A Bipartisan, Consensus Approach to Health Care Reform:

Recommendations to Congress and the Administration on Health Care Reform

America's Agenda
Health Care for ALL

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America's Agenda and its member organizations are committed to a common mission: achieving guaranteed access to affordable, high quality health care for every American.

Yet expansion of quality health care to millions of uninsured and underinsured Americans is not sustainable while health costs rise at rates that undermine living standards of working families, undercut employer profits, and put American businesses at a competitive disadvantage in the global economy. A study by the Henry J. Kaiser Family Foundation finds that premiums for employer-sponsored health insurance in the United States have been rising four times faster, on average, than workers' earnings since year 2000. Over roughly the same period, employer contributions to family health insurance plans have more than doubled.

Too often, labor and employer relations have often been marred by conflict over cost shifting as the health cost burden grows. In recent years, relentless inflation in health costs has created a shared interest among U.S. businesses and labor in reducing the overall rate of growth in health costs, which is severely jeopardizing the wellbeing of each. This historic realignment of business and labor interest in reforming a highly inflationary health care system creates an unprecedented opportunity to transform a fragmented and inefficient U.S. healthcare delivery system into a coordinated system that can drive down the rate of cost growth while enhancing the quality of care. These objectives are becoming the glue that is uniting stakeholders who were adversaries in past reform efforts behind a common approach to health cost containment.

The emerging consensus over reform of America's health care delivery system has consolidated around a common understanding of three major drivers of health costs:

1. There is epidemic growth of chronic disease in the U.S. population. At least 75% of overall health spending is associated with treatment of chronic disease. In Medicare, 95 cents of each health care dollar is spent on treatment of chronic disease. The number of Americans with costly chronic diseases such as heart disease, diabetes, and hypertension is rising sharply. There is a significant acceleration in prevalence of chronic conditions among juveniles.

2. More Americans are receiving more expensive care, but outcome measures show that more expensive care isn't necessarily better care. In fact, a Rand Corporation study shows that chronically ill patients receive only 56% of clinically-recommended services.

3. In large part, the administration of U.S. health care is inefficient and costly, draining valuable dollars away from provision of quality care.

Over the past 15 years, private employers, health care providers, and state governments have acquired substantial experience in managing rapidly rising health costs. Although the scale of private enterprises, health providers, state, and local governments is too small to neutralize systemic drivers of health costs over time, private sector and state government experience in managing the impact of major cost drivers is instructive for the design and enactment of effective federal legislation.

The recommendations below represent a growing consensus about how the major cost drivers can be countered through enactment of health reform policies that will prevent and effectively manage chronic disease, develop evidence-based strategies for continuous quality improvement, align incentives for health system actors to adopt healthy and cost-saving behaviors, and harness health information technology to reduce administrative inefficiency and enhance coordination and quality of care.

Disease Prevention

Substantial federal funding needs to be invested in prevention of preventable disease, particularly chronic illnesses. We cannot expect to sustainably constrain health care cost growth if obesity and chronic disease rates continue to escalate. For instance, the number of diabetes cases grew by 40% over the past decade. Spending for diabetes accounted for 38% of the increase in health care spending between 1987 and 2001, hyperlipidemia for 22% and heart disease for 41%. According to the CDC, more than one-third of adults in the U.S. are obese, and two-thirds are either obese or overweight – which is roughly double the obesity rate of 20 years ago. One study found that obesity accounted for 27% of the rise in per capita healthcare spending between 1987 and 2001.

Current Congressional Budget Office (CBO) scoring conventions fail to reflect the health system savings that would be generated by targeted investment in disease prevention despite the World Health Organization calculation that at least 80% of all heart disease, stroke, and type II diabetes and up to 40% of cancer could be prevented if people ate healthier, exercised, and stopped using tobacco.

The truth that substantial savings will result from sustained investment in disease prevention is further supported by more than 15 years of extensive private sector experience in designing and implementing disease prevention and wellness programs that have generated significant returns on investment. A study by the National Business Group on Health found that employers can receive a three-to-one return on investment as a result of implementing comprehensive prevention and health improvement programs. Federal policy should be informed by these lessons of successful private sector experience.

