



Healthcare PromiseTM

A Blueprint to Deliver the Promise of Healthcare Reform

The Center of Excellence for Chronic Care ManagementTM

A Division of 2020 Health SolutionsSM
Little Rock, Arkansas
www.2020HealthSolutions.com



2020 Health SolutionsTM
Clearly seeing the future of healthcareTM

From small beginnings come great things.

—Proverb

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PREMISE

If we can agree...

That the healthcare system in America today does not meet everyone's needs and cannot be sustained in its current form, and

If we can envision...

A patient centered healthcare system that is accessible, affordable, sustainable and provides the best care in the world, and

If we can embrace...

A blueprint for genuine reform that has immediate, real world applicability with specific action steps for today, as well as clearly defined long-term objectives for the future, and

If we can embark...

On a journey with colleagues in the pursuit of excellence for those we are privileged to serve, and

If we can propose...

That we work together to refine the details of a transformed healthcare system leaving a lasting legacy for generations to come, then

When we succeed...

We will have delivered the Healthcare Promise™ and restored hope for millions.

EXECUTIVE SUMMARY

Our present healthcare delivery system is clearly unsustainable in its current form. Convincing arguments have been advanced that we are on a collision course with disaster. The tsunami of baby boomers reaching retirement will peak in the 2020s. Medicare is projected to be insolvent within a decade. Medicaid spending is pushing many states toward bankruptcy. Private insurance plans continue to decrease covered benefits while increasing patient cost-sharing. The burden of the uninsured increasingly strains the entire system. Healthcare providers struggle to do more with less, often compromising their desire for quality care. Recruiting the best and brightest for careers in healthcare is increasingly difficult due to the fragmented design of our current system. Meanwhile, legislators and policymakers behold the disaster-in-the-making and are earnestly seeking solutions.

The healthcare crisis in America is a chronic care crisis. The explosion of chronic disease in our nation is well-documented (Anderson, 2007); however, many stakeholders have yet to embrace the fact that the root cause of our overall crisis is directly attributable to the poor management of chronic conditions. As the incidence of chronic illnesses continues to escalate, our current system will collapse under the weight of sheer volume. Given the complexity and expense of treatment as we now deliver it, the simple fact is the system was not designed to address these needs. *Today*, approximately 75% of our healthcare funds are spent on the treatment of chronic disease. Unless we find a solution that decreases costs by improving chronic care management, sustainable healthcare reform has little chance of success.

We are trying to manage chronic care conditions in an acute care system. We have brought forward a 20th-century healthcare system in a vain attempt to meet 21st century needs. This system was primarily designed to provide healthcare in facilities and institutions. For those with insurance coverage, the system works fairly well for their acute care needs. However, for the uninsured and

those with chronic conditions, the system does not work well at all. Strong traditions, deeply entrenched interests and resistance to change have thus far stymied a meaningful overhaul of our current system. Most agree the redesign of healthcare is long overdue, but not everyone understands that a revitalized system must aggressively support chronic care management *outside* and *beyond* healthcare facilities in order to be sustainable.

A front line provider of healthcare has developed a solution. The successful management of chronic disease *must* occur on a daily basis in the home, workplace and community of the individual with a chronic illness. While the present healthcare system is not designed for that function, an award-winning model has been created and implemented which equips individuals for successful management of their conditions. This model incorporates strong patient-provider relationships, behavior change and adult education principles, clinical specialist oversight and extensive use of advanced technology - all as part of a proactive practice team under the direction of a physician.

Target chronic disease management first. Healthcare Promise™ is a three-phase program. Phase One begins with the management of chronic disease. Phase Two takes the monies saved from successful management of chronic conditions to reinvest in programs that will assist those *at risk* for developing chronic disease. Finally, Phase Three offers support to those who are well to prevent them from ever moving to the at-risk or chronic disease categories. This blueprint offers a simple, realistic and immediately actionable solution. Savings realized can be used to expand coverage to all Americans and fund extensive benefits that promote wellness and the maintenance of good health. *(A graphic depicting the three phases of the blueprint appears on Page 11).*

This paper presents a vision of how this can be accomplished quickly, within existing infrastructure and through clear steps that will align goals across the healthcare continuum. We request the investment of a few moments of your time to read the entire document to fully grasp the nature of this proposal.

SECTION I: HEALTHCARE PROMISE™ – A VIEW FROM THE MOUNTAINTOP

JAMES: A SOLDIER STRUGGLING WITH DIABETES WINS THE BATTLE

James faithfully served his country in the armed forces for 20 years. He retired with full benefits, only to be diagnosed with diabetes. His endocrinologist prescribed treatment utilizing current best practice standards and spent considerable time providing education regarding the consequences of his disease. However, James did not believe a disease could defeat him after the battles he had fought and won in the military, so he ignored the disease entirely. He resented his physician's orders to dramatically alter his lifestyle and was soon labeled "non-compliant" by the medical community.

*When James lost some of his toes to the disease, he still resisted the changes everyone told him were necessary. Then hope entered the picture - in the form of a home-based chronic care management program. Instead of repeating the directives he had already heard, his nurse sat down and asked, "James, what is **your** goal - what would **you** like to do in spite of having diabetes?" James replied that he wanted to return to gardening more than anything else. The nurse met him at his place of desire, and began to show him what it would take to reach **his** goal.*

Within a month, James had completely changed his diet and was fully compliant with taking his medications, bringing his diabetes under control for the first time. He was also back in the garden growing flowers and vegetables for his family and friends.

James has experienced healthcare reform in terms of his life and his health. His story offers us a small glimpse – a view from the mountaintop – of what healthcare in our nation could become. This paper details our journey in search of excellence and solutions as a provider. What you read in these pages represents the

outcome of our commitment to deliver the Healthcare Promise™ to our patients – people like James who need more than the current healthcare system offers. This is the report of our journey to date - with lessons learned, possibilities envisioned and an invitation to join us as we continue climbing this mountain.

FRESH PERSPECTIVES

The Healthcare Promise™ is established on the premise that all Americans have the **right** to evidence-based, patient-centered care. Healthcare Promise™ is based on shared **responsibility** between the healthcare provider and the patient. A reformed healthcare system will be perceived as a **privilege** by all Americans. Healthcare Promise™ is a proposed healthcare system that offers hope to all of us.

Our journey to Healthcare Promise™ is woven throughout the perspectives, beliefs, data, patient stories, accomplishments and vision we present herein. The fact that it originated with an actual provider of healthcare is noteworthy; that it arose from a provider within a small segment of the healthcare continuum is remarkable. However, as in real estate, it's all about location, location, location. It was our *location* in the healthcare continuum that enabled us to clearly see the problems healthcare faces and envision the possibilities of what healthcare could become.

