

Crossing the Quality Chasm: Where are We and What's Next?

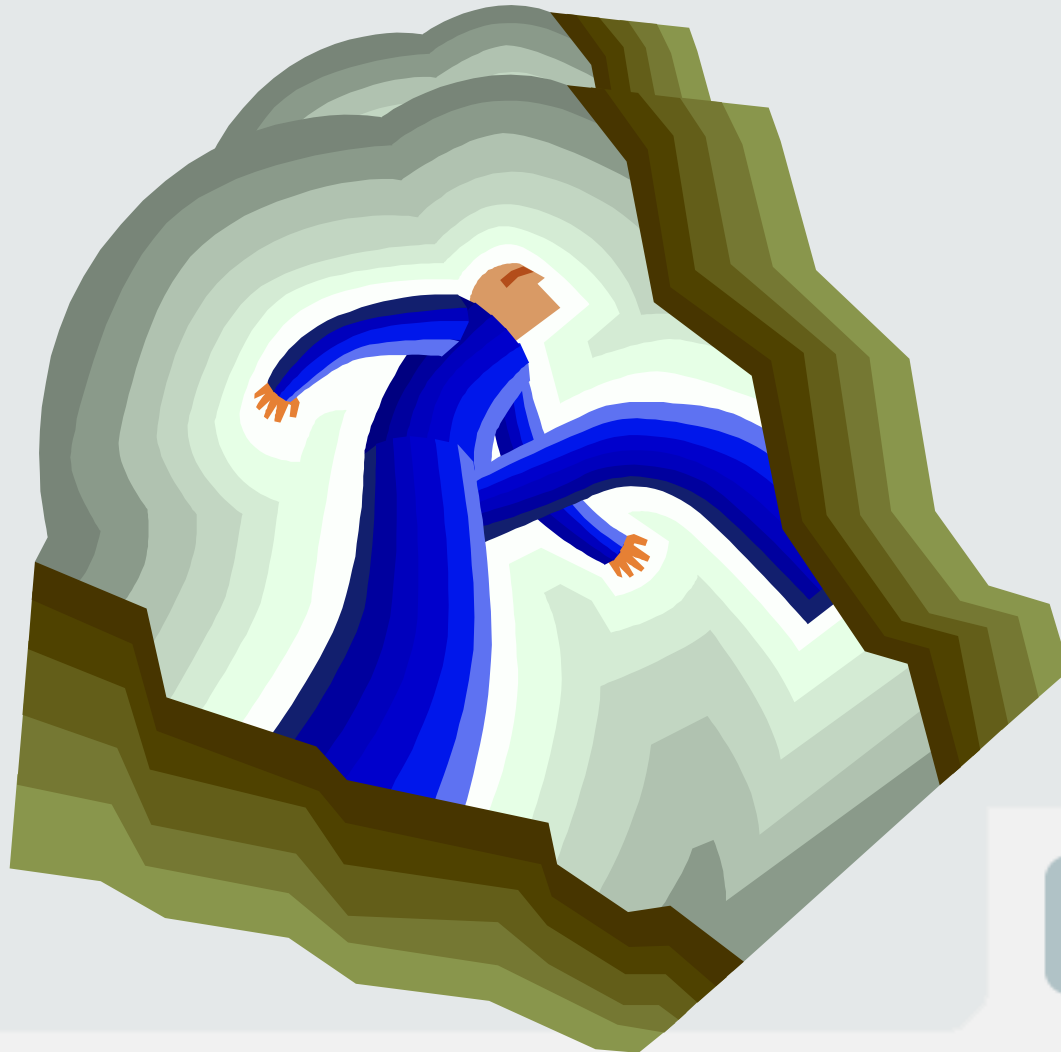
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Improving Chronic Illness Care

A national program of the Robert Wood Johnson Foundation





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Three questions

- Do we have enough evidence as to how to improve care?
- Can busy practices make the necessary changes?
- If so, will patients benefit?

Do we have enough evidence as
to how to improve care?

