Healing the Health Care System

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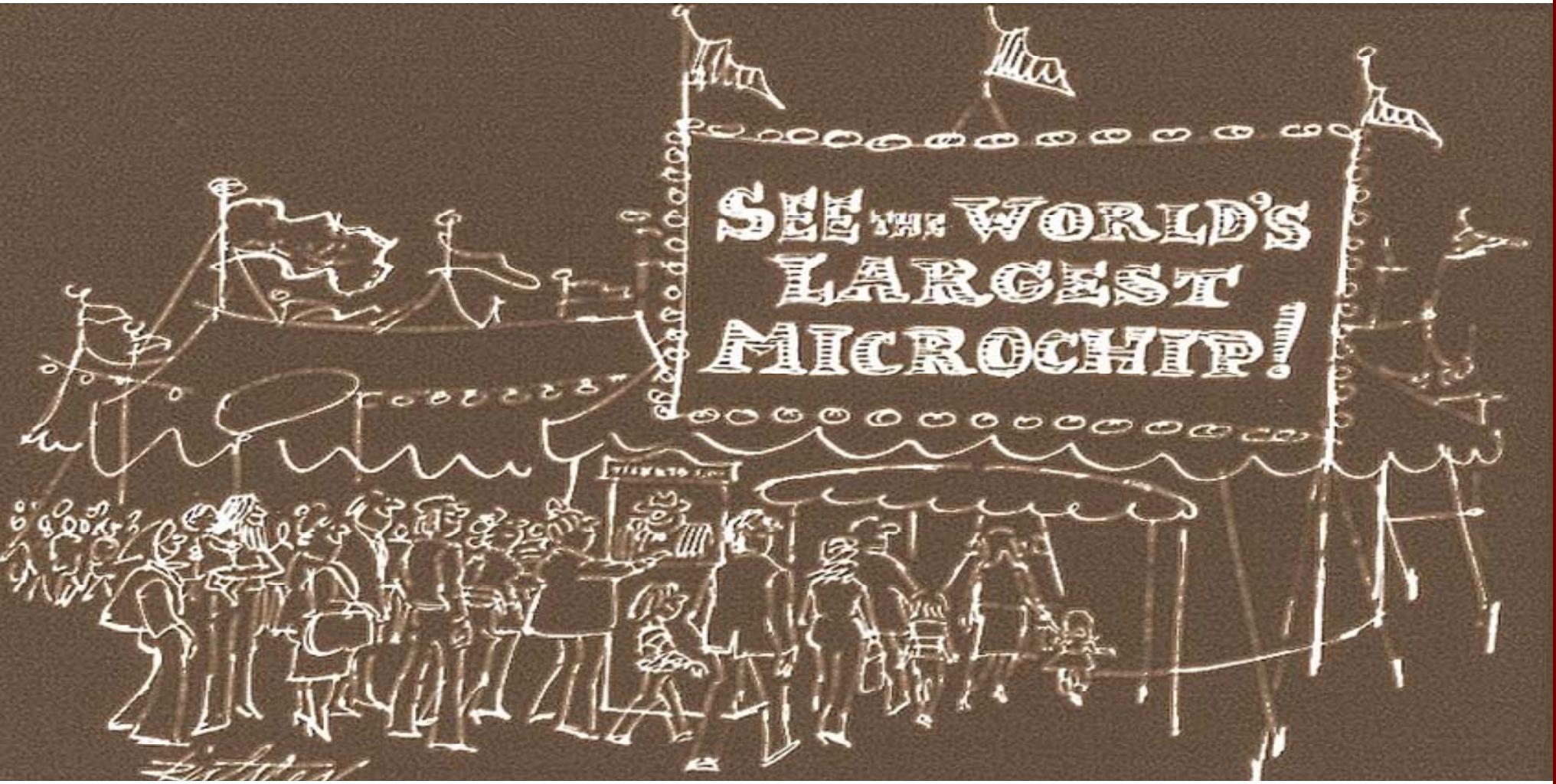
Paradox:

We are still practicing acute care medicine in a world of chronic disease

19^{th} century models at the dawn of the 21^{st} century

Some Ideas are Just Wrong



Chronic Care: A Universal 21st Century Challenge

- One in six Americans has a chronic condition that inhibits daily life
- In US, chronic disease accounts for:
  - 80% of hospital days (69% of admissions)
  - 83% of prescriptions
  - 66% of physician visits
  - 56% of ER visits
  - Almost 70% of all medical spending (95% for 65+)

RWJF, 1996

WHO has developed a plan for worldwide attention to chronic care

Some Ideas Need More Thought

Characteristics of Chronic Disease:

- Last a lifetime
- Accumulate with age
- Generally progressive, although the clinical course may have remissions and exacerbations
- Life-shaping
- Different meaning in different cultures

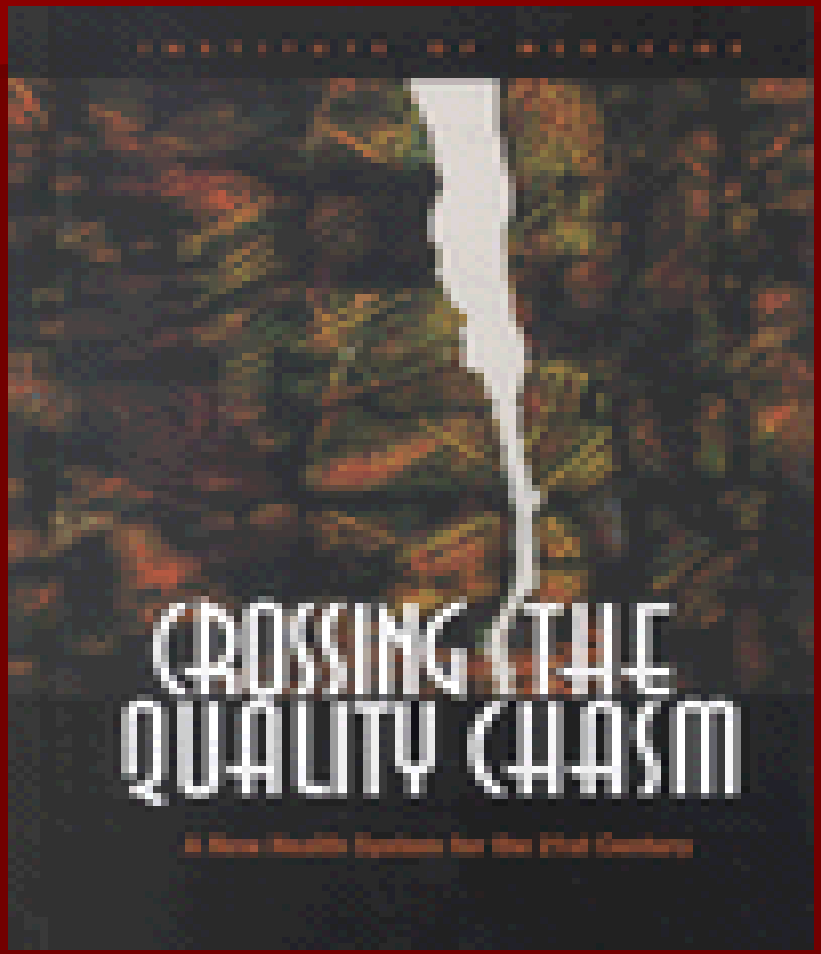
Goals of Chronic Disease Care

1. Manage the disease as well as possible to reduce the extent and frequency of exacerbations.
2. Prevent (or at least minimize) the transition from impairment to disability, and from disability to handicap.
3. Encourage patient to play an active role in managing his/her disease but avoid allowing the disease to become the dominant force in the person's life.

More Goals

4. Provide care in a culturally sensitive manner.
5. Integrate medical care with other aspects of life without medicalizing those aspects.