Americans want a healthcare system they can afford and readily access when necessary. They want assurances that the care they receive is the highest quality, with the greatest likelihood of positive outcomes. They want long-term assistance to remain at home and age in place. They want their services reimbursed by their healthcare payer without a hassle. They want a system that works for everyone. In essence, what they want and need is that powerful and intangible force called *hope* - hope from providers regardless of their diagnosis and prognosis, and hope from payers and policymakers that the healthcare system *will* be fixed in this window of opportunity that has opened before us. There is a vast difference in offering hope based on theory and offering hope based on results. What you read in these pages represents the outcome of our commitment to provide the best care - and ultimately hope - to our patients.

This solution was birthed in the most humble of surroundings: the homes of patients trying to navigate a fragmented, poorly-designed healthcare system full of gaps and inequities. Standing in someone’s living room and hearing their personal struggles does much to remove the healthcare debate from a theoretical plane and place it in extremely personal terms. While policy cannot be based solely on personal experiences, it should be constructed with sensitivity to the problems commonly faced by those whom the policy directly impacts. As a result, in this paper we will champion the patient - your loved one, your friend, your neighbor or perhaps even you - as the best baseline for measurement of a reform proposal.

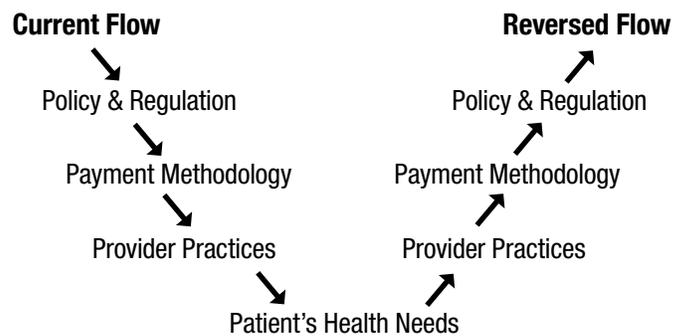
We developed this blueprint from the perspective of a homecare provider. Although we occupy a pivotal space in the healthcare continuum, it is little-understood since the service we provide is not associated with a building or facility and is therefore largely invisible. However, homecare routinely seeks to bridge the gaps in healthcare by coordinating care among multiple physicians, assisting patients with medication reconciliation (duplication and contraindication), connecting patients with community resources, and keeping patients at home and out of the hospital.

Our agency is a not-for-profit healthcare provider that, in the pursuit of patient-centered clinical excellence, encountered barrier after barrier to thwart the best outcomes for those we serve. We provide care to patients with Medicare, Medicaid, private insurance and no insurance. Every patient receives the same standard of care regardless of payer source. The annual budget includes expenses for staff development and technology to ensure all patients receive the highest quality care. While we are directly affiliated with the largest and most respected healthcare provider in the state, we also work with physicians and their patients from many other providers and facilities in the community.

We serve a geographic area that is both urban and rural. Our state ranks near the bottom in terms of income, health insurance coverage and healthy behaviors, and near the top in terms of the incidence of chronic disease. We lag behind in technology infrastructure and are trying to catch up with other areas of the country. While we have excellent medical facilities of national and worldwide reputation, and outstanding physicians of equal stature, their presence

alone has not resulted in high-quality health outcomes for many of the residents of our state. Since the model we developed works *here*, we believe it can be replicated in any community.

Through our regular interaction with stakeholders across the healthcare continuum, we realize that competing interests exist throughout the current system. While this is a reality that must be addressed with strong political will, the solution we offer has merit for each stakeholder *who is willing to place the needs of the patient first and foremost*. Thus, our contribution to the debate seeks to reverse the current paradigm in healthcare delivery as illustrated below:



In the current delivery model, policy and regulation define the rules of the game. Payer sources base their reimbursement on a combination of these policies, regulations and business interests. Downstream, providers’ practice patterns typically follow payment schedules. Sadly, the patient is at the bottom of this model and receives whatever care filters down through this very complicated matrix.

We postulate that reversing the flow of healthcare delivery in this country would be far more effective and much less expensive. In this care delivery model, the patients’ needs would define the providers’ practice pattern. This approach would be supported by reimbursement tied to patient outcomes. The provider would be incentivized to work with the patient in securing the best possible result from their treatment strategy. Policy and regulation would then support reasonable reimbursement for providers committed to patient-centered, evidence-based care. In this model, *the goals of improved outcomes and lower costs are aligned throughout the healthcare continuum*.

The reformed healthcare system as envisioned by Healthcare Promise™ would result in a system that is vastly different from the one we currently experience. (See Table A below)

Let us note from the outset that the solution we propose herein extends far beyond the homecare industry while at the same time including a crucial role for home health agencies in its design. Home health is an existing benefit in public and private health plans with agencies already serving communities throughout the nation. Extension of the home health benefit tied to additional training and development of homecare clinicians would offer a quick route to implementation of this proposal, and a quick return on

investment. However, this is but a first step on a long road to transformed 21st century healthcare.

We contend that grass-roots healthcare reform - fleshed out in the trenches of patient-provider relationships and in the midst of an outdated healthcare system - possesses the essential ingredients to successfully redefine healthcare. Such a system would stand on the basic foundation that healthcare is a right, responsibility and privilege for all Americans. It would exist to serve patients by providing the right care at the right time in the right place. Do not discount limited initial steps in this direction: *from small beginnings come great things.*

Table A

| Healthcare Today | Healthcare Promise™ |
|--|--|
| Patients fend for themselves in accessing and navigating the healthcare system - assuming they can access it at all - while often experiencing repeated defeats at health improvement attempts | Patients are supported by a proactive practice team that guides them through the healthcare system and equips them to accept personal responsibility for their health |
| Providers operate independently of each other, focused on what they do best, often to the exclusion of coordinating care with other providers to determine what's best for the patient | All providers work as part of the proactive practice team to coordinate the patient's care across the healthcare spectrum even as they continue to raise the bar of excellence in their own practice |
| Payers focus on controlling costs and typically resort to cutting or limiting benefits to achieve savings, which further restricts access and increases costs in the long-term | Payers - both public and private - reward care that is coordinated, evidence-based, and tied to the patient's outcomes - keeping patients at the optimal level of health their condition permits |
| Policymakers are besieged by competing interests seeking to maintain their position in the healthcare marketplace, and struggle to divide public funds in an outdated healthcare system | Policymakers define healthcare as a right for all Americans, and draft policies and regulations that enable and support a workable system which emphasizes shared responsibility by all stakeholders |

EVOLUTION OF A BLUEPRINT

Clear strategy that emerges from equally clear vision is the hallmark of transformative leadership. Nearly a decade ago we organized our business around five strategic focus areas. They became the drivers of change as well as the measuring rods to assess progress and ascertain our ongoing health as an organization. It was from the direction provided by these five areas that the blueprint for Healthcare Promise™ eventually emerged. As such, these strategic focus areas infuse the proposal we present in this paper. Table B describes each of these areas:

Table B

| STRATEGIC FOCUS AREAS | STRATEGIC OBJECTIVES |
|---|--|
| INDIVIDUALS Patient/Family/ Providers | <ul style="list-style-type: none"> Deliver patient-centered care Respect individual goals and values Share responsibility between patient and provider Engage in partnerships |
| CLINICAL EXCELLENCE | <ul style="list-style-type: none"> Incorporate evidence-based practice Support transparency of outcomes Extract best practices including those from fields outside of medicine Implement prepared proactive practice teams |
| FINANCIAL SUSTAINABILITY | <ul style="list-style-type: none"> Demonstrate clinical excellence = financial success Reinvest savings in comprehensive care |
| REGULATORY COMPLIANCE/ SAFETY | <ul style="list-style-type: none"> Comply with internal & external guidelines Structure system oversight to ensure quality/safety/program integrity |
| INFORMATION TECHNOLOGY | <ul style="list-style-type: none"> Enhance care delivery Promote efficiency Improve communication Enable information exchange Support decisions |

These five focus areas eventually led to the identification of an alarming trend in our patient population: the steady and dramatic increase in chronic diseases. In the early part of this decade, about 30% of our patients had one or more chronic disease diagnoses. By 2008, that number had risen to 55%. In the intervening years we proactively restructured our business to better serve our patients with chronic illnesses. It was this commitment to “raise the bar” in our

organization that produced Healthcare Promise™.

One of our first steps to manage the increasing incidence of chronic disease was investment in a small number of telehealth units. Our goal was ongoing monitoring of patient vital signs in an attempt to intervene before exacerbations required an emergency department visit and/or hospitalization. While this certainly occurred, and we successfully prevented many avoidable visits to the emergency department and hospital admissions, we were surprised by other issues the data began to reveal:

- Widespread instances of poorly controlled chronic conditions
- Lack of evidence based practices included in patient care plans
- Frequently undiagnosed and/or untreated depression in these patients
- Lack of patient engagement in self-management of their disease process
- Staff competencies inadequate to fully address the complexity of care needs

In reality, the data unmasked much of what is wrong with our healthcare system today. Our patients were not skilled or successful in managing their chronic conditions and we were not skilled or successful in helping them. We finally faced the hard reality that there is a huge gap between what the physician prescribes and the patient does. In response, our first effort was to seek partnerships with physicians and patients struggling to manage chronic conditions as depicted in the following graphic:



These partnerships are essential in the management of chronic conditions. However, we discovered they do not address larger issues in healthcare today that hinder effective chronic care management. *Structural support across the healthcare continuum is also essential for sustainability.* It was in this battleground of some success and many barriers that Healthcare Promise™ emerged.

As a daily provider of care to patients with chronic disease, we identified an immediate barrier in our own practice: we lacked a comprehensive care delivery model for this population. We initiated a search of the literature for a model suitable for the home environment, but found none. We once again faced the reality that we operate in an acute care system that is the focus of most research and development in healthcare.

From our desire to deliver a high quality standard of care - and out of sheer necessity - we finally constructed a new model specifically designed for chronic care management in the home. We named it The Home-Based Chronic Care Model™ because it is founded on Dr. Edward Wagner's landmark Chronic Care Model. This model is depicted in

the graphic below and explained in detail in Section II.

The initial success of the model led us to submit it for publication in a peer-reviewed journal. It was accepted and published in April 2008 (Suter et al, 2008) It has since garnered two national awards for excellence in innovation and quality: "The Excellence in Innovation Award" from the National Association of Homecare and Hospice (October 2008), and "The Spirit of Excellence for Quality Award" from *Modern Healthcare* (December 2008).

During the construction of our model, we realized that effective chronic care management is the logical starting point for healthcare reform. We currently spend 75% of our healthcare funding on the treatment of chronic disease. We suspect much of that is because we are relying on an acute care system that was not designed to treat chronic conditions. With a proven model for successful chronic care management and the extension of homecare benefits to better serve these patients, we could realize a return on investment in a relatively short period of time. *We contend that broad scale adoption of this approach would produce positive, remarkable and measurable results.*

