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Chronic Care and Its Place in Health Reform

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Disease Management Colloquium

May 19, 2008

Q: Why Health Reform?

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Q: Why Health Reform?

A: Because U.S. Health System Performance is Suboptimal

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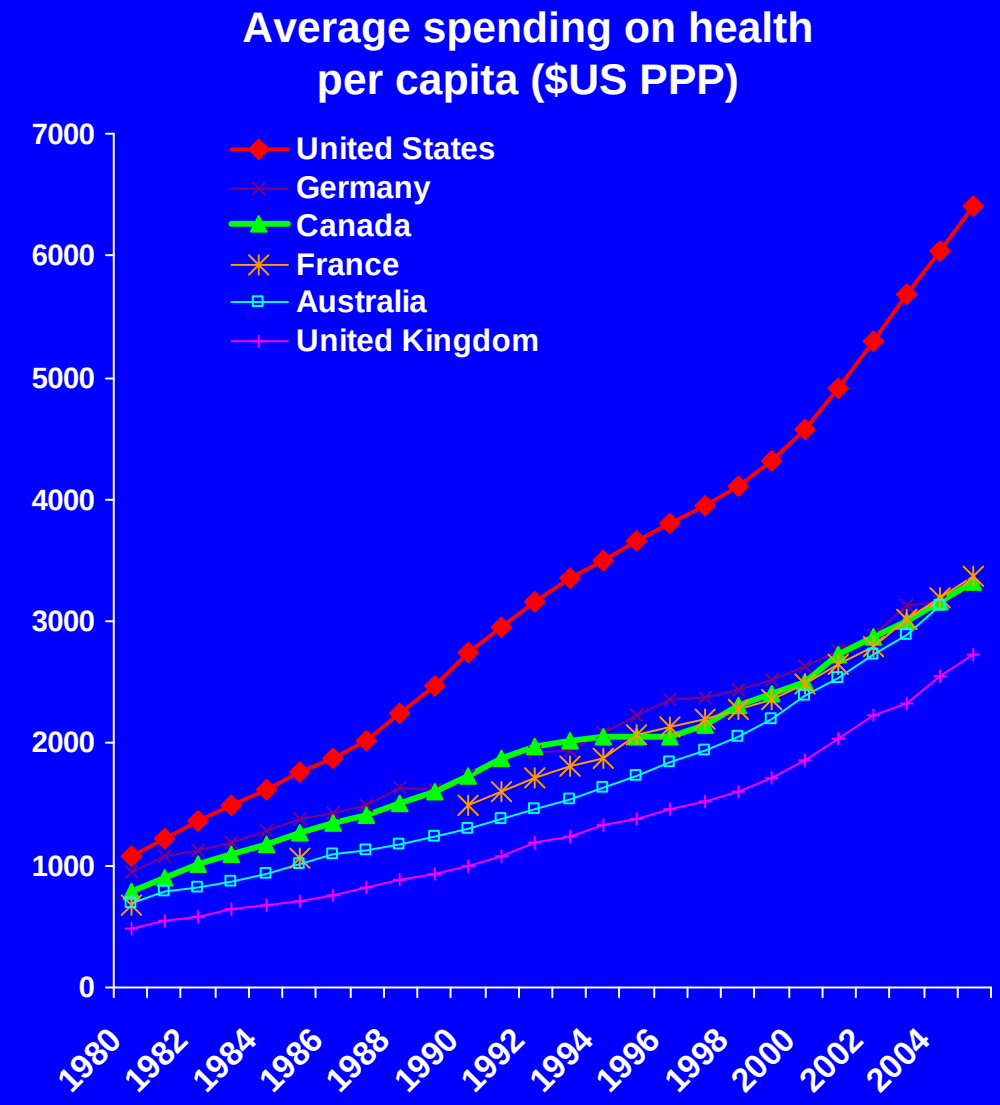
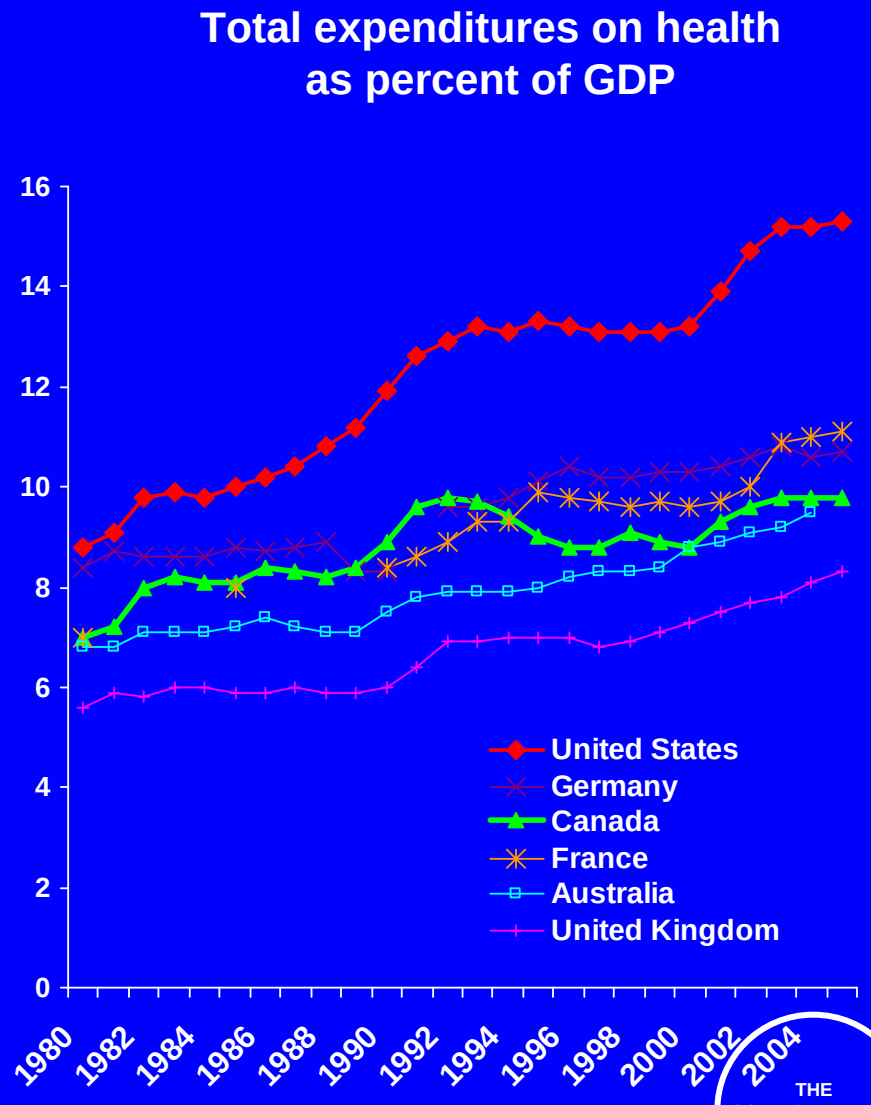
International Comparison of Spending on Health, 1980–2005





Source: K. Davis, C. Schoen, S. Guterman, T. Shih, S. C. Schoenbaum, and I. Weinbaum, Slowing the Growth of U.S. Health Care Expenditures: What Are the Options?, The Commonwealth Fund, January 2007, updated with 2007 OECD data