Components of Chronic Disease Care



- Patient experience of care
- Care delivery teams
- Organizations within which delivery teams and patients interact
- Regulatory and payment environment

What is involved

- New definitions
  - Prevention
  - Patients' roles
  - Time
  - Place
- New approaches
  - Professional roles
  - Expectations
  - Information technology
  - Management

A Lot Depends on Interpretation

Definitions: Prevention

- Prevent exacerbations
- Reduce expensive utilization
- Prevent dysfunction
- Avoid iatrogenic effects

Definitions: Patients' Roles

- 365/24/7
  - Shared responsibility
  - Shared risk
- Ongoing communication
- Shared decision making
  - Need better information
  - Need time

Definitions: Time

- Episode vs. Encounter
- Pay-off horizon
  - Up-front investment recovered over time
- Manage by change, not routine
  - Scheduling appointments
  - Length of appointments

Definitions: Place

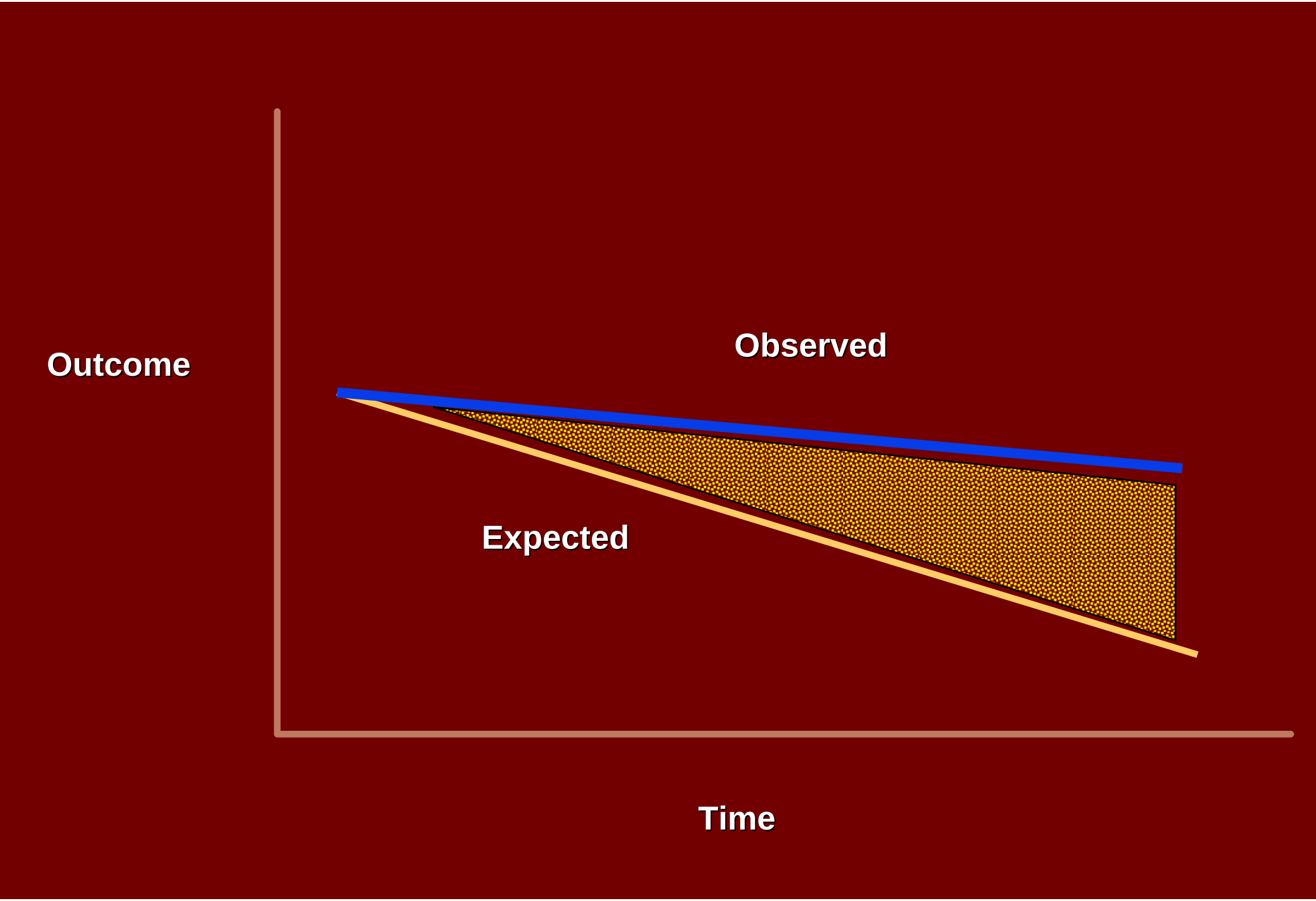
- Chronic care occurs across locations
- The same care can be provided in different settings

