-cutting tactics identified in Strategy #1.</p>	<p>Number of medical schools that include expand pain management in their curriculums.</p> <p>Number of practitioner education opportunities available.</p> <p>Number of primary care practitioners that participate in pain management related continuing education.</p> <p>Number of state level recommendations established by the National Association of State Mental Health Program Directors, Medical Directors Council implemented.</p> <p>Number of patient</p>

	<p>pain management needs of patients.<sup>25</sup></p> <p><b>Integration of Physical and Mental Health Care.</b> Evidence reveals that the rate of serious morbidity and mortality in the population with serious mental illness has accelerated. In fact, persons with serious mental illness (SMI) are now dying 25-30 years earlier than the general population, largely due to treatable medical conditions that are caused by modifiable risk factors such as smoking, obesity, substance abuse, and inadequate access to medical care.<sup>26</sup></p>	<p>understand expectations for therapeutic adherence and communicate with providers.</p> <p>d. Work with the media and elected officials so they better understand pain management and opioid use so they do not cast a negative light on the subject.</p> <p><b>Integration of Physical and Mental Health Care.</b></p> <p>e. Endorse and begin implementing the proposed state level recommendations established by the National Association of State Mental Health Program Directors, Medical Directors Council to address Morbidity and Mortality in People with Serious Mental Illness.</p> <ul style="list-style-type: none"> <li>▪ Prioritize the public health problem of morbidity and designate the population with SMI as a priority health disparities population.</li> <li>▪ Improve access to physical health care.</li> <li>▪ Promote coordinated and integrated mental health and physical health care for persons with SMI.</li> <li>▪ Support education and Advocacy, including developing guidelines to support providers, forming self-help/peer support networks and involving academic and</li> </ul>		<p>education opportunities available</p> <p>Number of primary care practices using Palliative Care Guidelines.</p> <p>Number of Palliative Care Consultation Teams.</p>
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		<p>association partners in planning and conducting training.</p> <ul style="list-style-type: none"> <li>▪ Assure financing methods for service improvements, including reimbursement for coordination activities, case management, transportation and other supports to ensure access to physical health care services.</li> <li>▪ Develop a quality improvement (QI) process that supports increased access to physical health care and ensures appropriate prevention, screening and treatment services.</li> </ul> <p>f. Promote the use of guidelines from the National Hospice and Palliative Care Organization that can help the clinician determine whether a hospice referral would be helpful.</p> <p>g. Promote the use of Palliative Care Consultation Teams that can provide assistance to physicians in caring for the sickest patients with the most complex illnesses.</p>		
<p><b>5. Recognize and promote the centrality of self-management to good patient care, and</b></p>	<p>Around 90% of the care a person needs to manage a chronic disease must be self-directed. Evidence is growing that self-management interventions, such as self-monitoring and decision making, lead not only to improvements in health outcomes and health status, but also to increased patient satisfaction and reductions in hospital</p>	<p>a. Identify, develop and disseminate evidence-based self-management practices and programs.</p> <ul style="list-style-type: none"> <li>▪ Develop a statewide training infrastructure to support local implementation of at least</li> </ul>	<p>This strategy will benefit from the supporting tactics identified in Strategy #1.</p> <p><b>a. Value Purchasing.</b> Bulk purchase and provide communities with evidence-based self-management support materials and</p>	<p>Number of evidence-based disease self management programs available on a statewide basis.</p> <p>Number of referrals made by primary care</p>

