Chronic Illness Care and the future of Primary Care

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Improving Chronic Illness Care
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Chronic Illness in America

- More than 125 million Americans suffer from one or more chronic illnesses and 40 million limited by them.
- Despite annual spending of more than $ 1 trillion and significant advances in care, one-half or more of patients still don’t receive appropriate clinical care.
- A much larger percentage receive little useful assistance in their self-management
- Patients and families increasingly recognize the defects in their care.

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Chronic Illness and Medical Care

- Primary care dominated by chronic illness care
- Clinical and behavioral management increasingly effective and increasingly complex
- Inadequate reimbursement and greater demand forcing primary care to increase throughput—the hamster wheel
- Unhappy primary care clinicians leaving practice; trainees choosing other specialties
- But, there is a growing interest in changing physician payment to encourage and reward quality

Proportion of Office Visits for Chronic Illness Care by Age - 2005

	Chronic Problem, Routine	Chronic Problem, Flare-up
All patients	30%	9%
Age 25-44	26%	9%
Age 45-64	37%	10%
Age 65+	42%	11%

NAMCS, Advance Data No. 387, 2007

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What Patients with Chronic Illnesses Need

- **A “continuous healing relationship” with a care team and practice system organized to meet their needs for:**

- **Effective Treatment (clinical, behavioral, supportive),**
- **Information and support for their self-management,**
- **Systematic follow-up and assessment tailored to clinical severity,**
- **More intensive management during high risk periods, and**
- **Coordination of care across settings and professionals**

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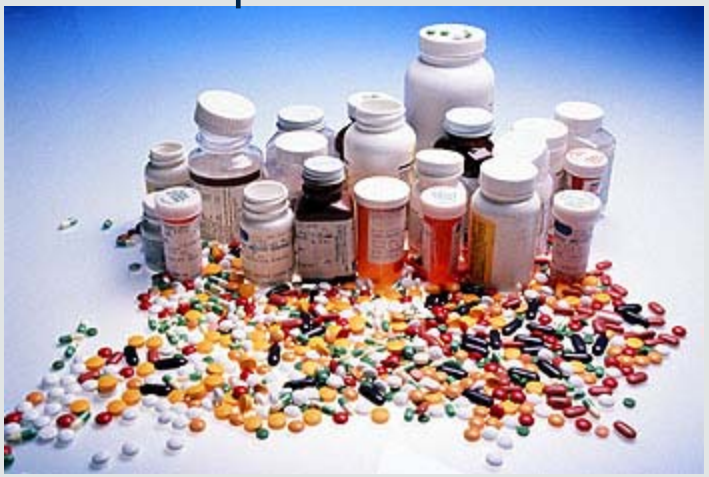
Greater care complexity and efficacy, but with lower self-efficacy?

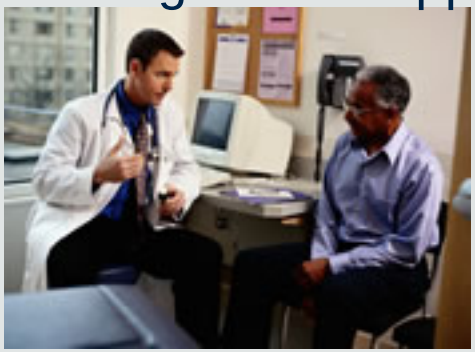
Multiple Medications



Complex Guidelines

Scheduled services	16-49 years care plan (guideline)		50+ years care plan (guideline)	
	Frequency yearly	Remarks	Frequency yearly	Remarks
Weight	√		√	
BMI	√		√	
Waist circumference	√		√	
BSL	√		√	
Urine	√		√	
Blood pressure	√		√	
Family history	√	Update records		
Exercise	√	Ask and advise	√	Ask and advise
Smoking	√	Ask and talk	√	Ask and talk
Alcohol	√	Ask and advise	√	Ask and advise
Pap smear	Every 2 years	From 18 years	Every 2 years	To age 70
Clinical breast exam	√	From 40 years	√	Only if no mammography
Pneumococcal vaccine	Every 5 years		Every 5 years	
Tetanus/Diphtheria vac			Every 10 years	
Home accidents			√	
Influenza vaccine			√	From 59 years
Physical function			√	
Nutrition			√	
Deafness			√	
Vision			√	
Mammography			Every 2 years	To age 69

Self-management Support



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Greater care complexity and ? lower self-efficacy

- Ostbye et al.* estimate that it would take 10.6 hrs/working day to deliver all evidence-based care for panel members with chronic conditions
- Residents and students report that a lack of confidence in one's ability to manage complex, chronically ill patients is driving career choice away from primary care.