An enhanced federal focus on prevention and chronic care should:

1. **Establish a national strategic plan for chronic disease prevention and preventive services. The Secretary of HHS should establish a new office dedicated to chronic disease prevention.** This office should ensure both inter-agency and intra-agency coordination and collaboration, and develop and implement a national strategic plan to prevent chronic disease that focuses on both the public health and clinical components of disease prevention. The plan should be developed in consultation with a wide array of private sector stakeholders including, but not limited to, patient groups, provider organizations, small and large employers, educators, and payers with the goal of identifying promising private sector practices and opportunities for public-private sector partnerships. The resulting plan should include measurable goals and objectives, and be updated every two years.

2. **Collect data and regularly report progress toward health goals.** The Secretary should develop a process to measure the number of individuals with key chronic conditions who receive coverage through federal health programs, identify and collect demographic and de-identified health data to detect and monitor trends in key health status indicators, such as number of primary care visits and percent of individuals with the chronic conditions who receive recommended services, among others. The Secretary should use the data to report on progress toward the goals identified in the chronic disease prevention strategic plan to appropriate congressional committees and the public every two years.

3. **Establish a new federally-sponsored, national public health campaign to turn the tide on obesity.** This campaign must be equal in commitment, scale, and intensity to the campaign that led to a dramatic decline in smoking. Campaigns that focus on early intervention targeted at schools and in the community hold promise in stemming this growing public health threat. In addition to promoting better health, studies suggest that slowing the rise in obesity would result in considerable cost savings – over $400 billion over 10 years according to a Commonwealth Fund report – while beginning to turn it back could yield even larger benefits.

4. **Establish federal funding for comprehensive coordinated national anti-smoking campaign.**

5. **Provide incentives, such as challenge grants, for state and local public health departments, schools, and community-based organizations to implement health promotion programs based on proven best practices.** Federal grant funding can be used to help public schools create more healthy environments for children – including improving nutritional standards, increased financial support for physical education, as well as providing school-based health screening programs and access to clinical services. In addition, standards for federal programs – such as the school lunch program – should be strengthened to assure better nutritional quality. Finally, federal grant funding should help promote healthier communities as well as make needed investments in comprehensive wellness and educational campaigns that promote healthy lifestyles.

6. **Create tax or other incentives for employers to help support adoption of evidence-based wellness and health promotion programs.** Legislation has been introduced in Congress that would provide a tax credit for employers that offer qualified wellness programs – that is, programs that meet standards consistent with evidence-based research and best practices. Employer-sponsored wellness programs that seek to engage employees in taking charge of their health and health care by offering comprehensive screening services and encouraging healthy lifestyles hold promise in improving employees' health and productivity and can be part of a comprehensive, national strategy to improve overall health and reduce costs.

7. **Create incentives in federal and private health plan programs to support active patient involvement in preventing chronic disease.** These incentives should encourage health plan efforts to improve health education and literacy, make preventive care more convenient and improve compliance through preventive care reminder programs. The program should also reward patient efforts to seek preventive care such as elimination of cost sharing for recommended preventive services.

8. **Increase financial support for the nation's essential public health infrastructure.** State and local health departments are the front lines in the battle to achieve healthier behaviors and better treatment of chronic disease. Yet this infrastructure is badly in need of additional resources to meet the growing challenge.

9. **Provide federal financial support for the formation and development of community-based prevention treatment and resources.** These resources are designed to integrate public health and primary prevention initiatives (diet, exercise, weight loss, smoking cessation, depression screening and treatment) with the more traditional health care treatment of children and adults in a community.[1]

10. **Ensure coverage of preventive services such as those recommended by the U.S. Preventive Services Taskforce or other appropriate entities in federally-funded or federally-supported health programs (i.e. Medicare, Medicaid, SCHIP, health plans participating in FEHBP, and any newly-created federal program).**

11. **Reduce or eliminate cost-sharing (co-payments and deductibles) for recommended preventive services in federally-funded or supported health programs.**[2] Cost-sharing discourages utilization of medical services. While this may make sense in some cases, it does not make sense for prevention. Early detection improves patient outcomes and reduces the need for costly interventions, so patients should be encouraged to seek preventive services.

Endnotes

[1] An example of such a resource is the Diabetes Prevention Program (DPP) lifestyle intervention program at YMCA locations. A formal curriculum was developed to train community workers to deliver a group-based adaptation of the DPP model at YMCAs. People who were at risk of developing diabetes who participated in the DPP program at a YMCA lost an average of six percent of their body weight and kept the weight off for a year. They also reduced their

cholesterol levels. More than 40 million U.S. families living within three miles of a YMCA and if the DPP program was implemented across the country, Dr. Ronald Ackerman of the Indiana University School of Medicine estimates the need for adult diabetes management could be reduced by 113 million member months by 2020.