The Home-Based Chronic Care Model™

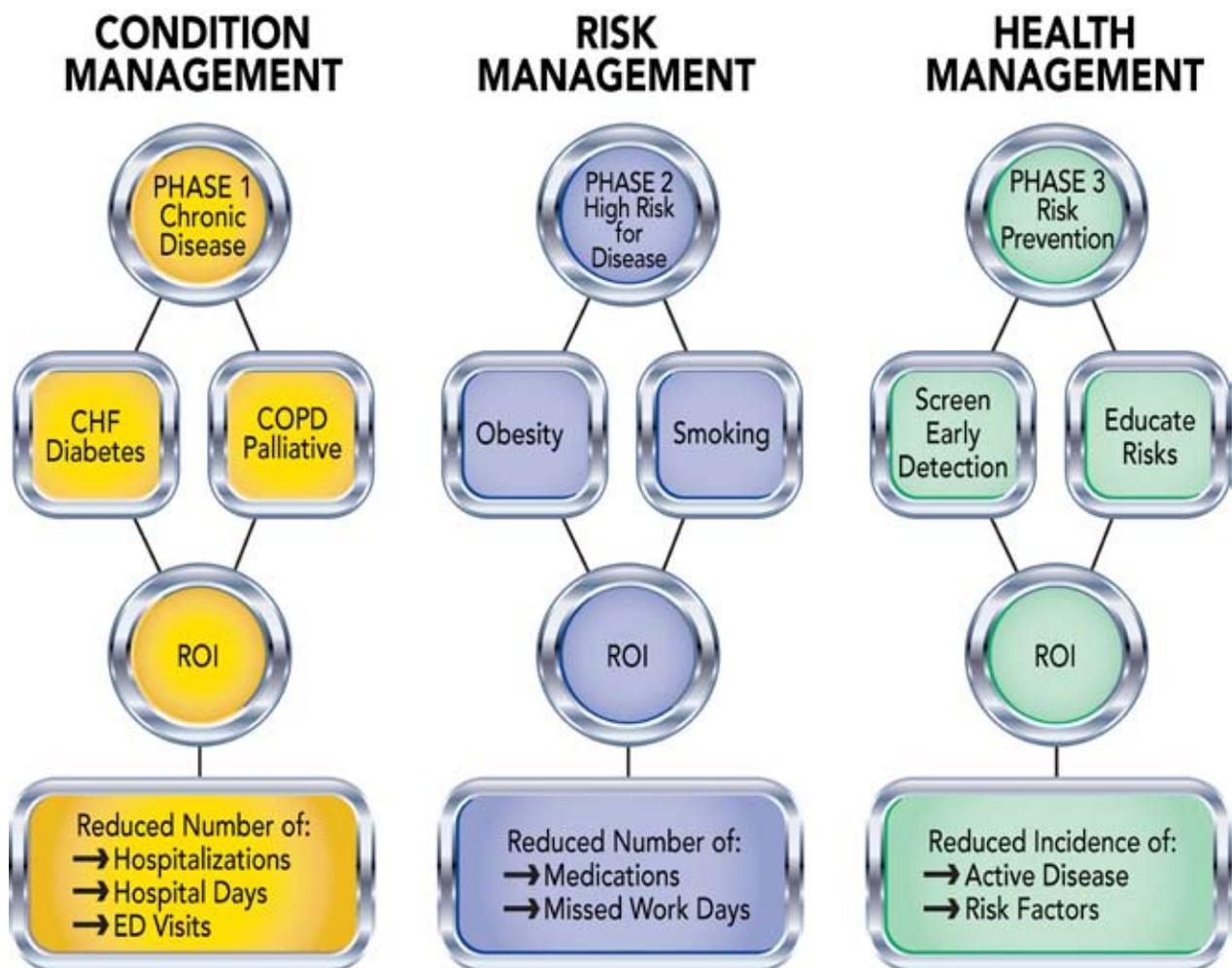


As we developed and implemented our chronic care model, we realized savings from this initiative could expand services to the remaining population - those who are at risk for chronic disease and those who are healthy. The at-risk group needs intervention to change behavior and lifestyle choices now so the development of chronic conditions can

be decreased or prevented. The healthy group needs support to maintain their health status and avoid moving into one or both of the other groups.

The following graphic depicts the blueprint of Healthcare Promise™:

Healthcare Promise™



The three phases of Healthcare Promise™ are the endgame of healthcare reform. This is the view from the mountaintop of what we can accomplish by working together. However, the journey to the summit always begins in the valley, and that is precisely where we started.

SECTION II: THE JOURNEY BEGINS WITH CHRONIC CARE MANAGEMENT

HAROLD: IN SPITE OF BLINDNESS, HE SEES HOPE

Harold is legally blind and his wife has dementia. Following a recent hospitalization, he was discharged from the hospital on Friday evening with 12 new prescriptions. On his way home he stopped at the pharmacy, only to discover his insurance covered just six prescriptions. Harold asked the pharmacist to fill the six most expensive, thinking they would be the most important. However, one of the unfilled prescriptions was the insulin ordered for his newly diagnosed diabetes.

When the homecare nurse came to his home on Saturday, she quickly identified the lack of medication needed to manage his condition. She connected him to community resources which supplied the missing medications. She also began the process of setting patient-specific goals to empower Harold for successful management of his disease at home. He had left the hospital in deep despair, but hope returned when he knew he could remain at home and overcome all the obstacles he faces.

We can easily agree that people like Harold deserve our compassionate service and continuing support. It was through repeated encounters with patients like him that compelled us to begin this journey. As a homecare provider we are often left to bridge the gaps in the healthcare continuum, and as a result we resolved to find workable solutions to dilemmas like his. In the process, we found much more.

IN SEARCH OF A SOLUTION

We watch daily as patients and families attempt to navigate a myriad of care settings and providers. Patients easily get

lost and disappear in the gaps. As homecare providers, we experience the same issues our patients do: care delivery that is fragmented, uncoordinated and economically segregated. We struggle daily to communicate with each patient's multiple care providers, and frequently find no single provider assumes clear accountability for patient outcomes. We wrestle with gaps in communication as clinical information systems are incompatible, if even in use. We struggle to interpret poor quality faxes from physicians whose directions often contradict other orders. We find medication duplications, omissions, patient confusion and various errors that hinder successful management of chronic disease.

As we pursued our organizational goal of improving chronic care management for our patients, we found ourselves constantly building "pontoon bridges" between the gaps in healthcare. We sought to build partnerships with patients and other providers, and were successful to some extent. However, we finally realized a comprehensive care delivery model was needed to consistently bridge the gaps in chronic care management. *Without a delivery model, excellence is unsustainable.*

After analyzing our current state of chronic care delivery, we turned to the literature and the findings of demonstration projects. Our experience in caring for patients with chronic disease taught us that medical interventions alone do not ensure successful self-management. Therefore, we did not limit our review to medical literature. We examined other fields of study such as adult learning and behavior change theory to glean best practices that would enrich our model.

LESSONS LEARNED FROM THE LITERATURE

Although many patients with chronic disease receive excellent care, many more struggle to manage their disease. Care is frequently uncoordinated and fragmented. Multiple variables compound the complexity of care delivery. A review of the literature provides insight into key issues often associated with poor care and undesirable outcomes. Table C summarizes our findings:

Table C

Factors Impacting Chronic Care Management

| Factor | Detail | Consequences |
|--|--|--|
| 1. Incidence and Prevalence | <ul style="list-style-type: none"> • Skyrocketing chronic disease incidence • Physician offices overwhelmed • Limited MD time per patient • 10.6 hours needed additionally to deliver quality chronic care - over and above current 40 hour week (Ostbre et al., 2005) • One in four Americans have multiple chronic conditions | <ul style="list-style-type: none"> • Acute needs overshadow chronic (Wagner, 1998) • Evidence-based guidelines not applied consistently • ~50% of patients do not receive recommended care (Asch et al., 2006) • No time for proactive care planning • Health care spending increases with the number of chronic conditions (Anderson, 2007) |
| 2. Payment methodology | <ul style="list-style-type: none"> • Physicians paid per visit, per procedure • Lack of care coordination fee | <ul style="list-style-type: none"> • High cost intensive interventions rewarded over primary care interventions • Lack of clear accountability leading to medical errors, waste, duplication • Patients left unassisted to navigate across different providers and settings • Poor communication of care plans to other providers and to patient |
| 3. Increasing complexity of chronic disease self-management | <ul style="list-style-type: none"> • Pharmaceutical advances and plethora of new medications: (Patients with five chronic diseases average 50 prescriptions.) • Better assessments leading to new treatments • Longer life span resulting in one or more additional chronic diseases to manage • Patients seen by multiple specialists | <ul style="list-style-type: none"> • Confusion/ lack of understanding/affordability leading to medication errors and poor self-management • Multiple specialists add more complexity, more prescriptions, more assessments, more treatments: patients with 5 chronic diseases see an average of 14 physicians (Anderson, 2007) • Increased healthcare utilization • Repeated treatment failures lead to hopelessness |
| 4. Poor health literacy | <ul style="list-style-type: none"> • 90 million Americans have difficulty understanding health information • Most healthcare professionals underestimate prevalence • Most medical information written at 12th grade level | <ul style="list-style-type: none"> • Medication errors, avoidable hospitalizations • \$73 billion spent in 2004 due to poor health literacy (Committee on Health Literacy, 2004) |
| 5. Unaddressed unique needs of elderly | <ul style="list-style-type: none"> • Older adults have a higher incidence of chronic diseases and are more likely to have multiple chronic conditions • Functional disability, visual changes, fall risk, homebound and isolation all compound complexity of chronic care | <ul style="list-style-type: none"> • Individuals with chronic diseases and functional abilities experience higher hospitalization rates (Anderson, 2007) • Visual changes and mobility problems lead to falls • Isolation increases risk of depression |
| 6. Depression | <ul style="list-style-type: none"> • 10-40% of patients with chronic diseases are also depressed (Sullivan, 2008) • Depression is not routinely assessed during physician office visits | <ul style="list-style-type: none"> • Depression is correlated with decreased interest in disease self-management, increased healthcare utilization, increased morbidity and mortality (Mitchell, 2008) • Patients treated for depression are often not receiving adequate antidepressant doses as recommended by expert guidelines |
| 7. Access and sharing of health information | <ul style="list-style-type: none"> • 15% of physicians utilize electronic medical records in ambulatory settings (Shih et al., 2008) • Systems currently in place are not interoperable, creating silos of information | <ul style="list-style-type: none"> • Dangerous lack of communication across care settings resulting in medication errors, duplications, omissions and increased avoidable hospitalizations |