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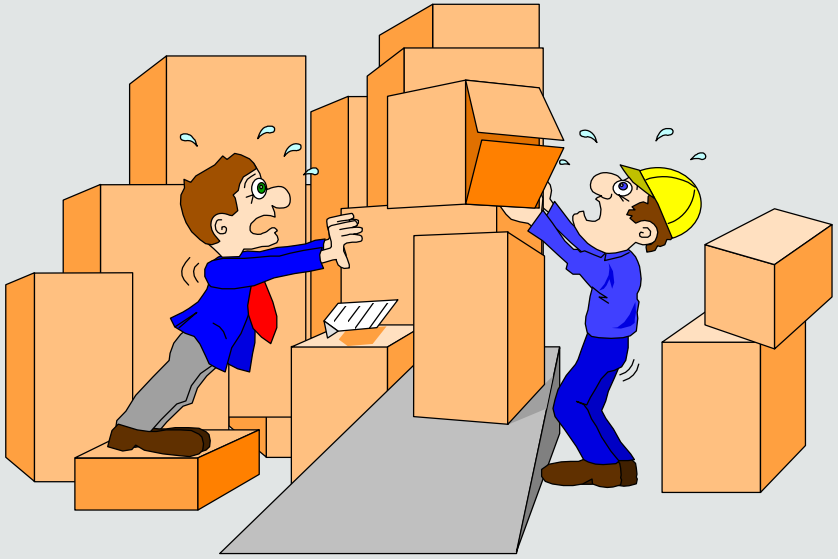
What's Responsible for the Quality Chasm?

- **A system oriented to acute disease that isn't working for patients or professionals**



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What to do?

- **The future of primary care (and our healthcare system) depends upon its ability to improve the quality and efficiency of its care for the chronically ill**
- **It will also require a recommitment of primary care to meet the needs of patients for timely, patient-centered, continuous and coordinated care**
- **That will require a major transformation or redesign of practice, not just better reimbursement**
- **But such transformations will be difficult to motivate or sustain without payment reform.**

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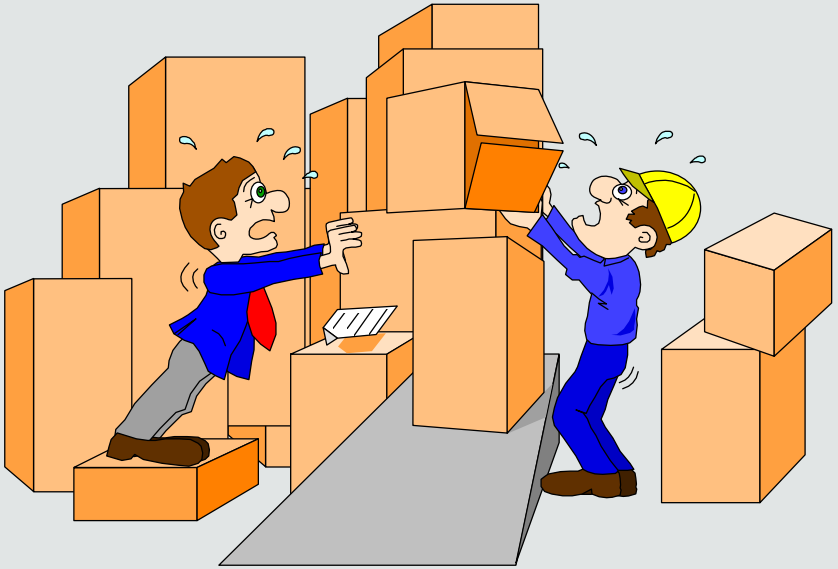
What kind of transformation or changes to practice systems improve care?



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Toward a chronic care oriented system

Reviews of interventions across conditions show that practice changes are similar across conditions

Integrated changes including greater use of:

- **non-physician team members in clinical roles**
- **planned encounters,**
- **modern self-management support,**
- **More intensive management of those at high risk**
- **guidelines integrated into decision-making**
- **registries**