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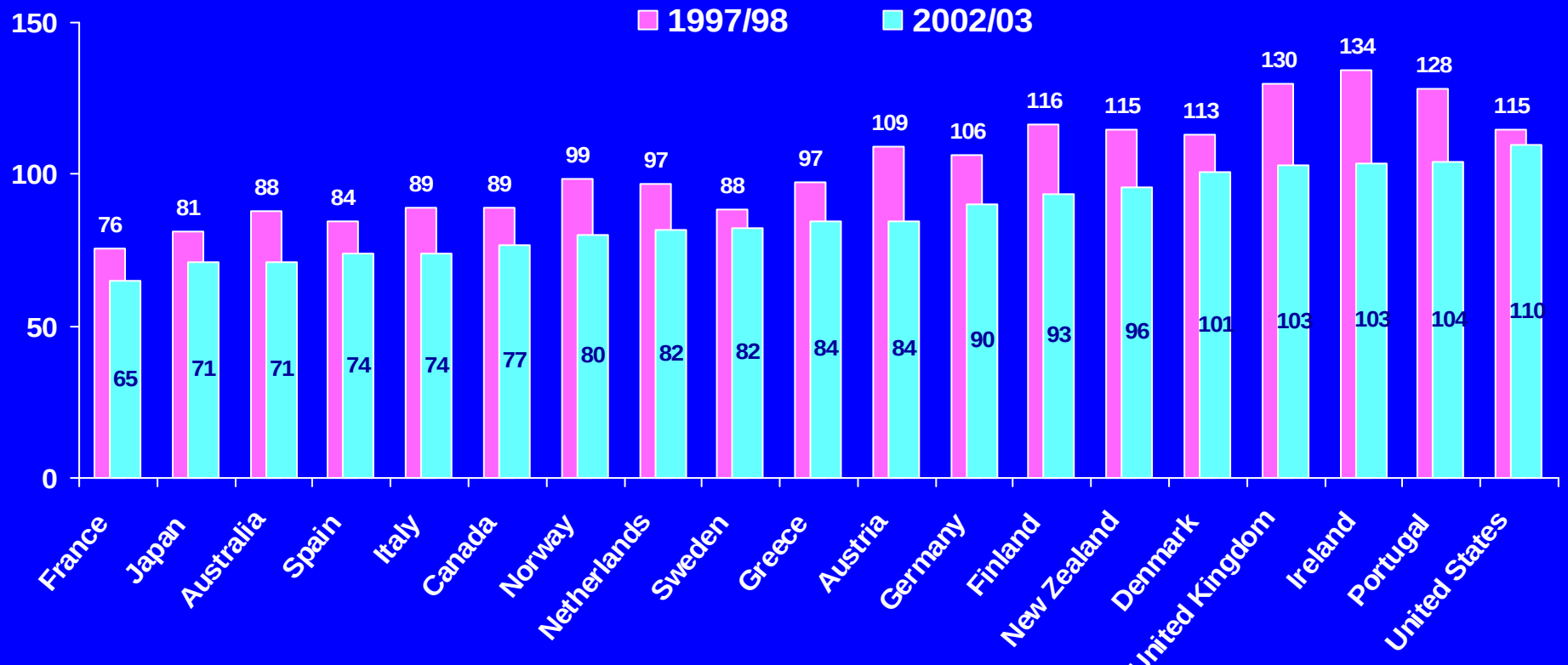
Mortality Amenable to Health Care

Deaths per 100,000 population*



* Countries' age-standardized death rates, ages 0–74; includes ischemic heart disease. See Technical Appendix for list of conditions considered amenable to health care in the analysis.
Data: E. Nolte, London School of Hygiene and Tropical Medicine analysis of World Health Organization (WHO) mortality files.

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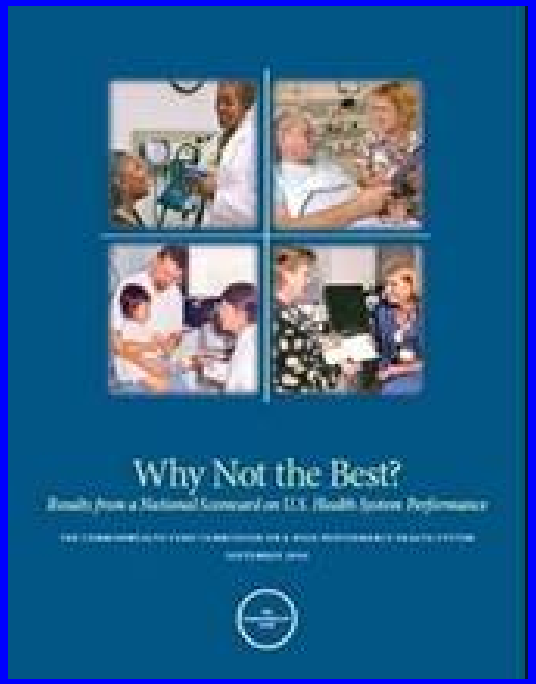
The Commonwealth Fund Commission on a High Performance Health System

Objective:

- **To move the U.S. toward a high performance health care system that helps everyone, to the extent possible, lead long, healthy, and productive lives**
- **To the Commission, a high performance health system is designed to achieve four core goals**
    1. **high quality, safe care**
    2. **access to care for all**
    3. **efficient, high value**
    4. **system capacity to innovate and improve**

Chairman: James J. Mongan, M.D.
President and CEO Partners HealthCare System, Inc.

US Scorecard: Why Not the Best?
Commonwealth Fund Commission National Scorecard



- 37+ Indicators
- U.S. compared to benchmarks

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Five Key Strategies for High Performance = Health Reform

