



Assembly Health Committee Special Briefing
Richard Pan, Chair, Assembly Health Committee

Improving Outcomes through the
Patient Centered Medical Home
January 29, 2013

California Chronic Care Coalition Comments
Liz Helms, President/CEO and Jerry Jeffe, Public Policy Director

Chairman Pan and Members of the Assembly Health Committee, thank you for giving the California Chronic Care Coalition (CCCC) the opportunity to provide comments today regarding 'Access to Care for the Chronically Ill.' I am Liz Helms, President and CEO, and next to me is our Public Policy Director, Jerry Jeffe.

The California Chronic Care Coalition is an alliance of non-profit health organizations, physician, provider and consumer organizations united to improve the health of Californians. 2013 marks the beginning of our seventh year working together.

Collectively, our Coalition represents over 16 million Californians with chronic conditions and diseases. Our mission is to improve the health care system so that all Californians with chronic conditions can access appropriate quality health care. The CCCC encourages the development of health care policies focused on prevention and wellness, including effective diagnosis, team-based coordination and management of chronic disease.

It is estimated that **75** cents of every health care dollar is spent on chronic conditions. That is unacceptable when we know we can do better. Coverage that enables access to affordable, quality health care that prevents is critically important for people with, and at risk for, complex chronic diseases and conditions. Prevention practices are essential to reducing health care costs.

When patients are not able to afford the tools and care necessary to manage their chronic conditions, they scale back or forego the care they need, which often leads to complications and suffering that could have been prevented.

This practice ultimately ends up increasing overall health care costs. We can do much better at building a healthy California while reducing health care costs and we believe we are headed in the right direction with the work being done to implement the Affordable Care Act in 2014.

Access covers an array of definitions and while California is making positive strides to improve health outcomes, social determinants of health in underserved communities contribute to all types of health disparities which must be identified.

However, we still see areas that need to be addressed if we truly want to accomplish an integrated team-based care approach. Covered California will improve access to coverage for all Californians and especially those with pre-existing chronic conditions but will it improve access to quality health care?

Patient Centered Medical Home – Full Integration of Team Care

There have been many names and models that share commonalities and best practices that can be viewed as patient-centered. In this Capitol many battles have been fought on how to define it. When the patient is able to establish an ongoing relationship with a primary care provider, working as a member of a physician-led team, we will be well on our way to shifting the paradigm from acute care to prevention and wellness. We applaud this legislature for bringing us all together to look at the best practices to achieve optimal outcomes.

Managing complex chronic conditions can be difficult and vary based on the co-morbidities each condition may present including mental health, alcohol and drug addictions, as well as proper pain management and oral health. Many complex chronic diseases are genetic but in many cases their complications are preventable. The co-morbidities of chronic conditions can lead to high blood pressure and diabetes. Obesity, as we are all aware, can for the first time reduce the life span of our children. The co-morbidities and societal costs of obesity are astounding.

The Problem of System Fragmentation

The CCCC believes a patient-centered medical home can work to, improve quality, manage complex chronic conditions, diseases and lower costs when all members of the team are working at the top of their license and the patient is engaged and educated. But, we are not there yet. We have under-utilized our allied professionals at their full scope of practice. For the last several years the patient centered medical home has

been discussed to extremes and to date there is still a fragmented system that is not fully engaged.

Consider for example, the use of the clinical pharmacist as a health care provider.

- Currently Pharmacists are not recognized in the Social Security Act (SSA) or Centers for Medicare & Medicaid Services (CMS) as Health Care Providers, practitioners, or Non-Physician Practitioners (NPPs)³.
- The following health care professionals are recognized as providers by the Social Security Act:^{3,9}
 - Physician assistants, nurse practitioners, certified nurse midwives, clinical social workers, clinical psychologists, and registered dieticians / nutrition professionals.
- Reform is essential for full implementation of team-based care.

CMS Final Rule in May of 2012:

- New regulations allow hospitals to expand definition of medical staff.
- Concept of “medical staff” broadened to include Physician Assistants (PAs), Advanced Practice Registered Nurses, (APRNs), and *Pharmacists* to perform all functions within their scope of practice.
- **Payment for services are not addressed**
- True implications are not clear

In a recent letter of public support for the report titled *Improving Patient and Health System Outcomes through Advanced Pharmacy Practice. A Report to the U.S. Surgeon General, 2011*, Dr. Regina Benjamin stated the following:

- Health care leadership and policy makers should further explore ways to optimize the role of pharmacists to deliver a variety of patient-centered care and disease prevention, in collaboration with physicians or as part of the healthcare team.
- Utilization of pharmacists as an essential part of the healthcare team to prevent and manage disease in collaboration with other clinicians can improve outcomes, contain costs, and increase access to care.