There is agreement that the healthcare system must undergo dramatic change in order to meet the needs of those who are losing the chronic disease battle. Multiple reports highlight new models and solutions advanced to solve this crisis. Although no model was

designed specifically for the unique needs of the patient in the home environment, our review of demonstration experiences identified valuable insights we incorporated in our model. Table D summarizes the current models:

Table D

Review of Models of Care / Proposed Solutions

| Model | Interventions | Results | Lessons Learned | Take Aways |
|---|---|---|---|---|
| <p>Medicare Health Support (MHS) Disease Management Demonstration</p> <ul style="list-style-type: none"> Largest CMS pilot to test Disease Management delivery model. Objective was to test a pay-for-performance model to improve quality of chronic care. | <ul style="list-style-type: none"> Care management Telephonic health coaching Various additional interventions varied by program (for example, telemonitoring, home visit for initial assessment) | <ul style="list-style-type: none"> Fees increased Medicare costs with little or no savings offset Impact on quality small No significant reductions in hospitalizations, readmission rates, emergency room visits or mortality rates (Bott et al., 2009) | <p>What worked:</p> <ul style="list-style-type: none"> Face-to-face interactions Program led by registered nurses Unique needs of elderly addressed Holistic approach Use of behavior change theory Remote monitoring with capability for timely response <p>What failed:</p> <ul style="list-style-type: none"> Telephonic interventions alone Disease-centric approach Providing information alone as behavior change method Limited primary care physician involvement (Bott et al., 2009; Kuraitis, 2007) | <ul style="list-style-type: none"> Trust building/collaboration important Use of behavior change techniques essential Physician led team important New layer of care adds to fragmentation/complexity |
| <p>Wagner's Chronic Care Model</p> <ul style="list-style-type: none"> Primary Care practice designed to build on the interrelationships of 6 essential elements (Wagner, 1998) | <ul style="list-style-type: none"> Links to community resources Organization values quality chronic care Provision of self-management support Separation of acute from chronic care with a clear division of labor Clinical information systems and decision support | <ul style="list-style-type: none"> Improvement in process measures, recommended therapies and clinical outcomes | <ul style="list-style-type: none"> Randomized trials netted the best outcomes Trials generally involved adding new staff and new resources Redesign costs practices money in the short term [\$6-\$22 per patient the first year. (Coleman et al., 2009)] | <ul style="list-style-type: none"> Cost to practices could be minimized by collaborating with home health teams to provide health coaching, education and assist with care coordination |

Table D Continued

| Model | Interventions | Results | Lessons Learned | Take Aways |
|--|---|--|---|---|
| <p>The Patient-Centered Medical Home</p> <ul style="list-style-type: none"> Physician meets criteria to serve as central resource of care. Added reimbursement | <ul style="list-style-type: none"> Primary care including coordination, prevention, and maintenance care. Proactive practice team Information technology Formal performance improvement (PI) plan 24 hour availability | <ul style="list-style-type: none"> Pilot testing is underway Early results are promising (Geisinger Health System reduced hospital admissions by 20%, saved 7% in medical costs – Mahon, 2008) | <ul style="list-style-type: none"> Additional care will take 10.6 hours/day above current care (Ostbre et al., 2005) Physician survey reveals lack of competency with patient education / care coordination (Anderson, 2007) Feasibility and cost to hire multi-disciplinary teams Lack of time or experience with implementing PI programs | <ul style="list-style-type: none"> Home health clinical teams match responsibilities of proactive practice team Home visits provide optimal setting and time for assessment, education and health coaching Home health has established outcomes-based quality reporting system utilized for PI initiatives |
| <p>The Guided Care Model</p> <ul style="list-style-type: none"> Primary Care practice based delivery model – described as “primary health care infused with operative principles of recent innovations for patients with chronic diseases” | <ul style="list-style-type: none"> Guided Care Nurse provides care coordination, health coaching, education, monitoring, and facilitates access to community services | <ul style="list-style-type: none"> Trial is ongoing To date, cost of care lower for Guided Care patients | <ul style="list-style-type: none"> Requires physician employment of Guided Care Nurse Requires three weeks of additional training for Guided Care Nurse, 3-4 months needed for physician practice integration (Boult et al., 2008) | <ul style="list-style-type: none"> Much of training content relates to home health competencies (health insurance coverage, working with family/caregivers, community resources) |
| <p>Care Management Plus Model</p> <ul style="list-style-type: none"> Physician clinics employ Nurse Care Managers | <ul style="list-style-type: none"> Nurse-led Team based Care coordination Self-management support Evidence-based guidelines Specialized information technology | <ul style="list-style-type: none"> Lower mortality Slightly more emergency room visits Reduced hospitalization rates (Dorr et al., 2008) | <ul style="list-style-type: none"> Clinics train and employ Nurse Care Managers Nurse Care Managers attend training every other month | <ul style="list-style-type: none"> Much of training content relates to home health competencies (for example, care for seniors, care giver support) |

We extracted from these themes, and from our experience on the front lines, the most efficacious innovations and interventions. We took “the best of the best” to develop a new care delivery model, one specifically designed for management of chronic disease in the home environment.