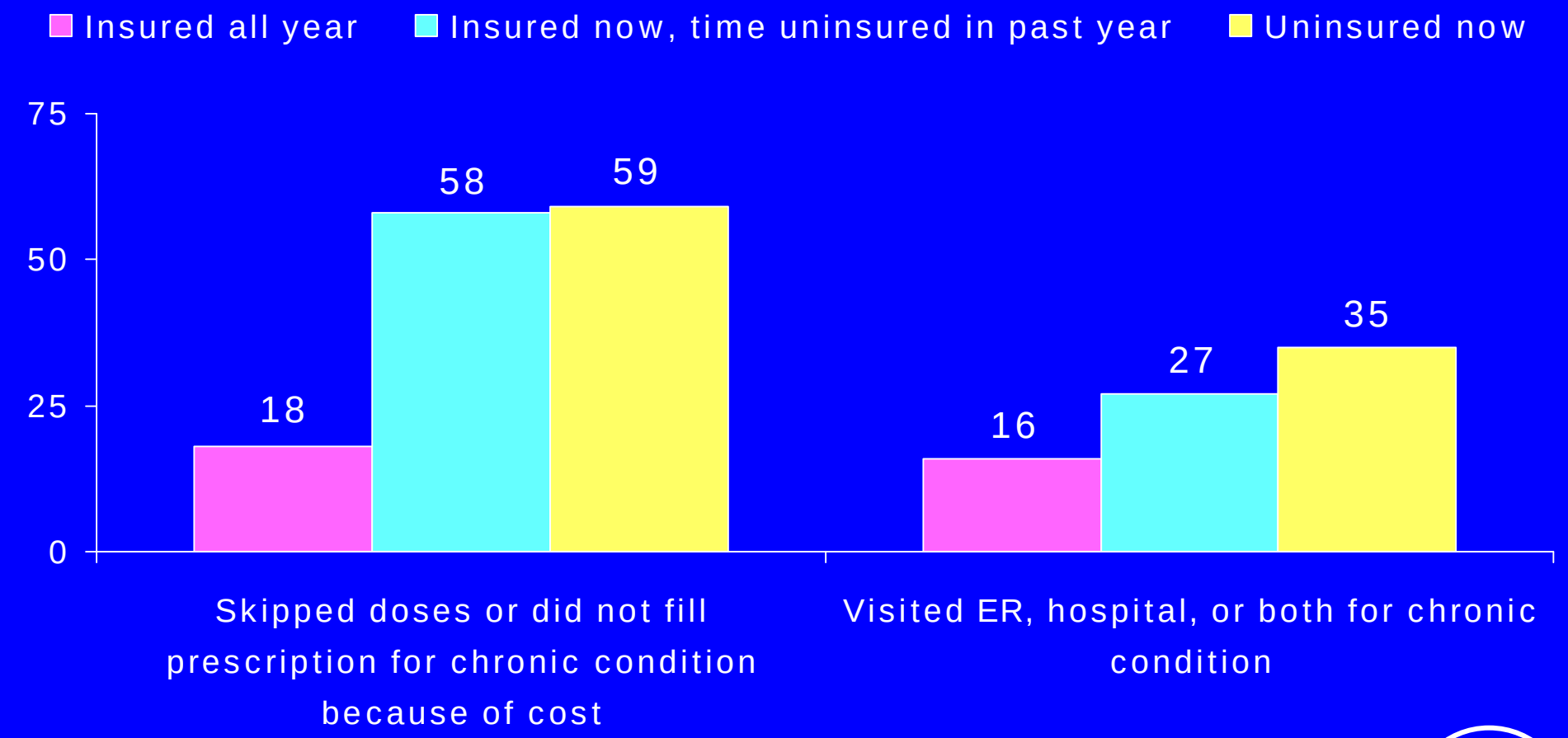
1. **Extend affordable health insurance to all**
2. **Align financial incentives to enhance value and achieve savings**
3. **Organize the health care system around the patient to ensure that care is accessible and coordinated**
4. **Meet and raise benchmarks for high-quality, efficient care**
5. **Ensure accountable national leadership and public/private collaboration**

Source: Commission on a High Performance Health System, A High Performance Health System for the United States: An Ambitious Agenda for the Next President, The Commonwealth Fund, November 2007

1. Extend affordable health insurance to all

Adults With No *or* Unstable Insurance Are Less Likely to Manage Chronic Conditions Well

Percent of adults ages 19–64 with at least one chronic condition*



*Hypertension, high blood pressure, or stroke; heart attack or heart disease; diabetes; asthma, emphysema, or lung disease.

Source: S. R. Collins, K. Davis, M. M. Doty, J. L. Kriss, A. L. Holmgren, *Gaps in Health Insurance: An All-American Problem*, Findings from the Commonwealth Fund Biennial Health Insurance Survey (New York: The Commonwealth Fund) Apr. 2006.

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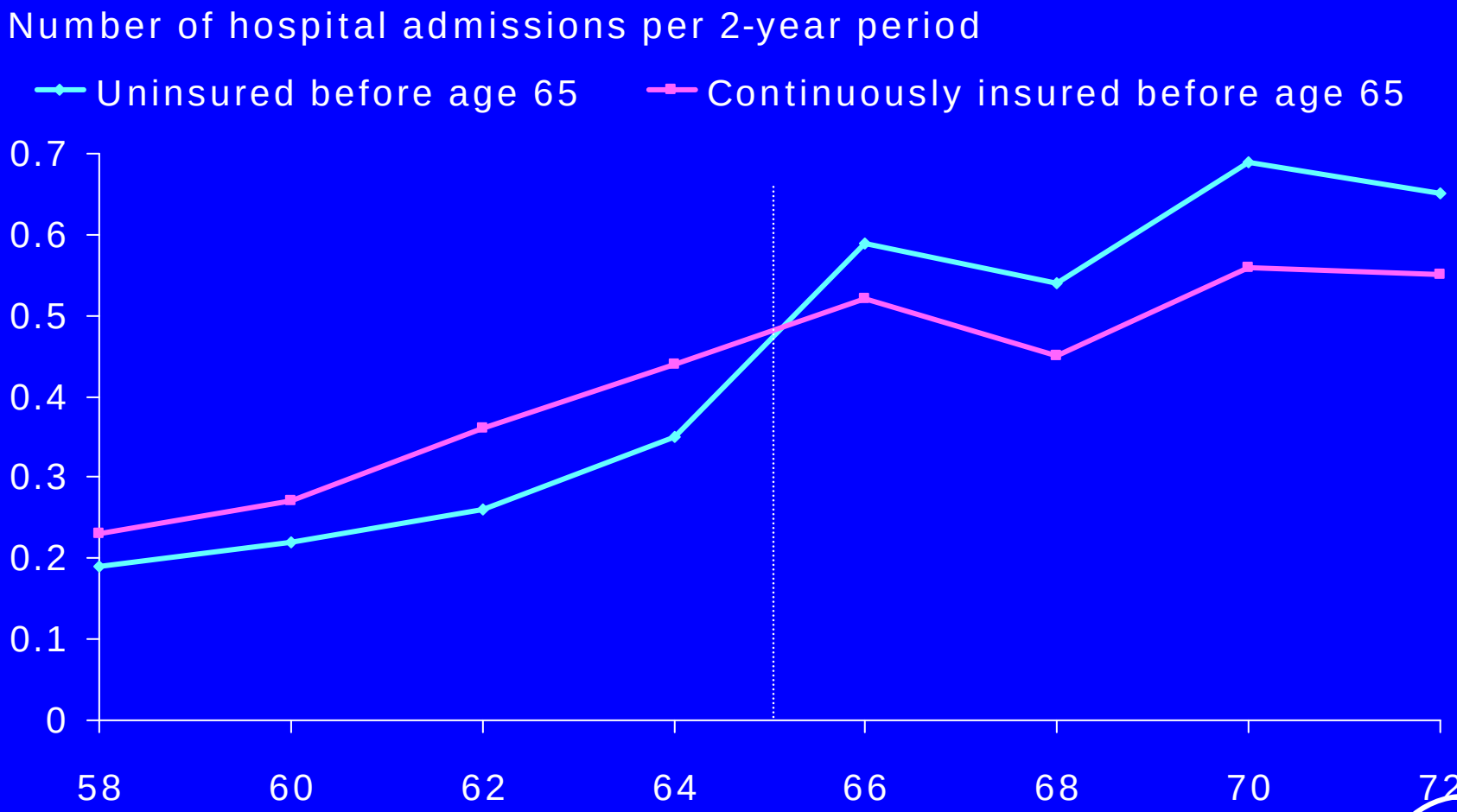
Previously Uninsured Medicare Beneficiaries With History of Cardiovascular Disease or Diabetes Have Much Higher Hospital Admissions After Entering Medicare Than Previously Insured



Source: J. M. McWilliams, et al., "Use of Health Services by Previously Uninsured Medicare Beneficiaries," NEJM 357;2, Jul 12 2007.

