

Issue Brief

Barriers to Integration

April 1993



National Chronic Care Consortium

The National Chronic Care Consortium is a network of health care providers across the country dedicated to reforming and improving the delivery of services to people with chronic conditions. A primary impetus for NCCC efforts is the emergence of chronic conditions as the highest-cost and fastest-growing health care segment. NCCC members are well aware that the nation's current method of delivering chronic care services is not doing a good job of serving the growing number of people with chronic care needs. At present, the financing, administration, and delivery of chronic care services is extremely fragmented. If we are to deliver chronic care effectively, we must give priority to issues of integration. Without such integration, the health and long-term care system will continue to result in increasingly high costs, frustrated providers, and dissatisfied consumers.

In this issue brief, the NCCC identifies major goals for achieving chronic care integration, discusses barriers to achieving these goals, and concludes with specific recommendations for government, payer, and philanthropy collaboration in removing integration barriers and dramatically improving the delivery of chronic care services.

Although this issue brief was written in 1993, its message is even more important today. Together we must meet the challenge of improving the financing, delivery, and administration of chronic care services. The future of the health care and the long-term care industry—as well as the well being of millions of Americans—largely depends upon our ability to do so.

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Goal #1 A Clear Vision

System integration strategies must emanate from a clear definition of a new service delivery reality. This new vision must be grounded in integrated health network concepts emphasizing chronic care issues.

Barriers **Most health care professionals view health and long-term care reform from narrow and isolated segments.**

Policymakers, payers, providers, and consumers generally have expertise or interest in one small segment of the health care system. Depending upon the individual or agency, the focus may be on such diverse areas as nursing home care, hospital care, preventive services, or accounting systems, and on such diverse activities as financing care, evaluating care, providing care, administering care, or analyzing policy. Each of these areas and activities is associated with its own base of experience, perspective, and goals. Artificial divisions are, therefore, created between many areas, such as between acute and long-term care, between mental and physical health, between medical issues and psycho-social issues, and between chronic care and rehabilitation. Diverse and narrow perspectives must be integrated if chronic care services are to be integrated. Successful reform rests on our ability to articulate a vision of care that is more future-oriented and holistic.

The term “chronic care” is often used interchangeably with “long-term care.” People with chronic diseases and disabilities require the full range of acute and long-term care.

Individuals with chronic diseases and disabilities move back and forth between physicians, hospitals, nursing homes, and other providers with great frequency over many years, even after a person requires ongoing residential care. Often conditions seen by nursing homes and alternative care programs are simply the final stage of a series of ongoing problems that have been seen by acute care providers for years. Isolating chronic care to the long-term care environment is simply not a reflection of reality and is a major impediment to integration.

Most health care professionals approach health care problems with the goal of curing an invading disease.

The goal in treating chronic diseases is to prevent further disability and to optimize an individual's function and well-being, given the individual's evolving health care status. The condition is not an enemy to be eliminated but has become integral to life. One's understanding of life changes accordingly. A "cure" orientation presents a substantial barrier to addressing a host of nonmedical issues and makes it difficult to integrate the multidimensional aspects of care. As Jennings, et al., (1988) note: "Intensive, high technology treatment oriented toward cure and full restoration of function, which has provided the dominant orientation for much of medicine in recent years, is usually inappropriate to the needs and problems of the chronically ill. A medical care system that lacks a sense of purpose beyond these goals will find itself increasingly uncertain and inept in the face of the demands placed upon it by chronic care."

Goal #2 Consistent Public Policy

The multiple layers of policy governing the continuum of acute and long-term care must be made more consistent in carrying out common goals.

Barriers **Separate policy authorities exist for major segments of chronic care financing.**

Medicare, Medicaid, Social Security Block Grants under Title XX, the Older Americans Act, and the Veterans Administration all provide chronic care direction. Each uses different policy assumptions and directives with a different program authority. There is no overall policy for care that crosses all federal mandates.

Separate administrative authorities exist for each federal program.