[2] Throughout this paper, the term "federally-funded or supported health insurance programs" refers to Medicare, Medicaid, SCHIP, health Plans participating in FEHBP, and any newly-created federal programs.

Chronic Disease Management

Our current health system presents multiple challenges to the effective and efficient care of chronically ill patients. First, the fragmented nature of our system means patients have multiple care providers who do not consistently communicate with each other, and are not individually or collectively responsible for the totality of patients' care. Second, healthcare is centered around care in a doctors' office or hospital, while evidence shows the overwhelming proportion of the care needed by chronically ill patients takes place at home and in the community. Third, our predominant provider payment systems reward high-cost medical interventions over higher-value primary care; they reward volume of care over quality of care. Fourth, the trend toward patients assuming higher burdens of cost sharing (i.e. deductibles and co-pays) in the health insurance market creates disincentives to patient utilization of chronic disease diagnosis and treatment services that contribute to effective disease management and cost control.

The following policy recommendations are designed to reduce costly inefficiencies in delivery of chronic disease care by reducing duplication of services and provision of inappropriate care, and to improve care coordination that leads to better health outcomes:

1. **Establish a public-private National Commission on Chronic Disease Management.** The Commission will advise the Secretary of HHS and the appropriate Congressional committees regarding effective strategies to improve coordination and quality of care for the millions of Americans who suffer from chronic conditions. The Commission will identify opportunities for public-private collaboration to improve treatment related to chronic disease, and review and commission health services

research to evaluate the effectiveness of alternative approaches to organizing, delivering, and managing evidence-based interventions to support delivery of care that are known to be effective.

2. **Require that within five years, all federally-funded or supported health programs offer a patient-centered medical home (or similar health care delivery model[3]) option to every beneficiary.**

   The "patient-centered medical home" is emerging as a leading model for efficient management and delivery of quality care (particularly to an increasingly chronically ill U.S. population), because it links multiple points of health delivery by utilizing a team approach with the patient at the center. A report by the Commonwealth Fund estimates that encouraging adoption of medical homes in Medicare would save $175 billion over 10 years.

   An ideal medical home setting emphasizes primary care, utilizes interoperable electronic records to maximize coordination, and involves the patient in decision making to maximize adherence to care plans. A medical home also emphasizes enhanced care through open scheduling, expanded hours and communication between patients, physicians and staff. Some variations broaden the patient-centered medical home model beyond the physician's office and into the community and the patients' home.

   The National Committee for Quality Assurance (NCQA) has designed a program to assess how medical practices are functioning as patient-centered medical homes. The program emphasizes the systematic use of patient-centered, coordinated care management processes. The NCQA standards are aligned with the joint principles of the American Academy of Family Physicians (AAFP), the American Academy of Pediatrics (AAP), the American College of Physicians (ACP) and the American Osteopathic Association (AOA), which define the key characteristics of the patient-centered medical home. (Principles are listed in *Appendix 1*).

   Patients with chronic conditions require additional care management services to avoid progression of their disease and should be encouraged to participate actively in their own care. Comprehensive disease management programs offered within a medical home environment have demonstrated promise to provide individuals with severe/or multiple chronic health conditions with interventions and support appropriately tailored on the seriousness and severity of the patient's medical condition, patient preferences, and needs. A medical home (or similar health care delivery model) providing care to beneficiaries of federally-funded or supported health programs should assure that patients diagnosed with a chronic disease care can participate in a qualified chronic disease management program.

3. **Align provider and patient incentives to form and join high performance health care delivery organizations and reward compliance with best practice guidelines for prevention and treatment of chronic disease within those organizations.**

Provider Incentives:

Fee-for-service reimbursements, which incentivize volume over value of services should be changed to a system of reimbursements that incentivize provisions of sets of services that conform to best-practice guidelines established by professional consensus and based on evidence. To advance this objective, we propose the following provider incentives:

a) Incentivize formation of medical homes by providing medical homes (and similar health care delivery models) a per-member, per-month bonus for each enrolled beneficiary of a federally-funded or supported health program.

b) Further incentivize formation of Community Health Teams (CHTs) by providing federal grants, or sharing in per-member, per-month bonuses for supporting provision of physician or medical home primary care to beneficiaries of federally-funded or supported health programs.