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Health Consequences of Gaps in Health Insurance Coverage

Deaths of Adults Ages 25 – 64, 2004

1. **Cancer – 164,832**
2. **Heart disease – 117,257**
3. **Unintentional injuries – 56,096**
4. **Suicide – 22,629**
5. **Uninsured – 20,000**
6. **Cerebrovascular disease – 19,075**
7. **Diabetes – 18,972**
8. **Chronic lower respiratory disease – 15,265**
9. **Chronic liver disease and cirrhosis – 17,173**

Sources: U.S. Department of Health and Human Services, National Center for Health Statistics, Health, United States, 2007, Table 31, p. 186 – leading causes of deaths; S. Dorn, "Uninsured and Dying Because of It," Urban Institute, January 2008, deaths attributable to higher risks of uninsured adults 25–54.

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2. Align financial incentives to enhance value and *achieve savings*

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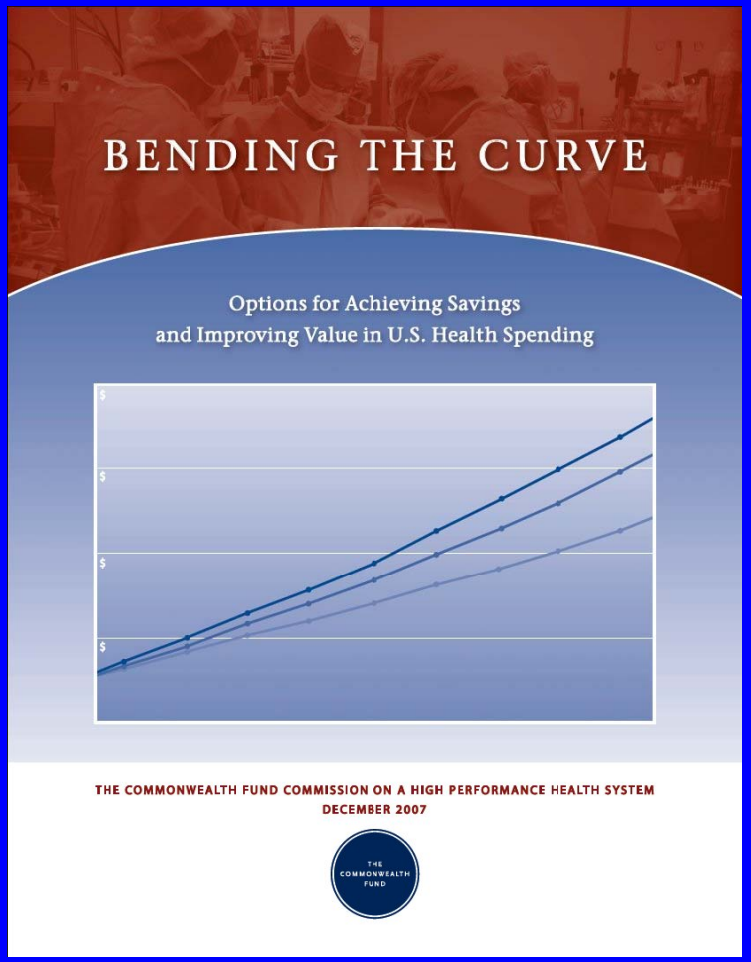
Options to Achieve Savings

Producing and Using Better Information

Promoting Health and Disease Prevention

Aligning Incentives with Quality and Efficiency

Correcting Price Signals in the Health Care Market



Source: ***Bending the Curve: Options for Achieving Savings and Improving Value in U.S. Health Spending*****, Commonwealth Fund, December 2007.**

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Fifteen Options that Achieve Savings
Cumulative 10-Year Savings

Producing and Using Better Information	
• Promoting Health Information Technology	-$88 billion
• Center for Medical Effectiveness and Health Care Decision-Making	-$368 billion
• Patient Shared Decision-Making	-$9 billion
Promoting Health and Disease Prevention	
• Public Health: Reducing Tobacco Use	-$191 billion
• Public Health: Reducing Obesity	-$283 billion
• Positive Incentives for Health	-$19 billion
Aligning Incentives with Quality and Efficiency	
• Hospital Pay-for-Performance	-$34 billion
• Episode-of-Care Payment	-$229 billion
• Strengthening Primary Care and Care Coordination	-$194 billion
• Limit Federal Tax Exemptions for Premium Contributions	-$131 billion
Correcting Price Signals in the Health Care Market	
• Reset Benchmark Rates for Medicare Advantage Plans	-$50 billion
• Competitive Bidding	-$104 billion
• Negotiated Prescription Drug Prices	-$43 billion
• All-Payer Provider Payment Methods and Rates	-$122 billion
• Limit Payment Updates in High-Cost Areas	-$158 billion

Source: ***Bending the Curve: Options for Achieving Savings and Improving Value in U.S. Health Spending*****, Commonwealth Fund, December 2007.**

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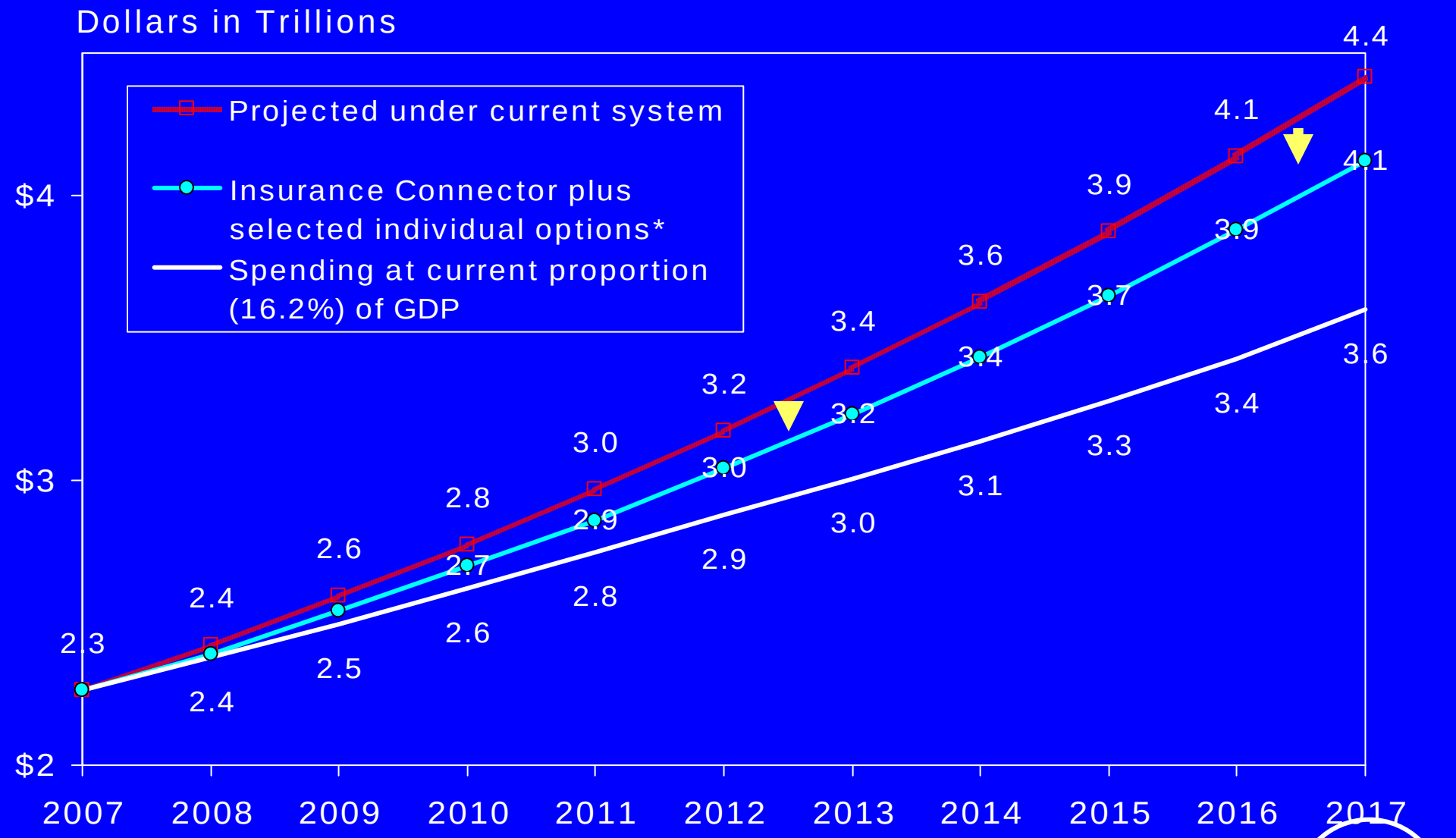
Total National Health Expenditures, 2008 - 2017 Projected and Various Scenarios



