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.
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

<table>
<thead>
<tr>
<th>Age</th>
<th>Chronic Problem, Routine</th>
<th>Chronic Problem, Flare-up</th>
</tr>
</thead>
<tbody>
<tr>
<td>All patients</td>
<td>30%</td>
<td>9%</td>
</tr>
<tr>
<td>Age 25-44</td>
<td>26%</td>
<td>9%</td>
</tr>
<tr>
<td>Age 45-64</td>
<td>37%</td>
<td>10%</td>
</tr>
<tr>
<td>Age 65+</td>
<td>42%</td>
<td>11%</td>
</tr>
</tbody>
</table>

NAMCS, Advance Data No. 387, 2007
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.
Greater care complexity and efficacy, but with lower self-efficacy?

Multiple Medications

Complex Guidelines

<table>
<thead>
<tr>
<th>Scheduled services</th>
<th>16–49 years care plan (guideline)</th>
<th>50+ years care plan (guideline)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency yearly</td>
<td>Remarks</td>
</tr>
<tr>
<td>Weight</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>BMI</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Waist circumference</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>BSI</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Urine</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Blood pressure</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Family history</td>
<td>Yes</td>
<td>Update records</td>
</tr>
<tr>
<td>Exercise</td>
<td>Yes</td>
<td>Ask and advise</td>
</tr>
<tr>
<td>Smoking</td>
<td>Yes</td>
<td>Ask and talk</td>
</tr>
<tr>
<td>Alcohol</td>
<td>Yes</td>
<td>Ask and advise</td>
</tr>
<tr>
<td>Pap smear</td>
<td>Every 2 years</td>
<td>From 18 years</td>
</tr>
<tr>
<td>Clinical breast exam</td>
<td>Yes</td>
<td>From 40 years</td>
</tr>
<tr>
<td>Pneumococcal vaccine</td>
<td>Every 5 years</td>
<td></td>
</tr>
<tr>
<td>Tetanus/Diphtheria toxoid</td>
<td>Every 10 years</td>
<td></td>
</tr>
<tr>
<td>Herp vaccinations</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Influenza vaccine</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Physical function</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Nutrition</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Gunshots</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Vision</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Mammography</td>
<td>Yes</td>
<td></td>
</tr>
</tbody>
</table>

Self-management Support
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.
What’s Responsible for the Quality Chasm?

- A system oriented to acute disease that isn’t working for patients or professionals
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.
What kind of transformation or changes to practice systems improve care?
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
Chronic Care Model

Community
- Resources and Policies
  - Self-Management Support

Health System
- Health Care Organization
  - Delivery System Design
  - Decision Support
  - Clinical Information Systems

Productive Interactions
- Informed, Activated Patient
- Prepared, Proactive Practice Team

Improved Outcomes
Essential Elements of Good Chronic Illness Care

Informed, Activated Patient  Productive Interactions  Prepared Practice Team

What is a productive interaction?

Patient needs are met!
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.
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.
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.
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.
Team Care

Define roles and tasks and distribute them among team members.
### Team Care: What roles and tasks?

<table>
<thead>
<tr>
<th>Roles</th>
<th>Tasks</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Population manager</strong> reviews registry, calls patients, performance measurement</td>
<td><strong>Determined by guidelines</strong></td>
</tr>
<tr>
<td><strong>Care manager</strong> provides more intensive management/follow-up for high risk patients</td>
<td>Diabetic foot exam</td>
</tr>
<tr>
<td><strong>Self-management Coach</strong> provides SM assistance</td>
<td>Peak flow measurement</td>
</tr>
<tr>
<td></td>
<td>Administering the PHQ-9</td>
</tr>
<tr>
<td></td>
<td>Follow-up phone calls</td>
</tr>
</tbody>
</table>
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
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.
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
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
<table>
<thead>
<tr>
<th>PPC-PCMH Element</th>
<th>CCM Element</th>
</tr>
</thead>
<tbody>
<tr>
<td>PPC 1 Access &amp; Communication</td>
<td>Translation services</td>
</tr>
<tr>
<td>PPC 2 Patient Tracking &amp; Registry Functions</td>
<td>Registry, Population management</td>
</tr>
<tr>
<td>PPC3 Care management</td>
<td>Use of guidelines, clinician reminders, team care, planned visits, follow-up</td>
</tr>
<tr>
<td>PPC4 Patient Self-management Support</td>
<td>Self-management support</td>
</tr>
<tr>
<td>PPC 5 Electronic Prescribing</td>
<td></td>
</tr>
<tr>
<td>PPC 6 Test Tracking</td>
<td></td>
</tr>
<tr>
<td>PPC 7 Referral Tracking</td>
<td>Community resources</td>
</tr>
<tr>
<td>PPC 8 Performance reporting and improvement</td>
<td>Performance measurement and reporting, QI</td>
</tr>
<tr>
<td>PPC 9 Advanced Electronic Communication</td>
<td></td>
</tr>
</tbody>
</table>
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
Contact us:

• www.improvingchroniccare.org

thanks