New Approaches: Professional Roles

- Downward delegation
  - non-physicians
  - non-professionals
- Primary care
  - simple cases
  - complex cases
- New teams
  - specialists & non-physicians

New Approaches: Expectations

- Cure vs. Management
- Measuring success
  - actual vs. expected


Outcome
Observed
Expected
Time

New Approaches: Information Technology

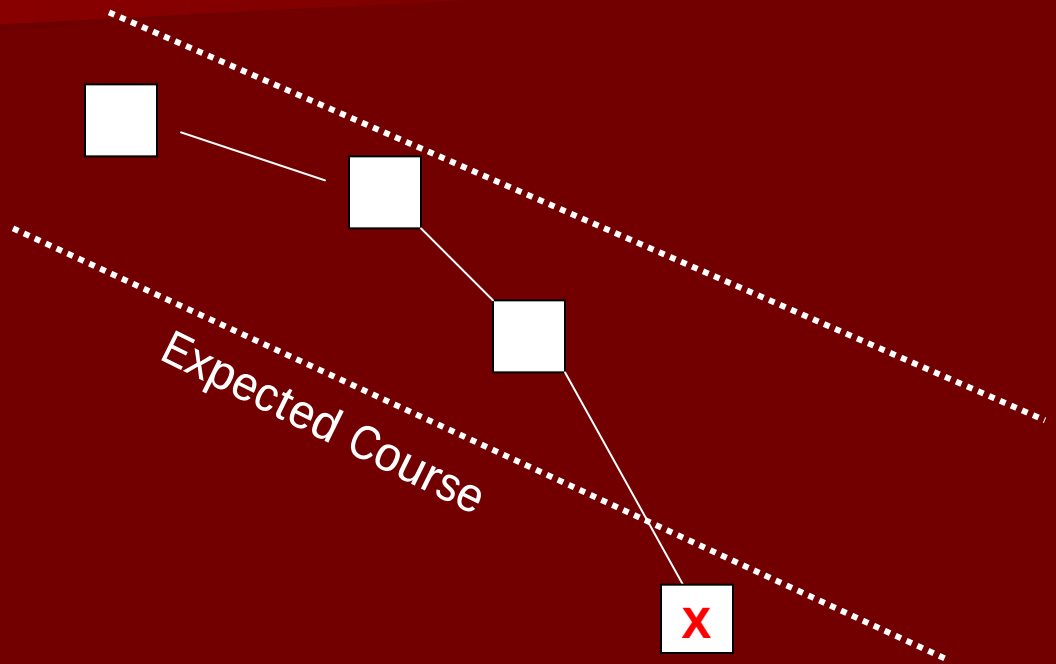
Problems with too much as well as too little information.
Need to focus provider & patient attention on salient data

- Validated protocols
  - professional
  - patient & family
- Just in time information
- Structured information
  - Clinical glidepaths