•Selected options include improved information, payment reform, and public health

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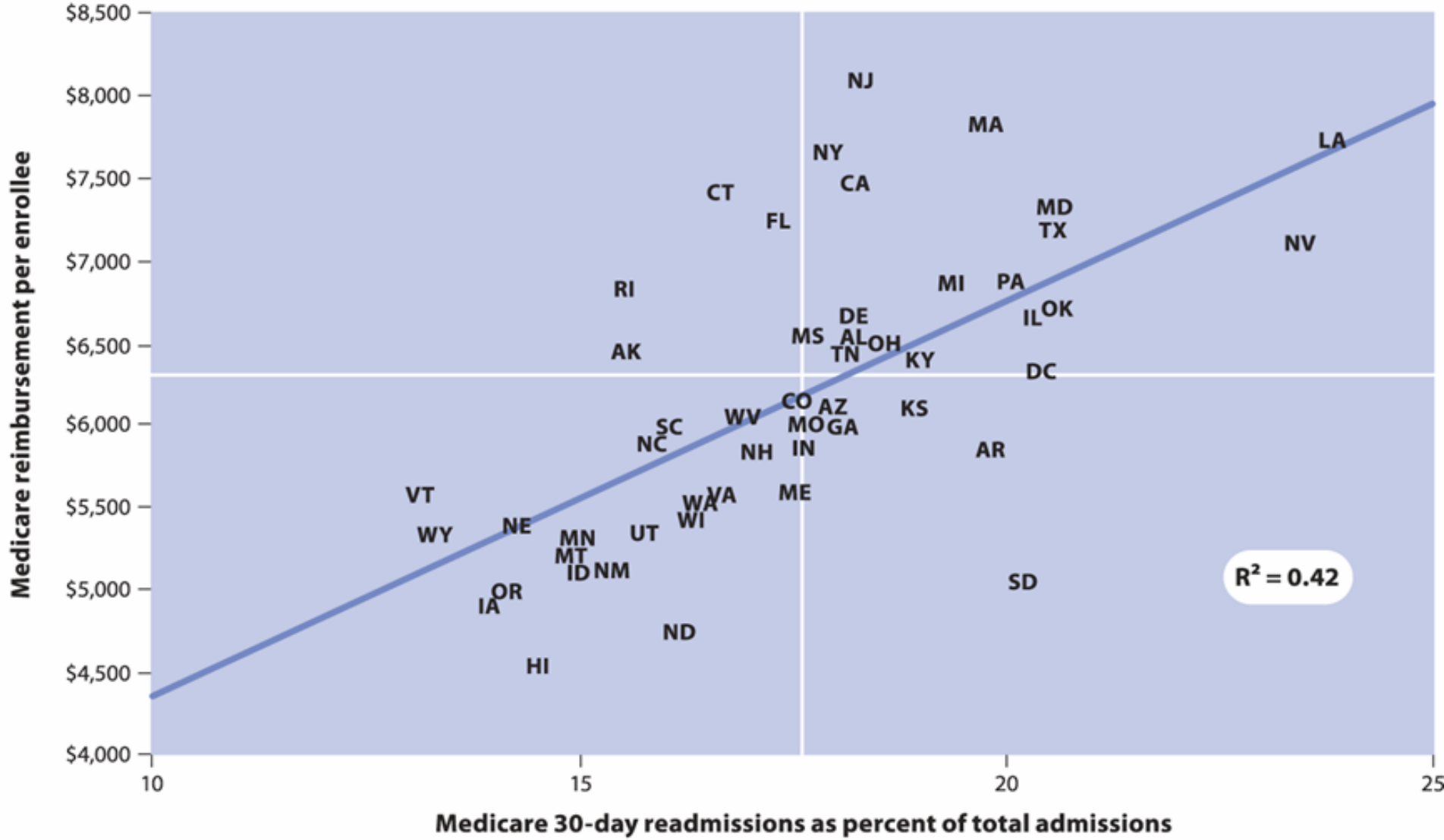
Source: Based on projected expenditures absent policy change and Lewin estimates.

Promising Strategies For Payment Reform

1. Patient-Centered Medical Home
2. Acute Episode Global Fee
3. Pay for Performance
4. Limiting Updates for High-cost Areas and High-cost Providers
5. Targeting Waste: Hospital Readmissions, Preventable Admissions, Unsafe, or Ineffective Care

Medicare Reimbursement and 30-Day Readmissions by State, 2003

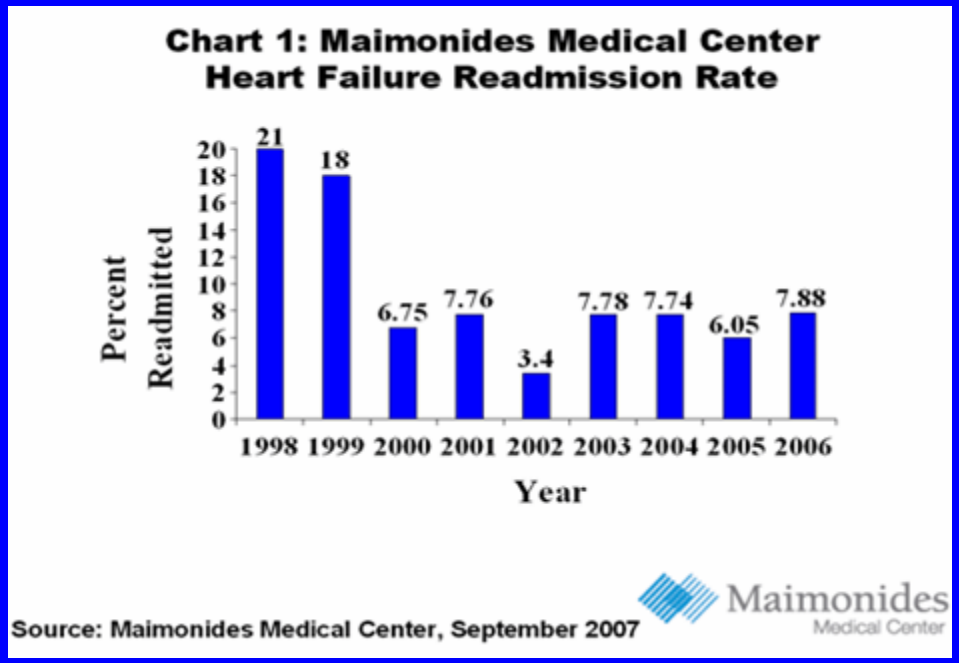


DATA: Medicare reimbursement – 2003 Dartmouth Atlas of Health Care; Medicare readmissions – 2003 Medicare SAF 5% Inpatient Data
SOURCE: Commonwealth Fund State Scorecard on Health System Performance, 2007

The Majority of Hospital Readmissions Could Be Prevented

2007 MedPAC report notes that 75% (13.3%/17.6%) of Medicare 30-day readmissions are potentially preventable

Maimonides Medical Center (NY) reduced readmissions by over 50% through coordinated team-based inpatient care and support with transition post-discharge.