   A CHT is a team of allied health professionals, including behavioral/mental health specialists, community outreach/prevention specialists (responsible for linking the patient-centered medical home or primary care practice with community-based prevention resources), nurse care coordinators (such as nurse practitioners) that provide multidisciplinary care support to primary care practices across a community. Their goal is to provide expertise designed to prevent disease and provide higher quality lower cost health care particularly targeting chronically ill patients. Further information about CHTs can be found in *Appendix 2*.

c) Provide bonuses to primary care physicians practicing in medical homes (or similar health care delivery models), who exceed benchmarks for consensus-based quality measures such as a reduction in ER visits, reductions in ambulatory sensitive admissions, reduction in 30-day readmissions, and percentage of patients who receive condition-appropriate medical services such as annual eye exams, HbA1g tests.

d) Expand Medicare's hospital quality incentive demonstration program to all hospitals.

   Even as lessons of current demonstration programs are integrated into design of the health care delivery system, expanding this voluntary program to all hospitals – and rewarding hospitals that consistently provide high-quality care based on consensus-based standards - holds promise for developing and improving a quality-based hospital payment system. It would also provide important incentives for hospitals to improve the quality of care they provide to their patients.

e) Allow providers to share in the financial savings associated with better care through formation of regional Accountable Care Networks.

   In our current health care system, medical providers often operate in silos with no

one provider responsible for a patient's medical outcome.

f) Providers that form regional Accountable Care Networks should be eligible for gain-sharing bonus payments if they 1) reduce the per capita growth in federally-funded or supported health insurance plan spending in their region, 2) they reduce hospital readmission rates , and 3) show continued improvement in clinical preventive treatments for chronically ill patients (*i.e.* annual eye exams, HbA1g tests).

Accountable Care Networks – a formal regional grouping of medical providers in which physicians (multispecialty), hospitals, medical homes, CHTs and other care providers are linked together and provide team-based care that includes coordination of transitions between patient care settings – hold promise for helping to promote more accountability improving care quality and controlling wasteful spending. The above-listed incentives encourage members of the Accountable Care Network to coordinate to fulfill this promise.

Patient Incentives:

The patient-centered medical home has demonstrated promise for significantly improving efficient management and delivery of quality care, particularly to an increasingly chronically ill U.S. population. In order to encourage beneficiaries of federally-funded or supported health programs to elect care of this quality, we propose the following patient incentives:

a) Waive all cost-sharing for all recommended preventive and clinically-recommended chronic disease management services for federally-funded or supported health program beneficiaries who opt to receive care through a patient-centered medical home (or similar health care delivery model).

b) Discount premiums for beneficiaries of federally-funded or supported health program who are diagnosed with chronic disease and elect to enroll in a qualified medical home chronic disease management program. Continuation of the premium discount would depend on ongoing patient compliance with his/her care plan.

4. Strengthen the primary care workforce

Transforming chronic disease management in the health care system requires a new emphasis on primary care and depends on the availability of a robust primary care workforce, including physicians, nurses, social workers, care managers, dietitians, pharmacists, occupational therapists, and other allied health professionals. Investments aimed at increasing our primary care workforce are crucial to make care coordination through the medical home and disease management programs a reality. Therefore, we recommend:

a) Increase payments to primary care providers in federally-funded or supported health programs.

b) Expand loan forgiveness and tuition assistance programs that encourage

potential primary care practitioners to enter the field (e.g. retiring a portion of medical and nursing school debt per year of service as primary care physicians and allied health providers, subsidizing continuing education of nurses to become nurse educators).

Endnotes

[3] A "similar health care delivery model" refers to a small primary care practice that contracts with a Community Health Team or "CHT" for supplemental support needed to qualify, at a minimum, for NCQA classification as a Level I medical home. (*See "Community Health Team" defined in Recommendation #3.b of this section.*)

Strengthening the Evidence Basis for Best Practice Guidelines and Quality Standards

Despite our health system's many challenges and the significant increase in our population's health risk factors related to the obesity epidemic, clinical outcomes have significantly improved in recent years across a range of conditions, such as cardiovascular disease and many cancers. Ongoing medical innovation provides the potential to continuously improve medical outcomes and increase health care value. For example, the progress being made in genomics and related fields toward personalized medicine holds promise for creating more useful and individualized tools for predicting susceptibility to disease, disease prevention, and targeting of treatments more precisely to each patient based on genetic information and other factors.