Medicare is federally directed, with administration through fiscal intermediaries. Medicaid is federally defined, but administered through states. Title XX Block Grants are largely administered through state and county government. The Older Americans Act is administered through state and area agencies on aging. VA benefits are directly administered through the Veterans Administration. Even where coordination agreements exist, basic differences in approach are maintained.

The bureaucratic process discourages innovation.

State and federal laws can sometimes convince providers that integrating care simply isn't worth the effort because of problems associated with working with state and federal bureaucracy. For example:

Waivers and Demonstration Projects: One way providers can try to expand and integrate their continuum of care is to apply for waivers of certain Medicaid rules and/or become an official demonstration project. Unfortunately, the path to integration via this road is fraught with bureaucratic and other problems. Waivers and demonstrations are authorized for specific, limited periods of time, meaning that providers must periodically go through a long, repetitive process of justifying the need for the waiver or project, even when the types of waivers requested may be used in nearly all states, or even when a simple extension is desired. The uncertainty of future funding can also discourage organizations from making real changes in their systems. Client-specific and service-specific information is generally required for reimbursement, making it difficult to integrate waiver/demonstration data and services with other data and services. Waivers and demonstrations are usually tied to a very specific population.

Home- and community-based waivers, for instance, are designed to serve only those individuals who would otherwise be institutionalized. This makes it difficult, if not impossible, to have integrated policies and procedures that cover an individual's chronic care needs across time, place, and profession.

Certificate of Need Laws: An increasing number of states are redeveloping certificate-of-need (CON) laws (Kent, 1993). Though they vary by state, these laws generally require providers to obtain state approval for major capital expenditures and the expansion of services. A 1974 law stimulating intense development of CON laws was repealed in 1987 because of problems with its implementation. Now, however, the issue is being revisited because of state frustrations with rising health care costs. CON laws now, as before, could present a substantial bureaucratic hoop for providers who are seeking to expand their continuum of services in order to provide integrated care.

State and Federal Enforcement Strategies: State and federal laws independently regulate individual providers. This makes it difficult to consolidate and integrate a full continuum of services. Entin (1993) succinctly defines the problem: "With a rapidly evolving system, it is now more important than ever for the government to recognize the problems created by the array of laws, regulations, and information agency policies and practices that overlap and intersect on any arrangement involving more than one health care provider. Lack of coordination among the enforcement agencies compounds the problem. It is time for government to acknowledge that a coordinated interagency approach to regulation is long overdue. The problem is not regulation. The problem is regulation in a vacuum without regard for the changing expectations for health care delivery, and the existence of other competing, sometimes inconsistent or contradictory demands."

National insurance carriers have many of the same problems with fragmentation and bureaucracy.

Each insurance company, driven by its own proprietary interests, sets up separate and unique administrative, financing, and delivery structures. Benefits, eligibility, care arrangements, and other policy and agency characteristics vary dramatically, and are often incompatible with public program approaches. The numerous sets of policies and procedures confronting providers adds to the cost and confusion of policy fragmentation.

Goal #3 Uniform Administrative Procedures

Administrative procedures must be rendered more uniform and supportive of efficient program operations.

Barriers Program directives are sometimes in direct conflict with one another.

For example, a community-based long-term care provider using both Older Americans Act and Social Security Block Grant (Title XX) funding must use a means test under Title XX but is restricted from using one under the Older Americans Act. Medicare provides incentives for short stay hospitalizations, yet Medicaid provides few incentives for addressing the more intensive care needs of hospital patients discharged to a nursing home. Different and conflicting policy stances are taken on such issues as case management and client and program contribution requirements. Different budget cycles, planning approaches, eligibility criteria, tracking systems, monitoring methods, and evaluation systems are used, with these variations existing between programs, between counties, and between states.

Each administering agent has an incentive to shift cost to the other, acting out of self-interest.