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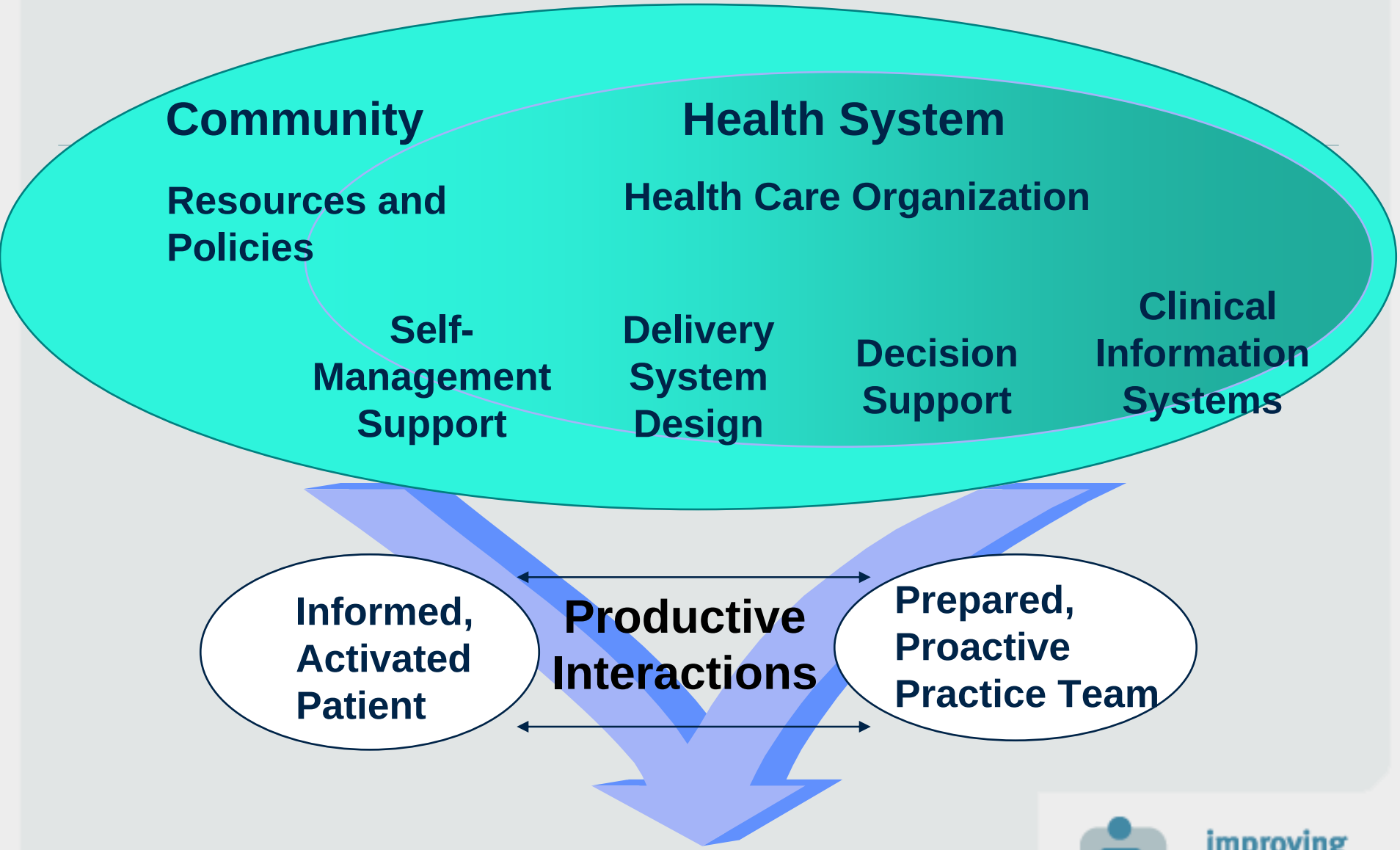
Chronic Care Model



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Essential Elements of Good Chronic Illness Care

What is a productive interaction?

Patient needs are met!

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What characterizes an “informed, activated patient”?

They have the motivation, information, skills, and confidence necessary to effectively make decisions about their health and manage it

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Self-Management Support

- **Have someone in the practice trained in effective self-management counseling.**
- **AND/OR develop a link with trained patient educator(s) in the community.**
- **Repeatedly emphasize the patient's central role.**
- **Organize practice team and resources to provide some self-management support AT EVERY ENCOUNTER.**

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Community Resources and Policies

- Identify critical patient services in your community.
- Discuss your needs (e.g., access, information) with the relevant community organizations.
- Encourage patients to participate in effective programs.

What characterizes a “prepared” practice team?

Practice organizes and plans care to make optimal care routine/the default.

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Delivery System Design

- Define roles and distribute tasks among team members.
- Use planned interactions routinely to support evidence-based care.
- Intensify treatment if goals not reached—stepped care and care management
- Ensure regular follow-up.
- Give care that patients understand and that fits their culture.