Source: MedPAC Report to the Congress: Promoting Greater Efficiency in Medicare, June 2007; Quality Matters: Mortality Data and Quality Improvement, September/October 2007, The Commonwealth Fund, Vol. 26

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3. Organize the health care system around the patient to ensure that care is accessible and coordinated

1. The Promise of Medical Homes: Health Care Expenditures and Mortality 5 Year Follow-up, United States, 1987-92

- Adults (age 25 and older) with a primary care physician rather than a specialist as their personal physician
  - had 33% lower cost of care
  - were 19% less likely to die (after controlling for age, gender, income, insurance, smoking, perceived health (SF-36) and 11 major health conditions)

Source: Franks & Fiscella, J Fam Pract 1998; 47:105-9.

"Medical Home" Is Vehicle to Provide Patient-Centered Primary Care

1. Superb access to care
2. Patient engagement in care
3. Information systems that support high-quality care
4. Coordinated care
5. Integrated and comprehensive team care
6. Routine patient feedback to doctors
7. Publicly available information

NOTE: It isn't sufficient for providers to "set up" a medical home

- **The patient must perceive s/he has one!**

Source: K Davis et al. A 2020 Vision of Patient-Centered Primary Care. J Gen Intern Med 2005;20:953-957.

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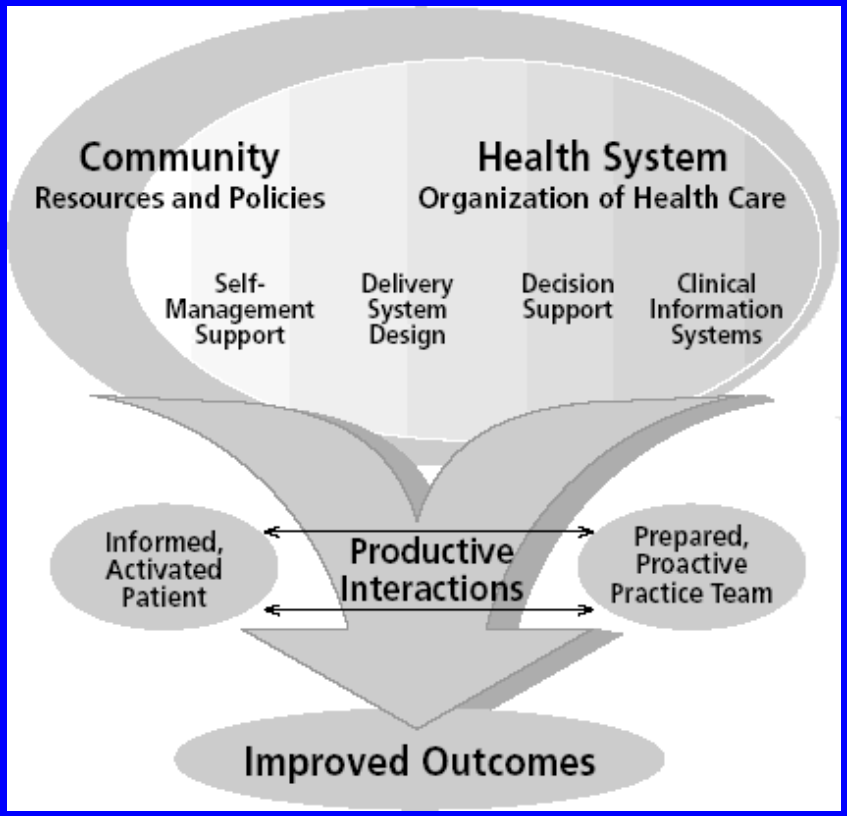
Chronic Care Model and Medical Home Fit Together



- **Chronic care model requires a team, patient-centered approach, IT support**

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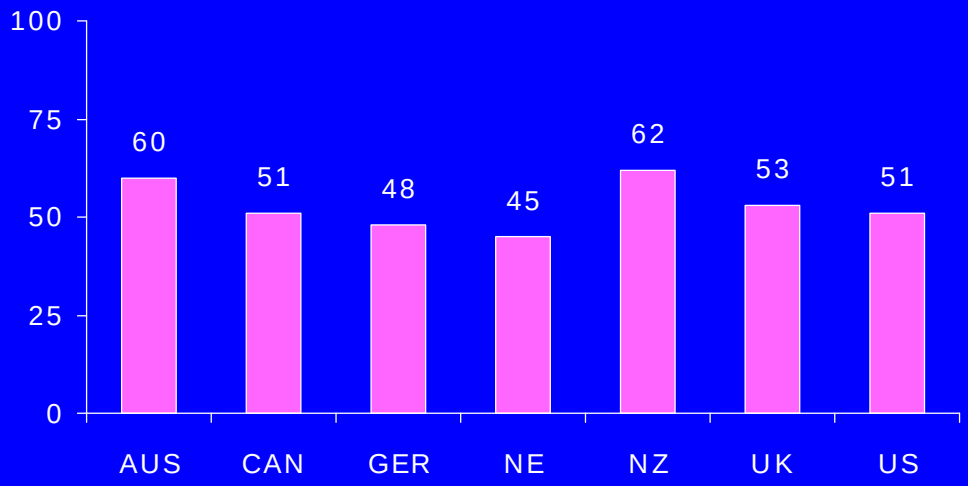
2007 International Health Policy Survey in Seven Countries

- **In each country, having a "Medical Home" improves patient experiences:**
  - **Patient safety**
  - **Coordination: with specialists/across sites of care; less duplication & delays**
  - **Patient satisfaction**
  - **Chronic care management**