Medicare, Medicaid, and private insurance are constantly shifting costs to one another, allowing all parties to avoid the cumulative benefits of integration across administering authorities. Use of state and local funds is constantly affected by federal directives. Costs shift from one pocket to another, sometimes without knowledge or federal intent.

Shared-risk opportunities associated with capitated financing are generally not passed on to providers through integrated contracting.

Most providers under contract with an HMO view “managed care” as a “one-way ratchet,” with singular focus on doing the same thing that was provided under a previous contract, only at less cost. There is virtually no opportunity to experiment, to substitute care, to integrate services, or to develop capability for managing care across settings. HMOs as payers write separate contracts for separate services (such as hospital care, nursing home care, and medical equipment) even though the services may be delivered to the same person for the same condition. As a result, disparate but related providers have little or no incentive to cooperate, let alone integrate. If services are to be truly integrated, HMOs must directly provide a greater proportion of services, or HMOs as payers must establish preferred provider relationships with integrated health networks in addressing the spectrum of problems associated with a defined population or a defined set of problems, e.g., hip fractures or strokes. Providers who serve the same patients must be given the opportunity to integrate their financing and care management capability across settings, with incentives to provide whatever combination of care is deemed most cost effective within agreed-upon cost limits and clinical outcome targets.

Goal #4 Outcome Orientation to Accountability

Policies governing provider practices must be less prescriptive of process and more focused on outcomes. Structures for finance administration must shift from containing costs within narrow health segments to giving providers incentives to collectively contain costs, prevent disability, and emphasize customer satisfaction across time, place, and profession.

Barriers Payers consistently micro-manage provider behavior.

Whether a public or private agency, payers are writing increasingly stringent contract or grant specifications for service delivery, and monitoring care for specific services on a case-by-case basis. Control is organized around issues of service amount, frequency, and duration for specific care segments, rather than based on outcomes. A recent proposal by the Health Care Financing Administration, for instance, would require HMOs to disclose details of physician-incentive plans that affect Medicare and Medicaid enrollees. As the American Hospital Administration notes, “It would make far more sense to monitor the health outcomes of Medicare and Medicaid enrollees in prepaid health plans to assure that they are receiving quality health care than to micro-manage the administrative arrangements within these health plans” (AHA, 1993). It is difficult for program integration to occur in the absence of outcomes-based management and global budget targets that allow for provider flexibility and innovation.

The formula for calculating payment rates to HMOs is fundamentally flawed, providing disincentives for plans to serve Medicare enrollees via risk contracts.

Formula variables are poor predictors of real costs: Medicare risk contracting is one of the few vehicles providers have for integrating a variety of chronic care services and delivering them to Medicare enrollees on a capitated basis. Unfortunately, evidence for almost a decade shows the inadequacy of the payment formula (the Average Adjusted Per Capita Cost, or AAPCC) in predicting service utilization and reflecting the real cost of care. Repeated recommendations for including a measure of health status (using proxies such as prior use, functional status, and specific chronic disease indicators) to the formula’s basic demographic characteristics have not been implemented. The inability of the AAPCC to reflect real costs makes HMOs worry that they will not be adequately paid, while some policy makers worry that HMOs will be overpaid for the

care they provide. HMO concerns about being underpaid are especially serious when the issue is chronic care. As Manton and Stallard (1992) note: "For HMOs there is a strong incentive not to enroll the non-institutional disabled because the loss associated with such persons is by far the highest [in our study of AAPCC rates].... Thus, an HMO would have to over-enroll or under-enroll only a small number in this group to have a sizable financial effect." Other general problems with the AAPCC that make HMOs wary of entering a risk contract (much less targeting a chronically ill population) include the use of old data in determining payment rates and inadequate payment rates for rural areas.