<p><b>incorporate this recognition into the health care culture.</b></p>	<p>and emergency room costs.</p> <p>Self-management support is part of a set of strategies to improve chronic disease care and curb the escalating economic and public impact of chronic illness. Through their daily decisions about diet, exercise, self-measurement, and medications people with chronic illness play a central role in determining the course of their disease. They need the support of their health care providers to make and sustain changes in these areas. While many health care organizations are interested in helping their patients manage their chronic conditions, those organizations need new organization capacity, clinical skills and strategies to be able to do so.<sup>27</sup></p> <p>There are many evidence-based chronic disease self-management tools and programs that have proven outcomes and are being implemented in community and health care settings. The Chronic Disease Self- Management Program (CDSMP), developed by the University Stanford Patient Education Research Center, is a flagship program being funded by federal agencies, health care systems and foundations, and endorsed by many disease specific organizations. The CDSMP is being implemented in many settings in Ohio.</p> <p>Research supports the efficacy of the CDSMP:</p> <p>Investigators from the Agency for Healthcare Research and Quality compared health behaviors, health status, and health services use in patients age 40 to 90 years (average age 65) who had completed the CDSMP. When compared to baseline measures taken for the 6 months prior to the CDSMP,</p>	<p>three evidence-based disease prevention and health promotion programs (e.g., chronic disease self-management, physical activity, nutrition, falls prevention, depression).</p> <ul style="list-style-type: none"> <li>▪ Increase the number of employer sponsored self-management programs.</li> </ul> <p>c. Determine the best methods for linking primary care practitioners with community-based, evidence-based self-management programs.</p> <ul style="list-style-type: none"> <li>• Determine the most appropriate role(s) (e.g., prescriber, provider, evaluator) the primary care practitioner should play in the implementation of a self-management program.</li> <li>• Incorporate evidence-based self-management recommendations and local referrals in patient registries.</li> <li>• Ensure that patient participation in self-management programs is tracked and recorded in the patient’s electronic health record either directly by the patient and/or community provider and that the patient and primary care practitioner can track progress.</li> </ul>	<p>training. (e.g., workbooks, licenses)</p>	<p>practitioners.</p> <p>Number of employer sponsored self-management programs.</p> <p>Annual cost per patient participating in an evidence-based self-management program vs. state average.</p> <p>Patient satisfaction.</p> <p>Compliance with care plans.</p> <p>Hospital admission and readmissions, including costs.</p> <p>Emergency room visits, including cost.</p> <p>Primary Care Staff satisfaction.</p>
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	<p>researchers found that CDSMP participants had:</p> <ul style="list-style-type: none"> <li>• Increased exercise.</li> <li>• Better coping strategies and symptom management.</li> <li>• Better communication with their physicians.</li> <li>• Improvement in their self-rated health, disability, social and role activities, and health distress.</li> <li>• More energy and less fatigue.</li> <li>• Decreased disability.</li> <li>• Fewer physician visits and hospitalizations.</li> </ul> <p>Cost research shows that the CDSMP saved from \$390 to \$520 per patient over a 2-year study period because participants used fewer health care services. CDSMP participants used less hospital and physician services than they had used before participating in the program, and less than those who had not participated in the CDSMP control group.<sup>28</sup></p>	<ul style="list-style-type: none"> <li>• Provide incentives/rewards to primary care practitioners whose consumers benefit from participating in community-based self-management programs.</li> </ul> <p>d. Provide consumer incentives/rewards for the appropriate use of self-management supports.</p>		
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<sup>1</sup> Note: suggested tactics are examples only, derived from a general literature review and survey of other states' initiatives and policy brainstorming; further work is needed to: (1) determine the extent to which these tactics are already under development or in progress in Ohio through, for example, the quality collaborative of the OHA; (2) probe the merit and viability of these tactics; and, (3) assess which mix of tactics would work best in Ohio.

<sup>2</sup> Note: disparities could include, but are not limited to, the following examples: age, culture, disability, ethnicity, gender, geography, race, religion, and sexual orientation.

<sup>3</sup> Note: suggested tactics are examples only, derived from a general literature review and survey of other states' initiatives and policy brainstorming; further work is needed to (1) determine the extent to which these tactics are already under development or in progress in Ohio through, for example, the quality collaborative of the OHA, (2) probe the merit and viability of these tactics, and (3) assess which mix of tactics would work best in Ohio.

<sup>4</sup> Partnership for Solutions, *Chronic Conditions: Making the Care for Ongoing Care*, September 2004 Update. Available at <http://www.rwjf.org/files/research/Chronic%20Conditions%20Chartbook%209-2004.ppt>.

<sup>5</sup> DeVol, Ross and Bedrousson, *An Unhealthy America: The Economic Burden of Chronic Disease*, Milken Institute, October 2004.

<sup>6</sup> DeVol, Ross and Bedrousson, *An Unhealthy America: The Economic Burden of Chronic Disease*, Milken Institute, October 2004.

<sup>7</sup> McGlynn E et al, "The quality of health care delivered to adults in the United States," *New England Journal of Medicine*, 2003 June 26; 348 (26):2635-45.

<sup>8</sup> Wennberg JE, Fisher E, and Skinner J., "Geography and Debate over Medicare Reform." *Health Affairs*, February 2002, Web exclusive, <http://healthaffairs.org>.

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- <sup>9</sup> Wennberg JE, Fisher E, Goodman D and Skinner J, *Tracking the Care of Patients with Severe Chronic Illness: The Dartmouth Atlas of Health Care 2008*, The Dartmouth Institute, April 2008.
- <sup>10</sup> Coleman EA, “Falling Through the Cracks: Challenges and Opportunities for Improving Transitional Care for Persons with Continuous Complex Needs”, *Journal of the American Geriatric Society* (2003) 51, 549-555.
- <sup>11</sup> Friedmann B and Basu J, “The Rate and Cost of Hospital Readmissions for Preventable Conditions” *Medical Care Research and Review* 61, 225-240.
- <sup>12</sup> Coleman E A, Perry C, Chalmers S, et al, “The care transitions interventions: results of a randomized controlled trial,” *Arch Internal Medicine*, 2006 166 (17): 1822-8. Also available at <http://www.caretransitions.org/documents/RCT.pdf>
- <sup>13</sup> Schoen C, Osborn R, and Hugn PT, et al. *Taking the Pulse of Health Care Systems: Experiences of Patients with Health Problems in Six Countries*, The Commonwealth Fund, Health Policy, Health Reform, and Performance Improvement, November 3, 2005/Volime 16. Available at: [http://www.commonwealthfund.org/publications/publications\\_show.htm?doc\\_id=313012](http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=313012) .
- <sup>14</sup> The Robert Graham Center: Policy Studies in Family Medicine and Primary Care, American Academy of Family Physicians, *Physician Supply and Demand Consultation to the Ohio Board of Regents*, February 25, 2007.
- <sup>15</sup> Fox M, “Medical “home” plan cut hospital admission: study”, *Reuters*, September 10, 2008.
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