Clinical Glidepath

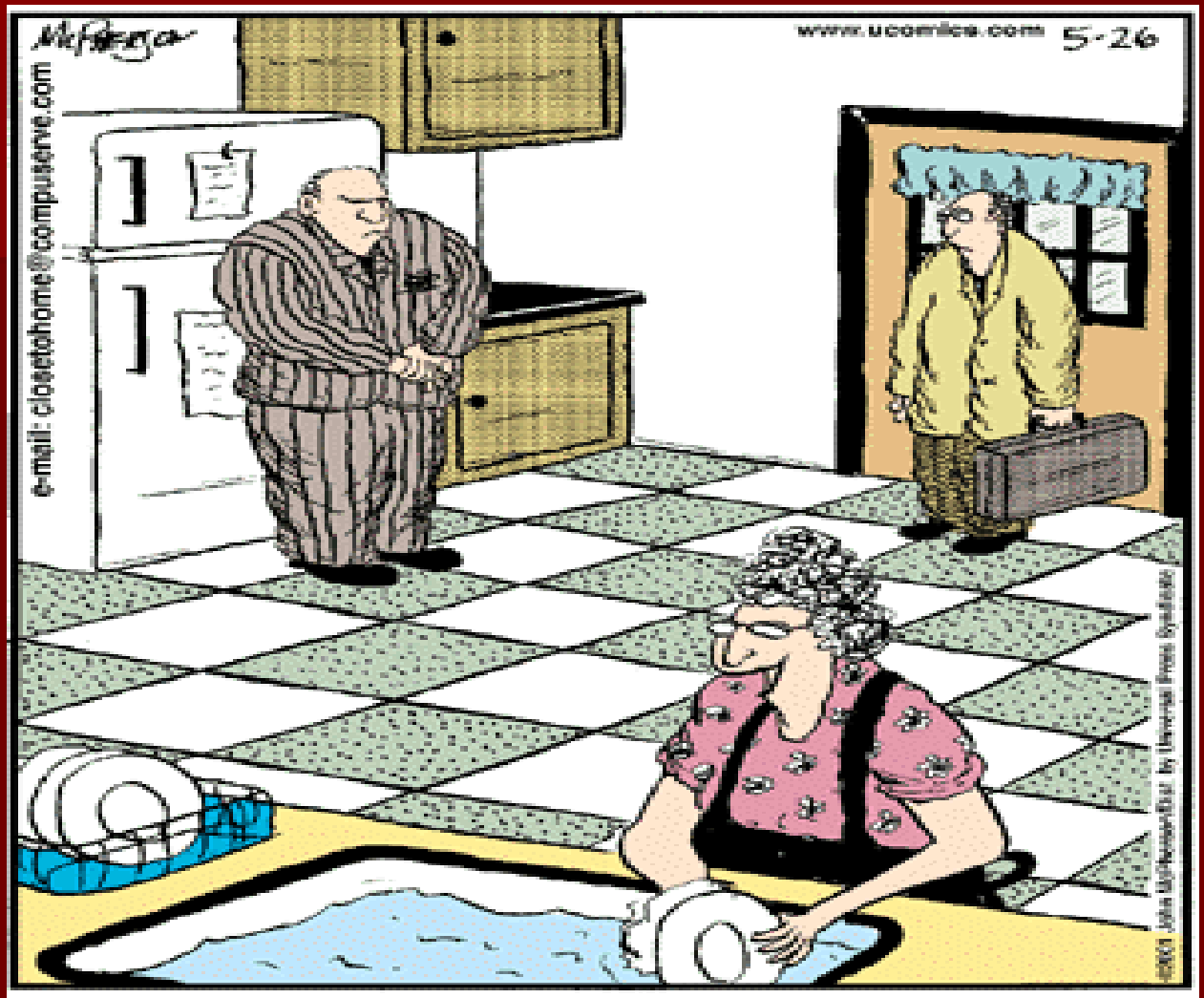
- **A Clinical Glidepath is a way to observe one or more parameters of a patient's condition on a regular basis to be able to compare the observed state with the expected state.**
- **It is a tool to improve communication between patients and primary care providers.**
- **If the patients stays within the expected course, nothing need be done.**
- **But if the patient's clinical course deviates, this change should trigger immediate closer attention to ward off a problem while it is early.**

Clinical Glidepath



New Approaches: Management

- Disease management
  - Often independent
  - Targeted



"Oh, that's Mr. Cardazy. Our HMO has determined that we're in the high-risk group for heart disease, so Mr. Cardazy has been assigned to help us make smarter food choices."