Because payment rates are based on average costs, the AAPCC rates penalize HMOs that are located in areas where managed care has stimulated overall cost reductions:

The AAPCC theoretically pays HMOs 95% of the average amount Medicare would expect to pay for someone not enrolled in an HMO in their area. The basis for this type of payment is that there are enough inefficiencies in the health care system so that HMOs can receive 5% less than the average cost of care and still provide high-quality and innovative care because the HMOs have the increased flexibility of managing care within capitated rates. In some areas of the country, however, the degree of HMO penetration has forced providers of all types to implement increasingly aggressive cost-saving strategies. Average costs then approach an efficiency threshold that leaves little room for attaining additional efficiencies without adversely affecting quality. A frequent HMO response is to drop out of the risk contract market completely. This not only reduces opportunities for integrating care in a managed care system, but drives up costs as well.

There are incentives for other providers (in addition to HMOs) to avoid high-cost, complex, and multidimensional cases: The incentives to avoid serving people with chronic conditions goes beyond the HMOs discussed above. Insurance companies generally have incentives to enroll healthy people and hope they leave before their care needs become extensive. DRG payments to hospitals provide them with an incentive to target some problems and avoid others and to fill beds as often as they can with relatively "healthy" patients and avoid complex care cases. Nursing homes are becoming more like hospitals, but have few incentives to integrate medical care with custodial care. Even where case mix approaches are used, the formula for payment frequently creates an incentive to send patients to other locations for care, thus containing their own costs but increasing overall costs. Physician reimbursement formulas offer greater incentives for specialists than for primary care physicians, with all incented to avoid the management of multiple, complex care problems. Virtually all providers have financial incentives to avoid serving persons with multidimensional, ongoing, and high-cost care needs. With no incentive to address the most expensive problems in health care, the overall problem only escalates for everyone.

Goal #5 Integrated Provider Networks

Integrated provider networks must be established to provide all aspects of a person's care within a predefined capitated rate. Risks for cost savings must be shared equitably among key players, with rewards for historical and future cost-saving behaviors.

Barriers **Chronic care providers maintain separate program identities.**

Acute and long-term care providers are increasingly in the same business, but administrators seldom recognize this. Provider strategies, budgeting and reporting cycles, health policy direction, in-service training, operational structure, and approaches to quality assurance are all developed and maintained in relation to supporting separate programs. Providers use separate forms, separate systems, and separate approaches, with little regard for their compatibility with other care providers serving the same person. Such separation exists within the vast majority of vertically integrated systems. It is clear that providing all programs under a single administration does not mean that programs are integrated. An underlying reason why programs remain separate is the existence of separate financing structures for each care component.

Most laws are written to enable providers to compete rather than cooperate.

While competition is an important value to maintain, the concept of market competition frequently serves as an impediment to coordinated care, where quality and cost savings can be realized in serving the chronically impaired. Antitrust laws are consistently reported as inhibiting program integration and network development. If the primary issue is demonstrating whether an action will produce redeeming consumer benefits, then the notion of using market concentration to determine whether competition will be unduly harmed by joint activities is simply not appropriate. Chronic care is mostly financed through public sources, where cost controls and customer safety are closely regulated. Traditional market forces have little relevance in chronic care. Collaboration among related care providers is consistently demonstrated to be critical to effecting quality and cost containment. This is particularly true under capitated, risk financing arrangements.

Program administrative expertise is specialized and segmented.

There are very few expert generalists with skills that cross administrative and provider boundaries. There are very few people who know the technologies of managing care in more than one setting, e.g., hospitals, home care agencies, nursing homes, assisted living arrangements, and community-based services.

Trust among acute and long-term care providers is limited.

Hospital administrators often view long-term care as a second-class profession. Nursing home administrators do not always trust acute care providers. In pursuing collaborative efforts, the strongest partner frequently maintains dominance, regardless of the potential benefits to be accrued through partnership.

No one knows the cost of care for any major chronic condition, let alone what combination of care is most cost-effective.

We generally know the cost of specific care segments such as nursing home care, hospital care, and home health care. We are gradually coming to know what approach to care, within isolated care segments, is most cost-effective. Yet, no one knows how much care costs across time, place, and profession.

Information systems do not routinely integrate information about people, conditions, care, cost and results.