Post-discharge Programs for CHF Patients

- **18 RCTS, follow-up 3-12 months**
- **Care by team coordinated by nurse care manager, clinic or home visits plus phone, focus on medications and self-management**
- **25% reduction in readmission**
- **13% reduction in all-cause mortality**
- **Greater improvement in QOL**
- **Net cost savings \$536 per month**

Phillips et al. JAMA 2004; 291: 1358



Can busy practices do it? RAND Evaluation of Chronic Care Collaboratives

- Studied 51 organizations in four different collaboratives, 2132 BTS patients, 1837 controls with diabetes, CHF, asthma
- Controls generally from other practices in organization
- Data included patient and staff surveys, medical record reviews
- Organizations made average of 48 changes in 5.8/6 CCM areas

Do patients benefit?

RAND Findings

- **Asthma and diabetes pilot patients more likely to receive appropriate therapy.**
- **CHF pilot patients more knowledgeable and more often on recommended therapy, had 35% fewer hospital days**
- **Asthma pilot patients had better QOL**
- **Diabetes pilot and control patients had significantly better glycemic control (pilot>control); control improvement related to spread.**
- **Diabetes pilot patients had significantly reduced CVD risk**

Can we improve chronic illness care beyond the early adopters?

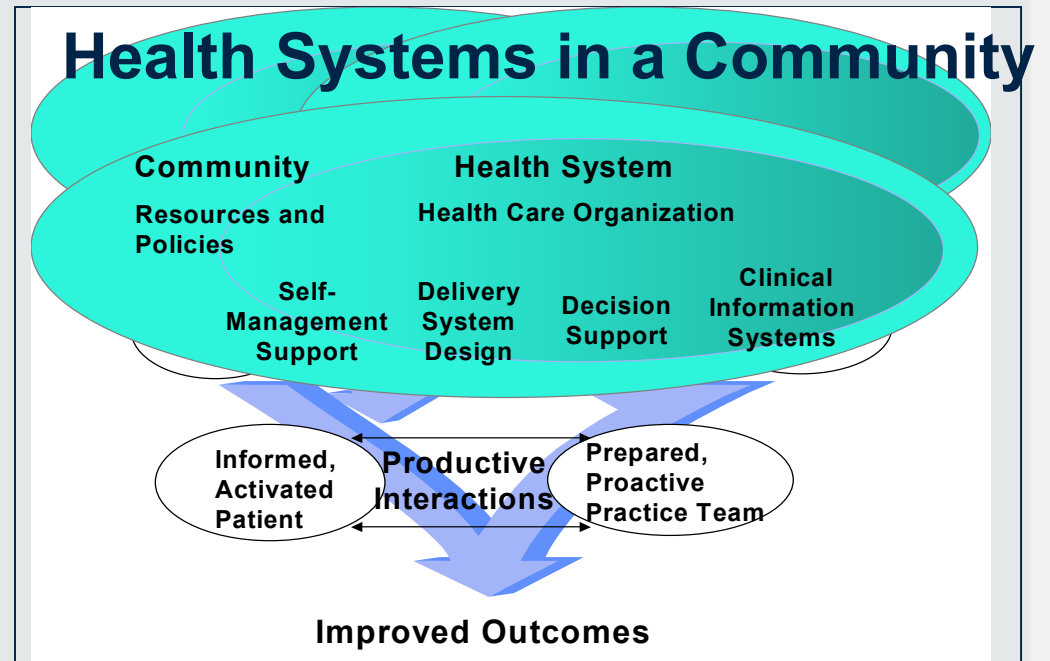
- The VA did it
- Community Health Centers are doing it
- Kaiser Permanente is doing it
- Etc., etc

BUT

1. Do the successes of large systems like the VA or BPHC have relevance for the larger, disorganized medical community?
2. Can “systemness” be a community property?
3. What are its key components?

“Systemness” as a Community Property

- Leadership and integration
- Performance measurement
- Changed incentives
- Models of change
- Programs for learning and dissemination
- Shared infrastructure
 1. Guidelines
 2. IT software and support
 3. Care management
 4. Consumer education



Widespread Practice Change

Improved Community Outcomes

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Leadership and integration must include the clinicians

Alan Glaseroff, MD

- A family doc trained at Case Western Reserve and UCSF
- Set up practice in Humboldt County in 1983
- Has been CMO of Humboldt-Del Norte IPA since 1995
- that organization is now a national model for professionally led QI
- A CHCF Leadership fellow, he now guides the PBGH, Lumetra and CAFPP collaboratives



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