While the goal of health care is to achieve low-cost, high-quality care and patient satisfaction, “it is a complex road to get there,” said Dr. Barbara Wirth, program manager with the National Academy for State Health Policy, during a Chronic Disease Policy Academy held in conjunction with The Council of State Governments 2013 National Conference.

Health homes, an enhanced model of primary care first introduced in the 1960s, can be used to improve care and lower costs. According to Wirth, health homes create teams of clinical and nonclinical workers that view the person as a whole.

“The ultimate goal is to have a team approach where patients are linked with the appropriate processes they need,” Wirth said.

Key health home model features include:

- Multi-stakeholder partnerships, including specialty care providers and supportive social services;
- Qualification standards, including established goals such as decreased emergency room visits;
- Standards tied to payments;
- Clinical and nonclinical staff team;
- Care including chronic, acute and mental health;
- Health information technology—health homes need to maintain patient information, but also be able to communicate with other health services such as the emergency room;
- Data and feedback to ensure evidence-based medical practice with electronic medical records accessible by all practitioners treating the patient; and
- Practice education—Wirth points to practice education as the cornerstone component of health homes. Staff from one practice meets with other practices to share information and determine what works and what doesn’t.

As Wirth outlined the key components and usefulness of health homes, she reminded legislators these changes take years.

“It is a marathon, not a sprint,” she said.

Wirth also let legislators in on a secret to health home success. While health homes need an interdisciplinary team for success, she identified nurse care managers as the “secret sauce for success.” Nurse care managers are a steady point of contact and care for the patient.
Dr. Joseph Parks, chief clinical officer for the Missouri Department of Mental Health, agreed on the importance of care managers. He also said if states want to reach the low-cost, high-quality care goal, they must focus on mental health and its impact on chronic disease.

The differences between mortality rates for the general population and for those with a mental illness are staggering. According to Parks, people with mental illness die 25 years younger than the general population, on average. The main cause of death for people with mental illnesses was general health conditions.

Parks also said people with a mental illness are more likely to be obese and “smoke at rates equivalent to the 1960s.”

Of the population of smokers, 44 percent of them have a mental illness.


According to Owens, common issues are lack of treatment, patients not taking medications, unmet clinical goals, uncoordinated care with multiple providers, and avoidable emergency room and hospital visits.

Owens also posed a question to legislators: “We hear about super utilizers and high-cost patients. Should we focus all efforts on that population?”

Her answer was a resounding no.

She said states need to focus on patients with uncoordinated care in all cost brackets. Patients in the low cost bracket with uncoordinated care eventually move to higher cost brackets after several years of uncoordinated care. According to Owens, if states only focus on the high-cost super utilizers, they will not prevent the low-cost uncoordinated care patients from eventually moving into the high-cost group.

Owens said policy improvements like automatic refills and refill reminders improve patients’ adherence to drug therapy, as do simplified regimens and medications with fewer side effects. Research shows that half of all patients taking maintenance medications for a chronic disease stop taking their medications within a year of starting therapy. The CVS Caremark Pharmacy Care Research Institute estimates that excess medical costs are as much as $290 billion annually due to medication nonadherence.

“Support policies that get providers to work together,” said Owens. “Measure success and reward them.”

Raechelle McMahan, with Aetna Pharmacy, offered three suggestions to control costs for specialty drugs, which can cost $3,000 per month on average, as compared to traditional drug costs of $60 per month.

One cost-control step is to implement quantity limits. This allows the pharmacy to give new patients a 28-day supply to determine how the patient reacts. It also allows the pharmacy to follow up and make sure the patient is taking his or her medication. After determining the medication is right for the patient, automatic refills and 90-day supplies can be implemented.

Another method to control costs is step therapy, which encourages patients to take the lower cost drug first. If the lower cost medication is not effective, patient care be stepped up to more expensive
drug options.

Prior authorization also contains costs. It ensures the medication is appropriate for the patient and that it has desired outcomes.

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