Most information systems are organized to support a single interest, such as management function (e.g., costs monitoring), place (hospital, nursing home, home health), profession (medical care) or program (Older Americans Act or Medicare). Information about the cost of providing chronic care across time, place and profession is simply unavailable. Information systems exist primarily to maximize billing for a care segment, to track expenditures in relation to budgets for a segmented purpose, and to maintain a record of care provided for a care segment. Seldom are providers able to even track clients across settings, let alone track their case and costs, because different patient identifiers are used everywhere. In fact, the basic nomenclature and structure of record-keeping vary from one system to another, even in performing the same function. While the technology exists for integrating information systems, integrated information is almost nonexistent.

Goal #6 New Service Delivery Structures

Care must be managed across time, place, and profession, with emphasis given to primary care, disability prevention, and ongoing care management.

Barriers Care is planned and managed within isolated care segments.

Virtually all care planning is organized within the boundaries of hospitals, nursing homes, home health programs, and other provider settings. Physicians, therapists, nurses, and social workers also have their own approaches to assessment, care planning, delivery, and monitoring of their segment of care. People are “admitted” and “discharged” from one care setting without any regard for the need to manage care across time, place, and profession and the need to view movement between providers as transitions within the same care process rather than a hand off between unrelated care episodes.

The specialist is king.

Primary care physicians, the key integrators of medical care, have less prestige and fewer financial rewards than medical specialists, and the shortage of primary care physicians is growing. Even in social services, generalists are seen as less important players. Chronic care program integration requires that we put incentives in the proper order, with priorities beginning with the customer and caregivers, proceeding to the generalist caretaker, and then to the specialist.

Incentives reward treating a crisis rather than preventing the evolution of disability.

Current reimbursement structures and health care curriculum do not demonstrate a value for primary prevention, ongoing primary care, and psycho-social services. Preventing the evolution of disability throughout the course of a serious and persistent chronic condition holds a lower value than treating the specific medically-related symptom seen at the time of a visit. In most cases, high-tech treatment that targets curing a specific condition in a short span of time is given paramount concern, regardless of the long-term effects. Chronic conditions are multidimensional, volatile, complex, and long-term. They require an ongoing managed care process that targets interventions on those risk factors that predispose an individual for further disability.

There is no recognized authority for managing care across time, place, and profession.

Primary care physicians are assumed to have authority for managing medical conditions in an ongoing way, but specialists are often in control during periods of hospitalization. Support in helping the chronically impaired and their caregivers manage the array of ongoing psycho-social issues across time, place, and profession is almost nonexistent. No professional or group of professionals is consistently held responsible for multidimensional, ongoing care, even though chronic care is a multidimensional, ongoing problem.

Case management policies reinforce fragmentation rather than facilitate integration.

Almost every health care setting conducts its own assessments, care plans, and referrals. Case management seems to add to the fragmentation more often than integrating what exists. Often providers maintain control over their own care segments, while case management advocates seek independent care management authority: thus, integration is nearly impossible. National demonstrations focus on issues of case size rather than key care intervention strategies across time, place, and profession. Unless case management is integral to a provider network and considered part of the ongoing cost of doing business, neither care quality nor care efficiency will result.

Goal #7 Empowered Care Recipients

Patients and primary caregivers must be empowered to gain better control over the care process.

Barriers Caregivers often have little or no support.

Families are tremendously dedicated to caring for individuals with a chronic disability and provide the vast majority of care to people with chronic care needs. However, the provision of ongoing support by caregivers is extremely difficult. Decreasing mortality rates and an increase in the number of women in the workplace, for example, means that caregivers are less readily available and are more likely to have chronic conditions themselves. Efforts to care for a disabled family member can jeopardize one's job and well-being. Problems for caregivers include prohibitions against reimbursement to family members who provide care, lack of caregiver knowledge about supportive services, and caregiver reluctance to use formal services.

Customers are largely uninformed on the cost, organization, and consequences of chronic care.