Adults with a Chronic Disease Who Report Having a Medical Home*



- **But many in each country do not have a medical home**

***Regular provider; knows you; easy to contact; coordinates your care**

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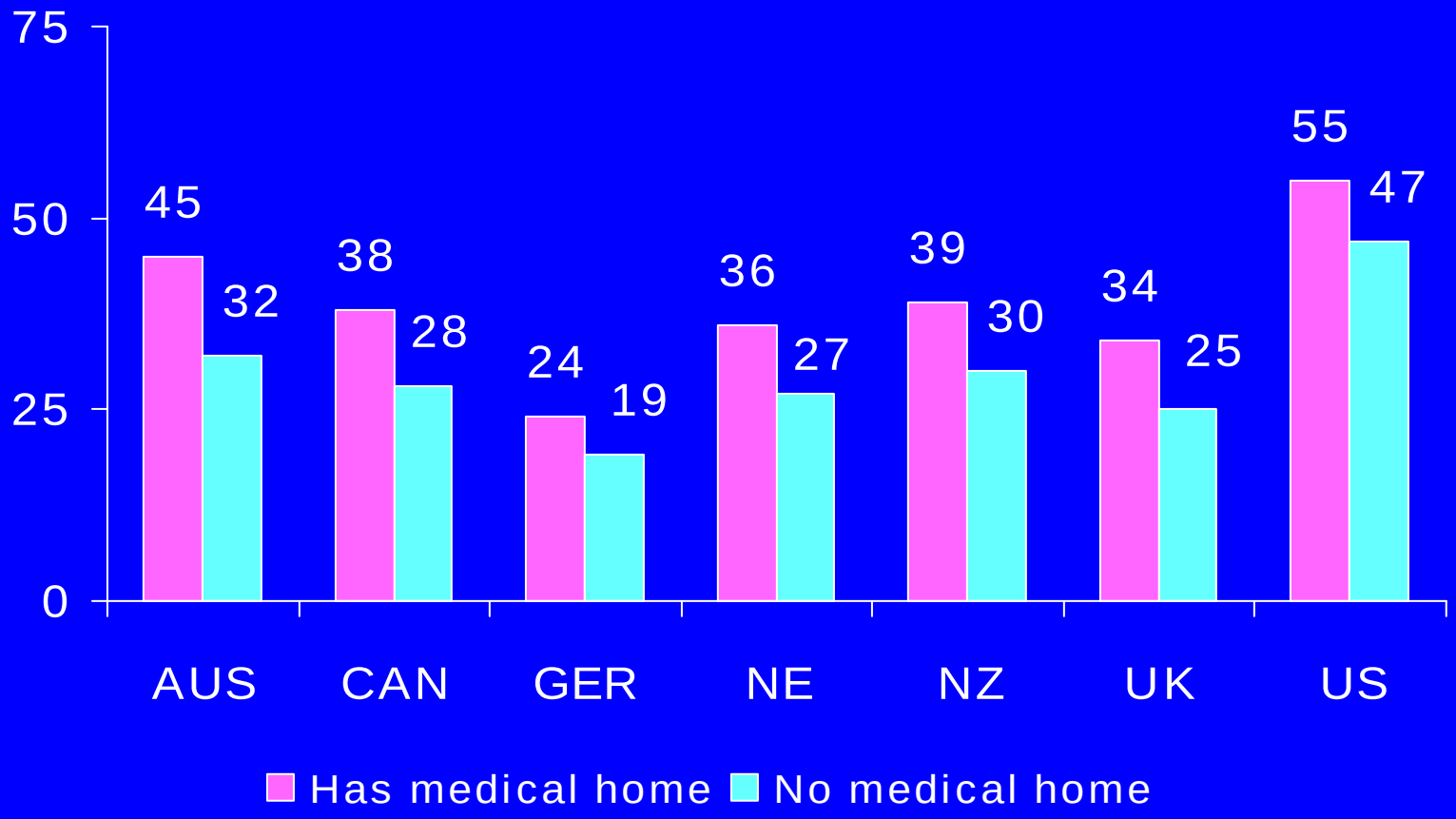
Doctor Gives You a Plan for Self-Management, by Medical Home

Base: Respondents with chronic disease

Percent reporting “yes”



2007 Commonwealth Fund International Health Policy Survey

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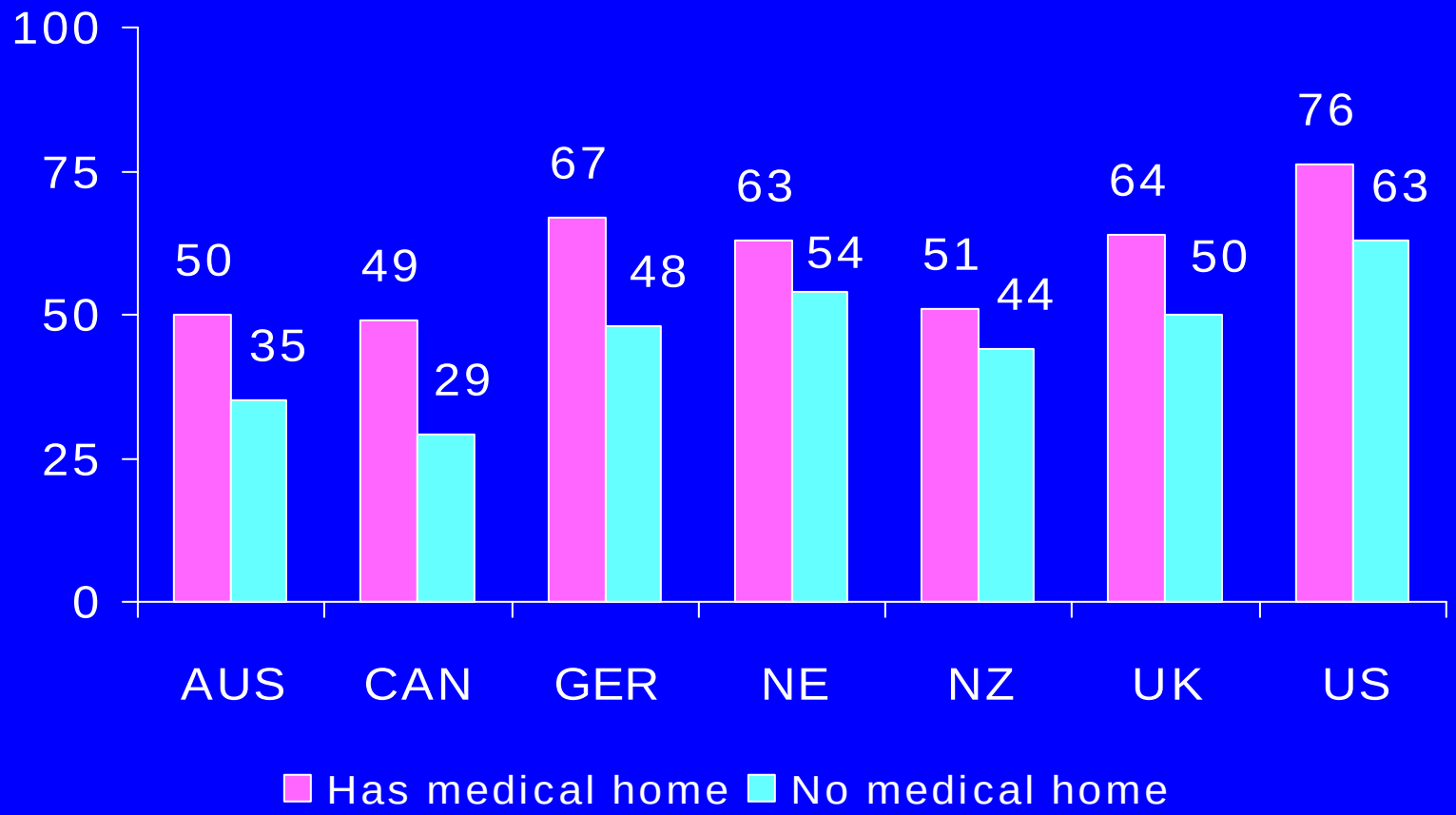
Receive Reminders From Regular Place of Care When Due for Preventive or Follow-Up Care for Chronic Condition, by Medical Home