Construction of The Home-Based Chronic Care Model™

The Chronic Care Model developed by Dr. Wagner (1998) is an influential and accepted guide for the care

of patients with chronic disease. Our agency conducted an analysis of our care delivery using Wagner’s model to determine where we met the model’s intent and where we were lacking. We identified additional focus areas essential for successful long-term chronic care management in the home and community. A new and expanded model was designed to solidify the partnership between the physician, the proactive practice team and the patient. We named this the Home-Based Chronic Care Model™. (Suter, Hennessey, Harrison, Fagan, Norman, & Suter, 2008)

Home-Based Chronic Care Model



The Four Pillars

1. Pillar One: High Touch Delivery System

Face-to-face visits form the basis of trust which facilitates partnership between the patient and the homecare clinician. The development of a trusting patient-clinician relationship is a driving force of this model. A guiding, non-judgmental communication style is of absolute necessity to establish trust. The *patient's* goals and aspirations are paramount.

High touch care begins with a comprehensive, holistic assessment that is critical to understanding the patient's needs and barriers to chronic care management. In conjunction with a physiological assessment, additional assessments that identify health modifiers, or conditions that have a profound effect on other conditions, are included. Assessment of cognitive status, depression and health literacy are considered standard care. Decision support assessment tools are built into the point of care software and are completed as part of the assessment process.

Based on the unique needs of each patient, select members of a multidisciplinary team partner to assist patients in achieving goals they set for themselves. Homecare team

members may include physicians, nurses, nurse specialists, pharmacists, social workers, chaplains, homecare aides, and occupational, physical and/or speech therapists.

Face-to-face visits are augmented with pre-planned telephonic visits to check in with the patient, and continue with goal progression assessments. Calls are frequently initiated by a telehealth nurse, an integral member of the homecare team. This nurse also provides positive reinforcement for successes attained as evidenced by the patient's electronically transmitted data.

2. Pillar Two: Theory-Based Self-Management Support

Self-management support is one of the essential elements of Wagner's Chronic Care Model (1998). We identified "self-management support" as an area to target for care improvement. According to the Wagner model, chronic care management is under the direct control of the patient and therefore self-management support must be a collaborative process. The goal of self-management support is to help patients and families acquire skills and *confidence* in managing their chronic illness.

Historically, healthcare providers have been taught to elicit healthy behavior change by providing health information as a means of logical persuasion. Unfortunately, providing information alone about appropriate chronic care management has been shown to yield fair results at best (Weiss, 2007).

Stephen Rollnick, William Miller and Christopher Butler state in their book *Motivational Interviewing in Healthcare* (Guilford Press, 2008), that healthcare today should focus on long term condition management through behavior change. In chronic disease management, many behaviors are necessary for optimal disease control. Examples of desired behaviors include limiting salt and fluid intake, wearing special footwear, checking blood glucose levels before meals, taking medication regularly and eliminating fat in the diet.

Two theories from the field of psychology captured our attention as having great utility for the facilitation of patient engagement and behavior change: Motivational Interviewing and Self-Efficacy. Motivational Interviewing (MI) was initially developed as an intervention method to assist alcoholics to cease problem drinking and since has been applied in work with patients who live with chronic disease. MI is a skillful clinician communication style which, when utilized well, elicits from patients their own motivations for making behavior changes. In clinical trials, patients exposed to MI are more likely to adhere to glucose monitoring, experience improved glycemic control, increase exercise, decrease sodium in their diets and adhere to other healthy life style behaviors. (Rollnick, Miller, Butler, 2008)

Self-Efficacy theory recognizes that patients with chronic disease must cope with complex management regimens (Bandura 1994). Self-efficacy is a belief that one has the capabilities to execute courses of actions required to manage situations. Simply stated, self-efficacy is a measure of a person's perception of his or her ability to reach a goal.

These theories and principles, when judiciously employed, guide the processes of patient engagement, exploration of ambivalence, identification of intrinsic motivation and development of an action plan for behavior change. Once it has been determined that the patient is ready to make a change, experiencing success sets the stage for improved

self-efficacy and improved self-management. Collaborative goals must be carefully crafted in a manner to maximize chances for successful goal attainment. It is paramount that homecare professionals plan and structure situations for patients in ways that bring success and hope to the patient's personal situation.

3. Pillar Three: Specialist Oversight

Evidence-based clinical practice guidelines must be integrated into care delivery in order to provide consistent high quality care. Clinical nurse specialists select current guidelines that are appropriate for home-based care and ensure that best practices are utilized. Electronic documentation systems are customized to incorporate evidence-based guidelines.

Home health agencies need only hire, or consult with, a few clinical nurse specialists possessing expertise in the management of populations with the most prevalent, complex and costly chronic diseases. Examples of specialists in areas of high incidence disease states are certified diabetes educators, wound, ostomy and continence nurses, and advanced practice nurses who specialize in targeted areas such as cardiac or pulmonary care. Inclusion of a palliative care specialist can facilitate appropriate transitions to end-of-life care.

Nurse specialists employed by our agency are not only highly experienced in their disease content area, but they are equipped with best practices related to behavior change. They ensure that the most up to date knowledge in their field - which is most applicable to care in the home - is brought to the field staff in a timely manner. Specialists serve as consultants to clinical staff and monitor patient population outcomes.

4. Pillar Four: The Use of Technology

Targeted use of remote monitoring for patients with chronic disease is a powerful tool for effective chronic care management. Early identification of exacerbations improves the likelihood of preventable hospitalizations. Many home-care agencies use remote monitoring systems, often referred to as "telehealth" in industry parlance. Telehealth units are typically comprised of a portable monitor that utilizes the patient's telephone network to transmit patient data such as blood pressure or glucose levels, or a report of symptoms, to the provider.

Home health agencies that provide remote monitoring are in a unique position due to the ability to collect and act on patient data. Experienced nurses, employed to monitor agency data, operate under the physician's plan of care. These nurses can obtain orders for medication changes or send nurses out to make same-day home visits in order to permit face-to-face evaluations and seek necessary interventions.

Participation in a telehealth program teaches patients to perform self management skills. Examples of skills reinforced by telehealth include measuring and recording important parameters such as weight, blood pressure, and blood glucose, and developing increased awareness of control of symptoms like shortness of breath, fatigue, and increased cough. Patients are encouraged as they see and physically experience positive results from implementation of behavior changes.