At the same time, the U.S. healthcare system suffers from well-documented system-wide problems of sub-optimal quality and value of care. The United States spends more money per capita than any other industrialized nation, but evidence shows U.S. patients routinely fail to receive recommended treatment and care. Landmark studies by the RAND Corporation have found that adults in the United States receive recommended care only a little over half the time (54.9%), and children received just 47% of recommended care overall and only 41% of recommended preventive service.

To get better value from our health spending we need a better understanding of what works, for whom, under what conditions, and why. Then, we need to develop standards based on evidence and consensus, and encourage medical practitioners to provide care based on those standards.

Following are recommendations to aid in the development of evidence-based standards for

effective preventive care, disease treatment and delivery of health services:

1. **Establish and fully fund a national center focused on research regarding comparative effectiveness of alternative disease prevention and clinical treatment interventions.** An independent, national entity should be established and provided with gaps sustained, sufficient funding to address significant in evidence about "what works" in health care and improve the quality of patient care. To have a meaningful impact on improved health care value, while informing patient and physician decision-making from a range of health care options, such research should examine the full range of medical technologies and care delivery and management.

   For example, comparative effectiveness research can help reduce wide, inappropriate geographic variation in health care costs, which leads to an estimated $700 billion in wasteful spending, but only if it examines the range of factors that drive this variation – including evidence gaps related to medical technology, care delivery, management and organization.

   Similarly, the national center should also undertake health services research that promotes greater understanding of the wide range of factors (such as financial incentives, use of health information technology, health management and organization) that affect the translation of evidence into practice and whether patients receive evidence-based care.

2. **Develop evidence-based standards and quality measures for reporting.** Quality measures should continue to be developed through a clinically-based consensus process with the best available clinical and scientific evidence. Quality reporting based on these consensus-standards should be implemented in all federally funded or supported programs.

   Quality measures should be validated as achieving measurable, meaningful improvements in patient outcomes (for example, measures that encompass complete episodes of care), not simply drive changes in infrastructure or processes of care.

Health Information Technology and Continuous Quality Improvement

America's health information technology (HIT) network should transform health care into a learning system that has the capacity to instantaneously diffuse new medical information and innovations in technology or delivery models throughout the health care system, and make self-corrections (such as identification and correction of systemic sources of medical errors) to drive continuous quality improvement.

Cost reduction and quality improvement associated with effective care coordination requires linkage of health care providers and patients through a nationwide HIT network. Minimally, this will require development and application of standards that allow interoperability of medical records among providers. In addition, the national HIT network should:

- Provide decision support to health providers based on evidence-based guidelines
- Provide for e-prescribing of medications and tracking of patient compliance
- Provide provider and patient reminders for recommended care
- Reduce administrative costs associated with patient billing and adjudication of insurance claims
- Streamline paperwork requirements associated with provider credentialing
- Support telemetry (or remote monitoring) of care, in homes and in remote locales
- Assure privacy and security of patient medical records

To advance these objectives, legislation addressing Health Information Technology should:

1. **Accelerate development of standards and full implementation of interoperable**

medical record keeping throughout the health care system, with security protections to protect against inappropriate access or use.

2. Fund the development of standards for automated, electronic hospital medical error internal data collection that will identify and enable self-correction of systemic sources of medical errors.

   Adoption by hospitals should be required in an expedited time period and assistance for adoption should be provided where necessary. Hospital medical error statistics should be publicly reported.

3. Provide payment incentives for the use of decision support tools that provide physicians with reminders and guidance based on consensus-based quality measures. The Certification Commission for Healthcare Information Technology (CCHIT) will release initial certification standards for Advanced Clinical Decision Support in June 2010. A payment incentive program should be established by the release date in an effort to encourage providers to begin using the tools immediately.

4. Provide payment incentives for use of HIT in all federally-funded or supported health programs.

   The incentives should be modeled on Medicare, which incentivizes providers to use e-prescribing tools to prescribe medication and track patient compliance.

5. Move toward development of a common 100% electronic insurance claims form and bill coding system.

6. Incentivize insurers to resolve claims disputes through electronic methods.

7. Provide subsidies to state boards responsible for credentialing medical providers to encourage the use of health information technology rather than paper-based applications.

8. Provide federal subsidies for adoption of telemetry (or remote monitoring). Subsidies should be provided for distant care of patients in rural areas where there is scarcity of credentialed medical professionals as well as for adoption of telemetry in homes and where use can reduce the need for office visits and improve outcomes.