Base: Respondents with chronic disease



2007 Commonwealth Fund International Health Policy Survey

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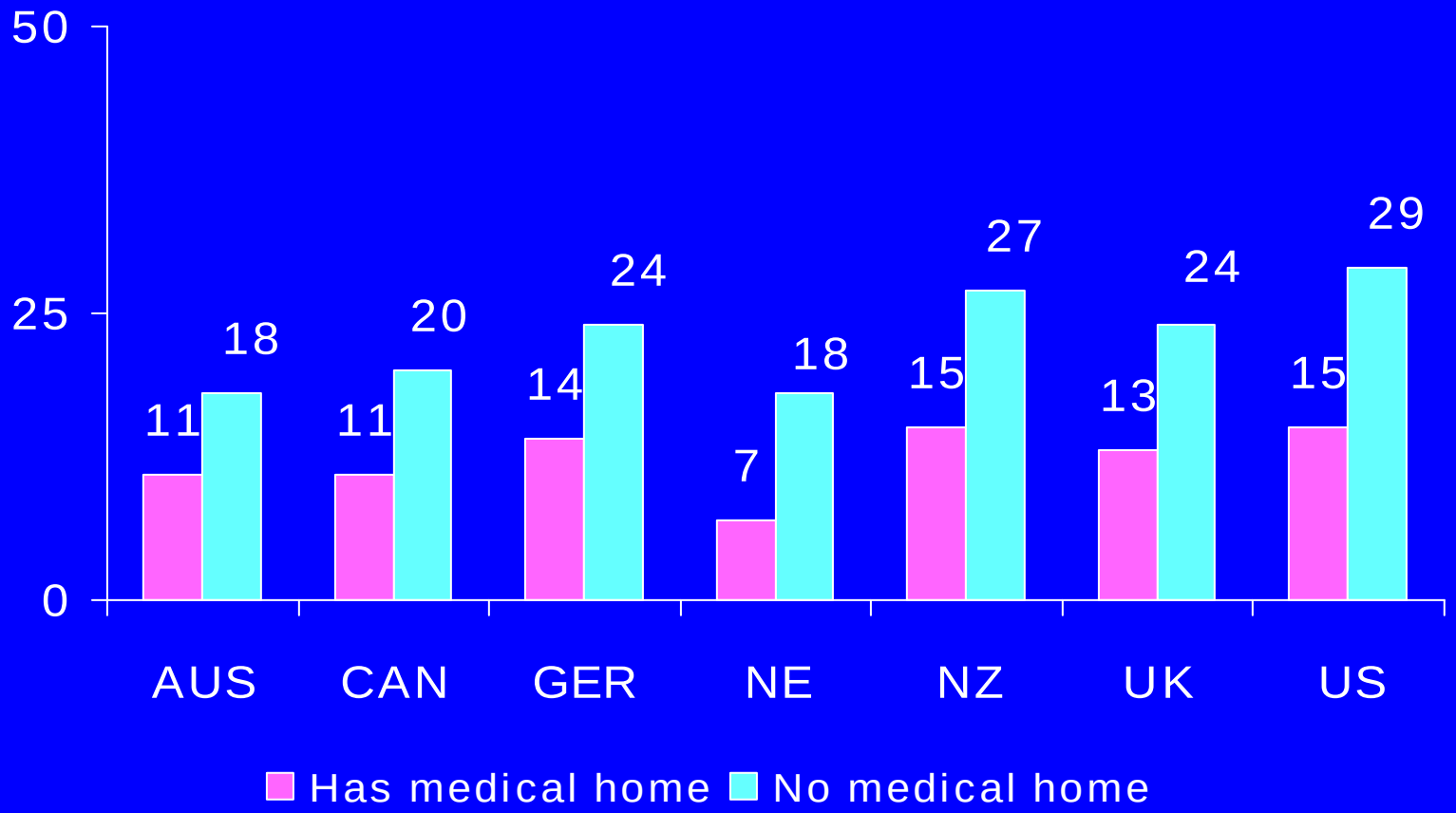
Receives Conflicting Information from Different Doctors, Nurses, or Other Health Professionals, by Medical Home

Base: Respondents with chronic disease

Percent reporting “often” or “sometimes”



2007 Commonwealth Fund International Health Policy Survey

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Geisinger Health Plan
Medical Home – Chronic Disease Management/Transitions in Care

Site	YTD 2006	YTD 2007	Increase/Decrease
Lewistown			
Admits/1,000	365	291	-20%
Re-admit Rate	19%	16%	-17%
Lewisburg			
Admits/1,000	269	232	-13.7%
Re-admit Rate	14%	9%	-34%

Germany: Disease Management

- **Care Model:**
  - **70% specialists; no gatekeeper; poor communication between primary care & specialists and between ambulatory care & hospital care**

- **BUT, insurer-run, physician practice-based disease management programs for chronic diseases**

Disease Management German-style

- Conditions: Diabetes, COPD, Coronary Heart Disease, Breast Cancer
- Funding runs through government to 200+ private insurers
  - Insurers receive extra risk-adjusted payments to cover patients with these conditions
  - Insurers pay primary care docs to sign eligible patients into programs & provide periodic reports back to the docs (the closest to coordination)
  - Positive results (1st 3 year evaluation – summer 2007)

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German Disease Management Programs: Are There Lessons To Be Learned?

Key Features:

1. Risk adjustment
2. Incentives for doctors and patients
3. Accreditation requirements: Clinical guidelines, minimum volume standards, patient education, and coordination of care
4. Primary care physician-led
5. Benchmarking, targets, feedback to physicians
6. Encourage secondary prevention

Karl Lauterbach, M.D.
Member of German Bundestag

Barmer Ersatzkasse Results
Diabetic Patients with and without DMP

Patients with Type 1 + 2 Diabetes	Patients with Disease Management (n=80,745)	Patients without Disease Management (n= 79, 137)
Hospitalization due to stroke (per 1,000 males)	8.8	12.7
Need for amputations (per 1,000 males)	5.6	9.1
At least one eye examination (per 1,000 diabetic patients)	780	538

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International Lessons

- Best international models are strong primary-care models vs. specific “care-coordination” programs
- In fragmented, specialized systems (e.g., Germany) strong practice-based disease management programs may be able to fill some of the gap

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4. Meet and raise benchmarks for high-quality efficient care

Spread of Best Practices

- Transparency
  - Need to know where to look for the best!
- Collaborations & “campaigns” work
- Other Dissemination Mechanisms
  - Academic detailing

5. Ensure accountable national leadership and public/private collaboration

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Accountable Leadership and Public/Private Collaboration

- National targets/standards of performance
- IT standards
- Comparative effectiveness
- Database(s)
- Annual report to Congress with recommendations
- ?National “structure” such as a “Federal Reserve” for health

What's Your Role?

i.e., The Roles of Physicians, Nurses, Provider Organizations, Hospitals, Hospital Systems

Roles for Providers and Provider Organizations

- **Extend affordable health insurance to all**
  - **Advocate for universal coverage**
  - **Advocate for administrative simplification**
- **Align financial incentives to enhance value and achieve savings**
  - **Participate in P4P programs such as Bridges to Excellence (diabetes management)**
  - **Organize around episodes of care**

Roles for Providers and Provider Organizations

- Organize the health care system around the patient to ensure that care is accessible and coordinated
  - Follow patient journeys through your care systems
  - Redesign/simplify care for the patient
  - Obtain regular (vs. intermittent) patient experience information
- Meet and raise benchmarks for high-quality, efficient care
  - Instead of aiming for the top quartile or decile, aim higher; aim for perfection!
- Ensure accountable national leadership and public/private collaboration
  - Advocate for national policies and infrastructure to support high performance

Roles for Providers & Provider Organizations

- Participate
- Innovate
- Advocate
- “Perfectionate”

Thank You!

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