New Approaches: Management

- Patient self-care (Lorig; J Fries)
  - Education
  - Motivation
  - Attitudinal change
- Doctor-patient partnerships
  - Information based
  - Patient empowering

Case Management Variations

- Eligibility management
- Care coordination
- Utilization management
- Disease management
- Chronic care management

Strategies for Improving Chronic Disease Care

- Interdisciplinary team care
  - Data elements v data collection
- Group care
- Direct consumer education
  - Web-based info re various conditions
  - On-line info that triggers individually tailored messages to consumers
  - Quality?

Strategies for Improving Chronic Disease Care (cont'd)

- Information systems
  - Computerized physician order entry
  - Clinical tracking systems
    - Mobile computing
- Restructured health delivery roles
  - Add nurses & others to fill in for MD gaps
  - Substitute NPs for primary care MDs

Strategies for Improving Chronic Disease Care (cont'd)

- Information systems
  - Computerized physician order entry
  - Clinical tracking systems
    - Mobile computing

Evidence of Success

- Increased clinic visits and reorganization associated with fewer hospitalizations and urgent care visits in VA
  - COPD
  - Pneumonia
  - CHF
  - Angina
  - Diabetes
  - Chronic renal failure
  - Depression

Ashton, NEJM, 2003

- Quality care related to better survival among vulnerable older patients

  Higashi, Ann Int Med, 2005

- Self-management programs for diabetes and hypertension improve outcomes

  Chodosh, Ann Int Med, 2005

- Medication adherence reduces hospitalizations for diabetes, hypertension, hypercholesterolemia and CHF

  Sokol, Med. Care, 2005

Paying for Good Chronic Care

- FFS does not fit chronic care philosophy
  - No ability to invest
  - Every item must become billable
- Managed care seemed to offer the ideal setting for chronic care principles, BUT it did not work as well as many had hoped

Why Did Managed Care Fail?

- Initial incentives favored case mix selection
- Providing better care did not create a competitive advantage
- Danger of attracting sicker clientele
- Hard to create a case mix correction for the full care spectrum
- Americans do not accept restrictions well

Payment Issues: Provider Level

- Expect to be paid for what they do
- Expand coverage to include new services
  - Monitoring
  - Counseling
- Pay for decreased inpatient/ER utilization
  - Share costs/savings
- Pay more per visit for fewer visits
- Pay for episodes instead of incidents
  - What to include in bundle?
- Pay for outcomes
- Subcapitate

Medicare Initiatives

- New case mix adjustments (HCC)
  - Address the tail specifically?
- Demonstration projects
  - Need to calculate funding long enough for pay back on investments
- Special Need Programs
  - Basis for risk adjustment?