Implementation of the Model

Once the model was completed, we began a phased implementation at our largest homecare agency. By refining processes and retooling clinicians, we ensured the model was implemented as designed. The following steps were taken to accomplish this objective:

- *Home-Based Chronic Care Certification Course developed*
- *Outcomes for program evaluation identified, measured and reported*
- *Clinical practice of model reinforced with inclusion of outcome and process measures in job descriptions and annual performance evaluations*
- *Criteria developed for the provision of telehealth (with a priority rating)*
- *Chronic Disease Care Plans created within the electronic medical record (EMR)*
 - *Expert disease specific guidelines embedded*
 - *Patient-centered goals emphasized*
- *Point of care assessments created within EMR; e.g. re-hospitalization risk, fall risk and depression assessment*
- *Concept of self-management support introduced in orientation of clinical staff*
- *Yearly competency test developed for concept refresher*

The success of this model depends on the competency of the homecare clinicians. We developed a course to equip our staff for success in this regard. Clinicians are certified as Home-Based Chronic Care Professionals upon satisfactory completion of both a certification exam and demonstration of appropriate use of the model in clinical practice. After passing the exam, individual clinical practice is audited for a period of three months to determine if comprehensive assessment tools, care plans and collaborative goal setting are implemented. Professional practice continues to be reviewed and refined during multidisciplinary care conferences, which are co-chaired by advance-practice nurses.

Technology has been integrated to support broad scale application and sustainability of the model. EMR-embedded disease specific care plans incorporate evidence-based guidelines. Disease-specific instructional guides are available for reference on each clinician's laptop. Point of care assessment tools, developed with automatic scoring and evidence-based interventions, facilitate decision support. As health information technologies meet new functionality requirements, and as providers become increasingly accountable for outcomes, implementation strategies continue to evolve.

The Home-Based Chronic Care Model™ represents an original contribution to the fields of chronic care management and homecare. It has been implemented in our daily practice and proven effective in improving health outcomes and decreasing avoidable hospitalizations. We have shared this model with the homecare industry, and we now offer it to the nation as a beacon of hope for those with chronic disease and a healthcare system struggling to care for them.

As Phase One of Healthcare Promise™, this model also presents a strategic opportunity for initiating healthcare reform. We can implement this phase *now*. As we realize better outcomes and significant cost savings, we can ultimately fund Phases Two and Three. The journey begins with chronic care management, but we hope it concludes with a transformed healthcare system for all of us.

SECTION III: CALL TO ACTION

STEVE: WHAT A DIFFERENCE A TEAM MAKES

Steve, at 48 years of age, lived alone and confined to a wheelchair. He suffered from both diabetes and congestive heart failure. He did not always take the dozen medications prescribed for his chronic illnesses. He struggled with blood sugar levels in the dangerously high 400-500 range. He recently had his right leg amputated below the knee due to a diabetes-related infection. Steve's physicians had become frustrated with him and labeled him as a non-compliant patient that refused to follow instructions.

Hope entered the picture following one of Steve's many hospitalizations: his physician ordered homecare services. Steve quickly formed a trusting relationship with Sandy, his home health nurse. He revealed to her that he was illiterate and could read only simple words. It became clear to Sandy that Steve had not refused to follow his doctor's orders; he simply did not understand the written instructions that had been given to him.

From that day forward, things began to change for Steve. Sandy tailored all instructions specifically for him. She found that he absorbed information best a little bit at a time, so she structured her visits and teaching accordingly. She also equipped him with a telehealth monitor that allowed him to check his blood sugars, blood pressure, pulse and weight on a daily basis. He received feedback immediately from nurses that were monitoring his data and they also discussed needed changes with a nurse specialist and his physicians. Steve was no longer alone. He had an entire team on his side.

This personalized intervention is paying off for Steve. He monitors his blood sugar daily and has been successful in keeping it in the 80-200 range. Instead of dwelling on how his diseases limit him, he talks about his goals and what he wants to do with what he has learned. He wants to learn to read and hopes to teach others about diabetes. After losing his leg and being hospitalized multiple times, he feels he has a first-hand understanding of the serious nature of diabetes. He wants to share his struggles and successes in mastering his diabetes.

It is for people like Steve that we must act. He was doing the best he could with his abilities in the healthcare system we have provided. However, when that system failed to meet him at his point of need, unnecessary complications, cost and unresolved issues ensued. Healthcare reform must bring hope and better care delivery to patients like Steve (and Harold and James). When it does, cost savings will be realized as a byproduct.

THE VALUE IN ACTING NOW

Implementing The Home-Based Chronic Care Model™ is the first step needed in order to reconfigure our healthcare system as envisioned in the blueprint of Healthcare Promise™. While implementation of the full blueprint is a long-term objective, there is *immediate* value for key stakeholders in the adoption of Phase One that addresses chronic care management.

1. Value for Patients

The greatest proponents of our model are the patients with chronic disease who now have hope. As we have implemented the model, we have seen the following value for our patients:

- *Decreased acute care readmissions*
- *Decreased emergency department visits*
- *Improved biometric indices (blood pressure, blood glucose, weight control, etc.)*
- *Identification of previously unrecognized risks and comorbid conditions*
- *Increased confidence in disease self-management*
- *Greater satisfaction with care*

2. Value for Physicians

Physicians in America cannot address the chronic care crisis by themselves. As identified by Wagner, they must have proactive practice teams to ensure the time-consuming burden of chronic care management is shared with other professionals. We see the following value for physicians:

- *Direct a multidisciplinary proactive practice team*
- *Utilize Home-Based Chronic Care Professionals competent in health coaching, motivational interviewing, patient education, access of community services and care transitions*

- Access ongoing remote patient monitoring to prevent disease exacerbation and monitor patient status between office visits
- Share in realized savings as a result of attaining pay-for-performance objectives
- Enable participation in the Patient-Centered Medical Home
- Eliminate necessity to add staff, make home visits or redesign practice

3. Value for Hospitals

CMS would like to move the Medicare program in the direction of paying for quality instead of quantity. CMS requires hospitals to report quality measures in order to receive the 2009 payment rates. Measures are being implemented to reduce the incidence of serious adverse patients outcomes (referred to as “never events”). Examples include wrong-site surgery, hospital-acquired infection, and development of pressure sores.

Determination of fiscal year 2010 payment will include a measure to track readmission rates for patients with heart failure, with other high risk diagnoses likely to follow. The next step in this process is adjustment of payments to hospitals - either up or down - based on readmission rates. In this environment, we see the following value for hospitals:

- Collaborate to reduce readmission rates for targeted diseases
- Align providers for pay-for-performance goals with potential of increased bundled payments

- Improve chronic care management to ease emergency department burden
- Ensure appropriate and timely transitions to end-of-life care that is both cost-effective and aligned with patient-specific goals

4. Value for Employers/Employees

Outside the Medicare population, there is a rapidly increasing number of working Americans who live with the challenge of chronic disease management – either their own or that of a family member. We can report that The Home-Based Chronic Care Model™ has been successfully adapted for individuals in the workplace. As a result, we see value for employers and their employees in these areas:

- Reduce unnecessary healthcare utilization (lower health-care costs)
- Increase productivity/decrease “presenteeism” (present, but not productive)
- Lower absenteeism (caused by either the employee’s or a dependent’s chronic illness)
- Improve job satisfaction
- Provide savings to fund programs requiring a longer time frame for return on investment (risk factor management and wellness programs)

5. Value to the Healthcare System

Table E summarizes the value we believe our model can quickly bring to the healthcare system if it is widely adopted:

Table E

| Current Healthcare System | Phase One: Chronic Care Management |
|---|---|
| Directed/ordered care | Guided care |
| Acute/episodic focus | Continuous care focus |
| Providers function in silos | Providers work together under leadership of physician |
| Patient education | Self-management support |
| Technology focused on diagnosing and treating acute conditions | Technology focused on monitoring chronic conditions and reinforcing behavior change |
| Established risk-adjusted quality outcome reporting system for homecare (OASIS) | Outcomes measured across the healthcare continuum |
| Reimbursement driven | Best-practice driven |

A healthcare system with enhanced value for all participants – regardless of role – is the ultimate outcome of Healthcare Promise™. Will you “climb the mountain” with us in pursuit of that goal?