- Recognition of pharmacists as health care providers, clinicians and an essential part of the health care team is appropriate given the level of care they provide in many health care settings.
- Compensation models, reflective of the range of care provided by pharmacists, are needed to sustain these patient-oriented, quality improvement services. (Veterans Health Administration)
- Health Information Exchanges for out-patient pharmacy are not yet well established and must be designed to bridge and improve the physician - pharmacist team as well as full integration to the 'Home'.

We have seen the results of our demonstration taking place in San Diego County and others around the country when use of the clinical pharmacist providing medication therapy management would bring significant cost savings to the system of care. Not only would that would be greatly advantageous to Medi-Cal, but more importantly **in the life of the consumer.**

A Model for Success: San Diego Right Care Initiative Demonstration

Clinical Activation

For the last two years the CCCC has been working in San Diego County helping to coordinate and build the health care model we believe will shift the paradigm from acute care to wellness and prevention.

As a partner and collaborator of the Right Care Initiative, RCI, we have already seen improvement in HEDIS measures for the control of Blood Pressure, Lipids and HbA1c. Clinical collaboration is ongoing with nine medical systems representing more than 80% of health care provided in San Diego County including:

- Arch Health Partners
- Council of Community Clinics
- Kaiser Care Management Institute
- Multi-Cultural Primary Care Medical Groups
- Naval Medical Center
- San Diego American Heart Association
- San Diego County Medical Society
- San Diego Veterans Administration Medical Center
- Scripps Medical Group
- Sharp Rees-Stealy Medical Group
- University of California, San Diego

Government officials including:

- San Diego County Health and Human Services Agency
- California Department of Managed Health Care,
- Right Care research team: UC Berkeley, UCLA, RAND and UCSD

This public-private partnership meets monthly through the University of Best Practices San Diego Colloquium. The groups are now sharing their data.

Our goal is to reduce heart attacks and strokes by 50% in five years and *strive towards making San Diego the first heart attack and stroke free zone in the nation.*

The RCI has included the clinical pharmacist on the care team and through two demonstrations 1) Skaggs School of Pharmacy and 2) a collaboration with United Health Care, Ralphs Pharmacy and the California Schools Voluntary Employee Benefits Association (VEBA). There has been significant improvement in the control of diabetes, high blood pressure and cholesterol.

Patient Activation and Public Awareness Campaign: **be-there**® San Diego catalyzed by RCI. Engaging the patient community to know their numbers and **be-there**® for life's special moments.

- Audacious goal to capture attention
- Extends the risk reduction efforts to all citizens
- Actively engages persons in their own health (care)
- Conveys ownership to population
- Taps in to community pride
- Patient learns self-managing skills

Aim: Achieve both screening for risk factors and compliance with interventions

Our work in San Diego has gained recognition at the national level, with the National Institute of Health (NIH), the Centers for Disease Control (CDC) and Centers for Medicare & Medicaid Services (CMS) to name a few. In addition, we have received San Diego County's HHS Director of Public Health Champion Award. Through our unprecedented collaborative effort in San Diego and statewide, we have seen a 7% improvement in control of blood pressure, lipids and HbA1c compared to the rest of the nation at 2%. Significant improvement!

As a community working together, San Diego has improved the health of its citizens and we have only just begun.

Looking Forward

So where do we go from here? What actionable items can the California Legislature put in place to improve outcomes through the implementation of a fully engaged patient-centered medical home?

Translating Public Policy into Action

Now that we have laid out a road map to better coordinate and manage chronic conditions and discussed the patient-centered medical home, it is now time to translate our comments into the world of public policy and action.

What we are suggesting is that you ask yourself and the other speakers this afternoon some key questions:

(1) Will your ideas or recommendations on patient-centered medical homes lead to better patient outcomes?

(2) Will the costs of managing chronic conditions through the use of patient centered medical homes either decrease the costs in the health care system or slow down the rate of growth?

We understand controlling costs is vital. But cutting or eliminating programs are not the only options. When you can control costs by improving outcomes and quality of care, you will create a system in which preventative efforts become the standard and not the exception. Patients will in turn be more likely to seek routine care that is readily accessible in their communities, helping to improve adherence and mitigating the high costs of emergency care.

We bring this up because some new programs or concepts will require start-up costs (i.e., new money) but they will help to bring down the cost of health care in the long run.

(3) Finally, please do not dismiss any new ideas, concepts, or innovations because they are different to the norm. Do not curtail innovation. Now is the time to support a diversity of ideas. We need time to try different approaches. There are more ways than one to get things done, as you will hear soon from the other speakers. Ask critical questions to root out ineffective and costly programs and ideas.

And lastly, please remember that above all let us not negate the role of patient advocates. Whatever we are as Californians, our voice when it comes to our wellness must be center stage, as we seek the best expectations and dreams for a quality of life we hope to have and pass forward for future generations.

On behalf of Liz Helms, the California Chronic Care Coalition, and me, we look forward to continuing to work with Dr. Pan while we look at the challenges still before us.

Respectively submitted January 28, 2013.

Liz Helms, President/CEO
Jerry Jeffe, Public Policy Director