Access for All

America's Agenda and its member organizations are committed to achieving guaranteed access to affordable, quality health care for every American. Any newly-created federal coverage program or federally-supported health program should include the benefit design and delivery system reforms outlined in this paper.

Appendix 1:
Principles of the Patient-Centered Medical Home

The American Academy of Pediatrics, American Association of Family Physicians, American College of Physicians and American Osteopathic Association, representing approximately 333,000 physicians, have developed the following joint principles to describe the characteristics of the patient-centered medical home.

Personal physician: Each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care.

Physician-directed medical practice: The personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.

Whole-person orientation: The personal physician is responsible for providing for all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life, acute care, chronic care, preventive services and end-of-life care.

Care is coordinated and/or integrated across all elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient's community (e.g., family, public and private community-based services). Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.

Quality and safety are hallmarks of the medical home:

- Practices advocate for their patients to support the attainment of optimal, patient-centered outcomes that are defined by a care-planning process driven by a compassionate, robust partnership between physicians, patients and the patient's family
- Evidence-based medicine and clinical decision-support tools guide decision making
- Physicians in the practice accept accountability for continuous quality improvement through voluntary engagement in performance measurement and improvement
- Patients actively participate in decision-making and feedback is sought to ensure patients' expectations are being met
- Information technology is utilized appropriately to support optimal patient care, performance measurement, patient education and enhanced communication

1. Practices go through a voluntary recognition process by an appropriate non-governmental entity to demonstrate they have the capabilities to provide patient-centered services consistent with the medical home model

2. Patients and families participate in quality improvement activities at the practice level

Enhanced access to care is available through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician and practice staff.

Payment appropriately recognizes the added value provided to patients who have a patient-centered medical home. The payment structure should be based on the following framework:

1. It should reflect the value of physician and non-physician staff patient-centered care management work that falls outside of the face-to-face visit.

2. It should pay for services associated with coordination of care both within a given practice and between consultants, ancillary providers and community resources.

3. It should support adoption and use of health information technology for quality improvement.

4. It should support provision of enhanced communication access such as secure e-mail and telephone consultation.

5. It should recognize the value of physician work associated with remote monitoring of clinical data using technology.

6. It should allow for separate fee-for-service payments for face-to-face visits. (Payments for care management services that fall outside of the face-to-face visit, as described above, should not result in a reduction in the payments for face-to-face visits).

7. It should recognize case mix differences in the patient population being treated within the practice.

8. It should allow physicians to be eligible for enhanced reimbursements associated with physician-guided care management in the office settings which are realized from cost containment in other areas of the health care system, such as the reduced use of hospital emergency rooms and preventable admissions and readmissions.

9. It should allow for additional payments for achieving measurable and continuous quality improvements.

Appendix 2:
Community Health Teams

A Community Health Team (CHT) is a team of allied health professionals, including behavioral/mental health specialists, community outreach/prevention specialists (responsible for linking the patient-centered medical home or primary care practice with community-based prevention resources), nurse care coordinators (such as nurse practitioners) that provide multidisciplinary care support to primary care practices across a community. Their goal is to provide expertise designed to prevent disease and provide higher quality lower cost health care particularly targeting chronically ill patients.

CHTs work with small primary care practices that do not otherwise have the resources to serve as a medical home or offer comprehensive disease management programs to implement care plans for chronically ill patients. Appropriately implementing a chronic care plan requires coordinated health care interventions and communications, including significant patient self-care efforts, systemic supports for the physician-patient relationship, a plan of care emphasizing prevention of complications, patient empowerment strategies, and the evaluation of clinical and economic outcomes on an ongoing basis.

Working closely with the primary care practice, the CHTs would coordinate individual patient care support, population management and plan ongoing quality improvement. In addition to care management, their functions include coaching, patient/family contact, assessment, transitional care management (from hospitals, nursing homes, home health agencies), reinforce the treatment plan, patient education, reminders and self-management.

One of their most important functions is the responsibility for providing both 24/7 on-going care management and transitional care. Medical homes and CHTs would work with physicians at discharge from the hospital to reconcile medications and create post-discharge care plans, provide 24-hour post-discharge care and serve as liaisons to community based prevention and treatment programs.

In order for CHTs to have maximum flexibility to work with patients "holistically," they should not be subject to the constraints or incentives of fee-for-service billing arrangements. For example, North Carolina, Vermont and West Virginia approach funding through a combination of federal and states grants, and contracts with primary care practices.

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