NO ONE CLIMBS EVEREST ALONE

We cannot rebuild the healthcare system without the cooperative efforts of stakeholders across the healthcare continuum. We have sought to explain the lessons we have learned and the future we clearly see. However, it is equally clear that we cannot reach our destination alone.

We believe our blueprint is simple in design, comprehensive in scope and realistic in implementation. We further believe that the homecare industry can and should have a significant role in jump-starting healthcare reform. With additional training for homecare clinicians to become certified in chronic care management best practices, and with funding for the technology essential to success, existing homecare agencies throughout the nation can be quickly deployed to address this crisis. Extending the Medicare home health benefit so that those with chronic disease could be monitored and supported long-term is also essential for this model to work on a broad national scale.

Numerous advantages recommend homecare for a leading role in addressing the chronic care crisis:

- *Experience in building relationships with patients - an essential ingredient to good outcomes*
- *History of caring for chronic disease patients (to the limited extent it has been possible in the current system)*
- *Engagement of patients in their home environment, where the battle with chronic disease is either won or lost every day*
- *Existing infrastructure in healthcare, eliminating the need to create a new one*
- *“Army at the ready” currently serving most communities in America*

It is our firm conviction that with an existing Medicare benefit - mirrored in most Medicaid and private insurance plans - and the existing infrastructure of homecare agencies already in place throughout the nation, we possess *today* a quick and reasonable route to effective chronic care management. Pragmatically, three steps would be necessary to implement the chronic care management phase of this blueprint in a matter of months:

1. *Extension of the home health benefit in public and private sectors to allow ongoing monitoring and support for beneficiaries with a chronic disease diagnosis by removal of the current homebound requirement, allowing care to continue long-term beyond the current episodic structure*
2. *Funding for specialized training for all home health clinicians to become certified in chronic care management principles and techniques*
3. *Funding for technologies essential for personal monitoring and population management*

Given these resources, homecare agencies could quickly recalibrate their operations to serve patients with chronic illness more effectively than ever. As patients become successfully engaged in self-management of their disease, avoidable visits to the emergency department and hospital can be minimized and produce a quick return on investment.

While our proposal calls for an increased investment of funding in homecare, this call must be viewed as part of a larger strategy. There are three important points to consider in this regard:

1. *The home is the least expensive place to provide healthcare. Care provided in the home today will result in savings to the patient’s payer - whether public or private - today!*
2. *Homecare has an established, risk adjusted outcomes-based reporting system used to promote high quality care.*
3. *The downstream impact of an effective chronic care management program will produce much greater savings as patients are kept out of facility-based care to the fullest extent possible.*

Homecare agencies currently possess working relationships with physicians, hospitals, case managers and - most importantly - patients with chronic disease. Capitalizing on these existing relationships would form the basis for the implementation of Phase One. Homecare agencies could easily and quickly retool their staff and operations with the policy and funding support advocated in this paper. Genuine healthcare reform could then be initiated in our country.

We advocate a traditional homecare program as the prerequisite for entrance of Medicare beneficiaries into a new program of chronic care management. The program would extend the current home health benefit with a focus on continuing the provider-patient relationship to achieve desired outcomes. By utilizing the existing infrastructure in homecare agencies around the nation, we can avoid costly construction of a new delivery system, a new outcome measurement mechanism *and* achieve a much quicker return on investment.

We seek to provide a voice for the homecare industry that declares our willingness and readiness to rise to the occasion and fulfill our role in national healthcare reform. With innovative leadership and favorable financing, the homecare industry can mobilize its thousands of agencies in a coordinated, concentrated attack on the chronic disease crisis we face in this country. Aligning incentives for coordinated care between physicians, a proactive practice team and patient-centered goals will result in remarkable improvement in health outcomes and a welcome decline in healthcare costs. It will also foster a culture of shared responsibility among providers and patients. In such an environment, seeds can be sown for lasting change and future sustainability of our national healthcare system.

SUMMATION

The goal of Healthcare Promise™ is to bring a fresh perspective to the healthcare debate in this nation a perspective born in the trenches of today's faltering system. We present a blueprint that speaks to the key ingredients of healthcare reform: high-quality care, accessibility and sustainability. By targeting chronic care management as the starting point, the savings realized can be reinvested in expanded access for the uninsured and ultimately the implementation of subsequent phases.

A realistic road to systemic reform is outlined in this paper. We readily admit a lack of details in some aspects of our

proposal. However, we believe we have defined a clear and precise place to begin the process, and have provided a basic blueprint for subsequent steps. For those who share our vision of a radically different, radically better healthcare system, we invite and welcome your collaboration and support to advance this proposal with stakeholders throughout the nation.

"We are not channels, we are instruments. Channels give nothing of their own, they just let water run through them. In our action, we are instruments in God's hand and He writes beautifully."

—Mother Teresa (Mother Teresa 1996)

If you share our values and mission, pick up your pen and join us in writing the next chapter in Healthcare Promise™. In so doing, you can participate in the transformation of our healthcare system. Where there has been despair, we can offer hope. Where there has been fragmentation, we can establish coordination. Where there has been inadequacy, we can deliver sufficiency. Where there has been competition, we can provide service. Where there has been mediocrity, we can rise to excellence.

We do not desire to make a difference in the world; rather, we desire to create a different world in terms of healthcare. If you hear that call, please join hands, hearts and minds with us as we pursue excellence in our service as healthcare providers to all Americans.

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Phase One Concepts in Action

Pillar One: High Touch Delivery

Compassionate care delivered by specially trained professionals using state-of-the-art technology



Pillar Two: Theory-Based Self Management Support

Personalized instruction coupled with collaborative goal-setting



Pillar Three: Specialist Oversight

Physician-led proactive team coordinates evidence-based care delivery



Pillar Four: Technology

Decision support guides quick and appropriate patient care intervention



Phase One of Healthcare Promise™ is bringing hope to patients with chronic disease today!