Most people think their insurance will cover care that it actually does not cover, and that care is more efficiently organized than it is. Often it is not until a person is immersed in a complex care situation that she or he learns the difficulty of obtaining care. The onset of a chronic condition may also be one of the first times that individuals fully encounter the need to optimize function rather than seek a cure that returns them to their "normal" state. Given the complexity of chronic illness and chronic care systems, consumers may not yet be a viable force for mobilizing change for service integration.

Consumers appear to have a strong bias toward defining choice in terms of freedom to select their own providers, even though they also want contained costs and quality care.

Under a limited resource environment, the issue of choice is realistically restricted to choosing two of three — cost containment, quality care, and freedom in selecting providers. Cost containment and quality care are by-products of integration. Provider preference as a priority choice issue must be modified, with customer cost participation for maintaining a provider outside the network.

Like most policy makers, payers, and providers, consumers are short-term focused.

Most people do not see the relationship between what they do now and what may happen later. Integration requires a long-term view. Chronic care requires a sense of a long-term problem. It requires recognizing that what happens today affects what must be addressed in the future. Everyone, including customers, must support a longer term view of care in order for integration issues to be fully effective.

Goal #8 Responsiveness to Change

Everyone must be open to the multidimensional aspects of integration and be ready and willing to respond appropriately.

Barriers **At the very time that there is the greatest need for innovation, we are least able to do so.**

Operating margins for Medicare and Medicaid payments are continually being reduced, with programs managed and care provided by fewer and fewer staff. Stress levels go up, and the flexibility, creative energy, and resources for innovation go down. Public and private investment in research & demonstration continues to be reduced as well. Fundamental systems reform requires a complementary research & demonstration investment. We must build upon the information accrued to date and support those who are willing and able to take risks in trying new approaches.

Our training of health care professionals is as fragmented as our system.

All the incentives are to put out more health care specialists. Curriculums that cross professions are almost nonexistent. Interdisciplinary training is undervalued.

Integrated care models are in their infancy.

On Lok is perhaps the most integrated provider system in existence, but its exclusive focus is on care for persons at-risk of nursing home placement. The Social HMO is an important financing demonstration with compatible values but with a smaller proportion of beneficiaries requiring chronic care. Demonstration of an effect on provider integration is still largely unknown. The application of provider integration principles among mainstream providers is largely untested. The integration of care in smaller metropolitan or rural areas may require a slightly different approach than systems developed in larger metropolitan areas because of the size of a population needed to support a range of chronic care services. The National Chronic Care Consortium, the only national organization comprised of mainstream acute and long-term care providers, dedicated to chronic care reform and the establishment of integrated care networks, is working to effect reform. Program integration requires a new national policy framework for the development and ongoing evaluation of prototype activities, and the infusion of resources necessary to allow policymakers and providers nationwide to innovate.

Conclusion and Recommendations

It is the vision of the National Chronic Care Consortium that, by the year 2000, acute and long-term care providers will realign themselves into customer-centered, systems-oriented networks of care. Health care administrators will broaden their sense of identity, and while separate administrative units may prevail, providers serving the same constituency will function as a single system. Providers will offer people with disabling chronic conditions a more simple, humane, cost-effective, and seamless continuum of medical care and ongoing life support.

Pooled payment of services will give networks of acute and long-term care providers the flexibility and financial incentives to work together in meeting a person's interrelated care needs across time, place, and profession. Organizational linkages between them will help prevent or retard the progression of a person's disability and enable more appropriate use of limited resources. Network structures will vary, but each provider network will possess four types of managed care capability:

Integrated systems management, to link the direction-setting of acute and long-term care executive leadership;

Integrated care management, to link the ongoing management of care across time, place and profession;

Integrated care financing, to pool payments to network providers through shared risk arrangements; and

Integrated information systems, to link decision makers across settings with more comprehensive clinical and cost data.

As an organization of the nation's most advanced acute and long-term care providers dedicated to leadership through example, the NCCC is eager to see that this vision comes to fruition. Its breadth of experience and capability, diverse geographical locations and organizational arrangements, and shared commitment to a common vision provide NCCC members with a unique opportunity to serve as a national laboratory in fundamental reform.