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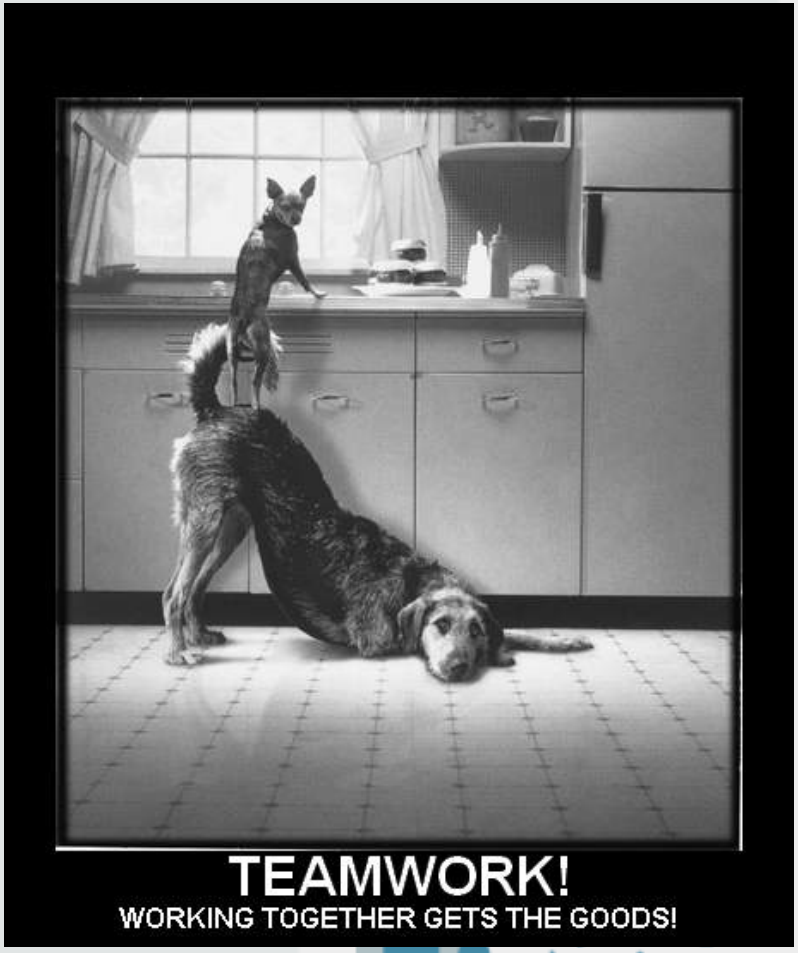
Team Care

Define roles and tasks and distribute them among team members.



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Team Care: What roles and tasks?

Roles

- **Population manager**
  reviews registry, calls patients, performance measurement
- **Care manager**
  provides more intensive management/follow-up for high risk patients
- **Self-management Coach**
  provides SM assistance

Tasks

- **Determined by guidelines**

  Diabetic foot exam
  Peak flow measurement
  Administering the PHQ-9
  Follow-up phone calls

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Planned Visits

- **Team plans and organizes their visits or other contacts with chronically ill patients**

  a) Prior to visit (session), team huddles to review registry to identify needed services

  b) Team organizes to provide those services

  c) After visit (session), team huddles to review follow-up

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Care Management

- **Definition: More intensive management of high risk patients.**
- **Consists of:**
  - More intensive self-management support
  - Closer monitoring of medications and medication adherence, medication adjustment
  - Closer follow-up
  - Coordination of care
- **Who Does it? Can be done by an individual or a team.**

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Clinical Information System: Registry

- A database of clinically useful and timely information on all patients provides reminders and feedback and facilitates care planning for individuals or populations, and proactive care
- Many commercially available EHRs do not have these capabilities
- Data MUST be entered once and only once—most efficient is to use registry summary as visit record AND data form

Why is registry functionality so critical?

- Population management
- Encounter planning and reminders
- Performance measurement

Does the CCM Work?

The Evidence Base

Coleman et al., Health Affairs, Jan. 2009

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Medical home – Chronic Care Model
Duplicative, Complementary or Antagonistic?

- Both emphasize and support patient role in decision-making
- MH redefines primary care responsibility
- CCM redesigns care delivery for planned care
- CCM and MH integrated into the Patient-centered Medical Home endorsed by ACP, AAFP, AAP, AOA

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The Chronic Care Model and the PPC-PCMH

PPC-PCMH Element	CCM Element
PPC 1 Access & Communication	**Translation services**
PPC 2 Patient Tracking & Registry Functions	**Registry, Population management**
PPC3 Care management	**Use of guidelines, clinician reminders, team care, planned visits, follow-up**
PPC4 Patient Self-management Support	**Self-management support**
PPC 5 Electronic Prescribing	
PPC 6 Test Tracking	
PPC 7 Referral Tracking	**Community resources**
PPC 8 Performance reporting and improvement	**Performance measurement and reporting, QI**
PPC 9 Advanced Electronic Communication	

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How do we get primary care off the hamster wheel?

- Eliminate FFS reimbursement for primary care
- Create high functioning practice teams
- Longer, better organized visits for chronically ill patients

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Contact us:

- **www.improvingchroniccare.org**

thanks

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