Conclusions

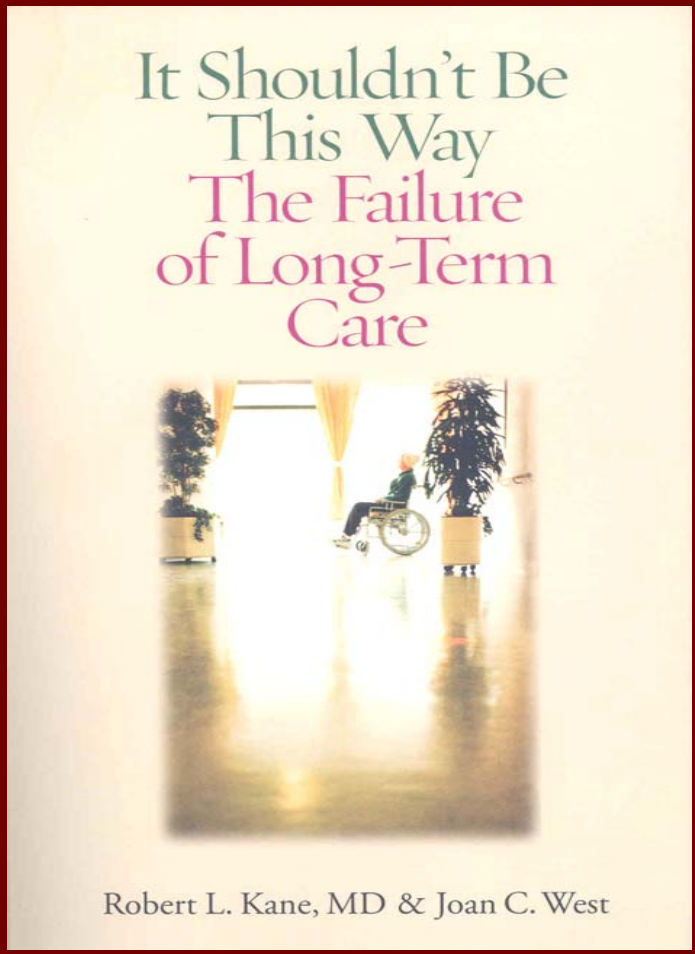
- Chronic disease is here to stay
- More must be done to bring the health care system into alignment
- There is good scientific evidence to show better care is possible
- Managed care does not seem to be the magic carpet
  - If managed care is to have any success, need better case mix payment system
- Changing the payment system is necessary but not sufficient

How You Implement Is Important

It Shouldn't Be This Way: The Failure of Long-Term Care

Robert L. Kane
Joan West

Vanderbilt University Press, 2005



PPECC

Professionals with Personal Experience in Chronic Care

Our mission is to draw upon the unique credentials of health care professionals as both care recipients (either directly or indirectly) and subject matter experts to promote the changes needed for aligning our medical system better with chronic illness care. Our message to policymakers and health system leaders—*If professionals working within the health care system are having serious problems with getting care for themselves and their families, then the system is failing in a major way.*

PPECC

Professionals with Personal Experience in Chronic Care

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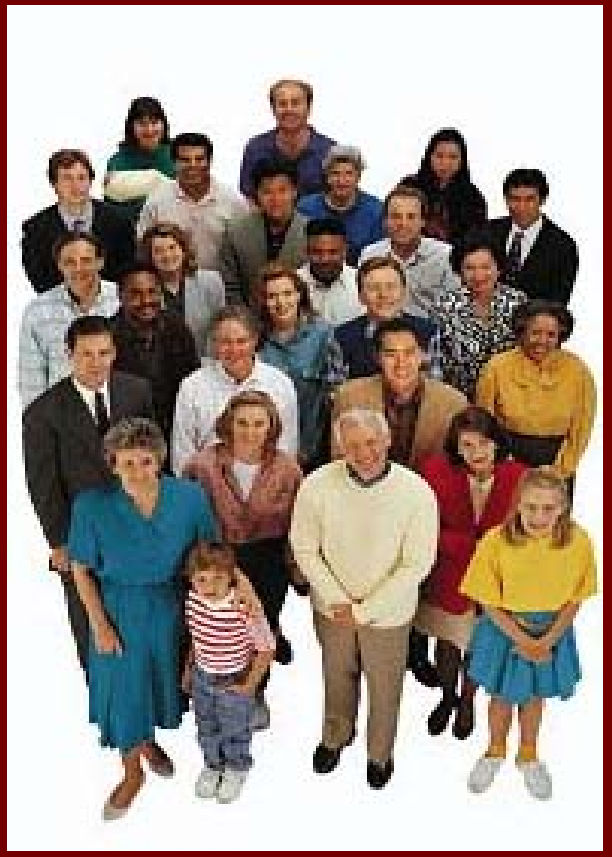

Meeting the Challenge of Chronic Illness

Robert L. Kane
Reinhard Priester
Annette Totten

Johns Hopkins University Press, 2005