NCCC members have been laying the groundwork for vision attainment since February 1991 by establishing locally based chronic care networks (CCNs) with provider-based managed care capability. Each CCN contains a complete continuum of preventive, acute, transitional, and long-term care services. Separate but diverse programs are being integrated to the extent possible even though current policy, financing, organizational, and professional circumstances frequently reinforce a piecemeal, crisis-oriented approach to care.

This comprehensive vision cannot be fully realized without collaboration among the nation's providers, government, payers, and philanthropy.

The starting point for this reform effort is for mainstream providers to step forward and establish integrated care networks.

The large and growing number of persons with chronic care needs in this country requires that integration strategies be developed for use by mainstream providers. Priority must be given to reforming the acute/long-term care infrastructure in response to the multidimensional, ongoing, and costly nature of targeted conditions. Mainstream providers nationwide must be represented, including rural and urban areas. The framework for this development must chronic care networks (CCNs), targeting the highest-cost and fastest growing care segments, and the launching point for service delivery reform. Each CCN will enable specialized and separate administrative units and programs to function as a single system through provider-based managed care. Integrative elements include integrated systems management, integrated care management, integrated financial management, and integrated information systems.

An affiliated group of public and private payers must work with mainstream providers in developing and testing new payer/provider relationships.

These new payer affiliations must lead toward new contracting arrangements being established with chronic care networks (CCN's) to enable network providers to effectively collaborate in managing care across time, place, and profession. Administrative practices must be simplified through capitated, pooled, outcome-oriented financing arrangements, with incentives provided to prevent, delay, or minimize the progression of disability among those served.

Financing formulas must enable payers and providers to equitably share in financial gain and loss commensurate with their ability and willingness to be at risk and to meet mutually agreed-upon performance expectations. Payments must include a health status adjustment to offer an incentive for targeting care for high cost, heavy care patients. The payer (or independent rate setting authority) should move toward structuring incentives for CCNs to contain overall costs across time, place, and profession; to prevent disability progression; and to maintain client satisfaction.

Policymakers must provide leadership in establishing a national vision of integrated care and must take immediate steps to begin the process of service delivery reform as a requisite to cost containment and health care access.

Congress must hold public hearings to highlight the pending shift from an acute to a chronic care business environment and to establish service delivery reform. The federal government must provide legislation plus an infusion of research and demonstration resources into the payer/provider community to demonstrate new integrated care networks. Policy governing the continuum of acute and long-term care must be standardized. Policies governing provider practices must be less structurally proscriptive, seeking instead to reward positive outcomes achieved, regardless of methods used, in preventing or minimizing the progression of disability rather than responding to medical crises. Structures for managing costs must shift from containing costs within narrow health segments, e.g., Medicare financing of hospitals, to managing costs across time, place, and profession for whole population groups.

Fundamental reform also requires philanthropic leadership and support of provider and public policy investments.

At the very time providers are in greatest need of change, there is a limited ability to finance it. Public and private investment is particularly important in developing new payer and provider management models, providing technical support for prototype development, monitoring and evaluating prototype activity, and providing a forum for collaboration and enable replication.

General support must be made available to bridge acute and long-term care systems, integrate fiscal management, integrate care management, and integrate information systems. Specific technical support is needed to define health status adjustment factors; establish preferred approaches for sharing risk among acute and long-term care providers; implement new methods for collectively preventing the progression of disability across time, place, and profession; and establish a core set of client, condition, care cost and outcome data necessary to monitor care across settings and to support continuous quality improvement.

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The National Chronic Care Consortium (NCCC) is a mission-driven organization of leading-edge health networks dedicated to transforming the delivery of chronic care services. The NCCC's mission is to serve as an operational laboratory for enabling innovative health networks to establish prototype systems for better serving persons with chronic conditions. For more information on the NCCC, please contact:

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