

Expanded Chronic Care Model in Chronic Disease Prevention

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Overview

- Burden of chronic disease
- Role of expanded Chronic Care Model in chronic disease prevention & health promotion
- Models for lifestyle behavior change
- PCMHs and ACOs
- What's Next?

Five Top Chronic Diseases

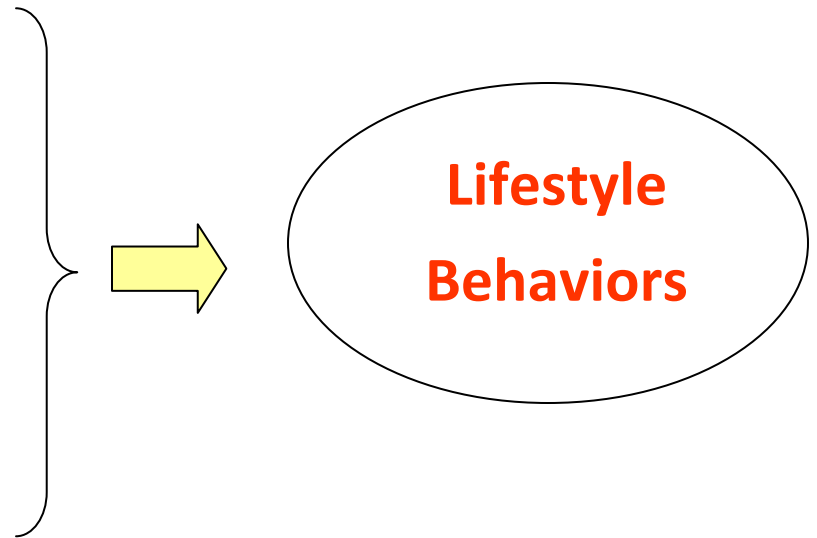
- Cancer
- Lung Disease – primarily COPD
- Heart Disease – primarily CHF
- Diabetes
- Asthma

66% of Medicare spending is for 20% of people with 5 or more chronic conditions

More than 84% of all health care costs are for people with chronic conditions

Four Top Risk Factors for Chronic Diseases

- Unhealthy diet
- Lack of physical activity
- Tobacco use
- Excessive use of alcohol



Current Risk Reduction Recommendations

- Eat 5 or more servings of fruits and vegetables every day
- Intense aerobic physical activity for 30 minutes at least 3 times a week
- No tobacco use at all
- Moderate alcohol use for those over 21

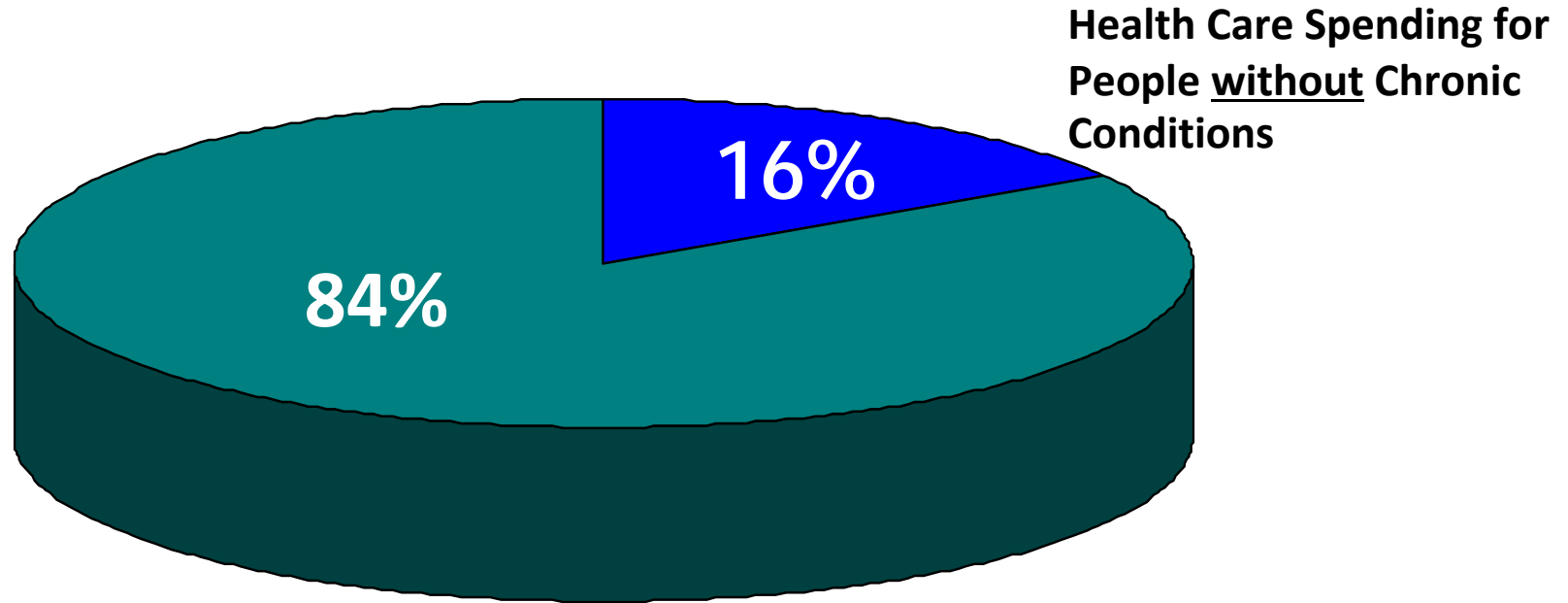
Burden of Chronic Disease - 1

- 7 out of 10 deaths among Americans each year are the result of chronic diseases
- Heart disease, cancer and stroke account for more than 50% of all deaths each year
- 133 million Americans (almost 1 out of every 2 adults) or 45% had at least one chronic illness
- Obesity affects 1 out of every 3 adults and 1 out 5 children (ages 6 & 19)

Burden of Chronic Disease - 2

- Approximately one-fourth of those with chronic diseases have one or more daily activity limitations
- Arthritis is the most common cause of disability (19 million report activity limitations)
- Diabetes is leading cause of kidney failure, nontraumatic lower-extremity amputations, and blindness among those ages 20-74
- Chronic disease is the greatest contributor to healthcare costs; accounts for 84% of spending

84% of ALL Health Spending is for People with Chronic Conditions



Health Care Spending for People with Chronic Conditions

Source: Medical Expenditures Panel Survey (MEPS), 2006. Data pulled from "Chronic Conditions: Making the Case for Ongoing Care 2010". Presentation by Anderson G. PhD. Accessed from www.rwjf.org/pr/slide.jsp, on February 15, 2011.

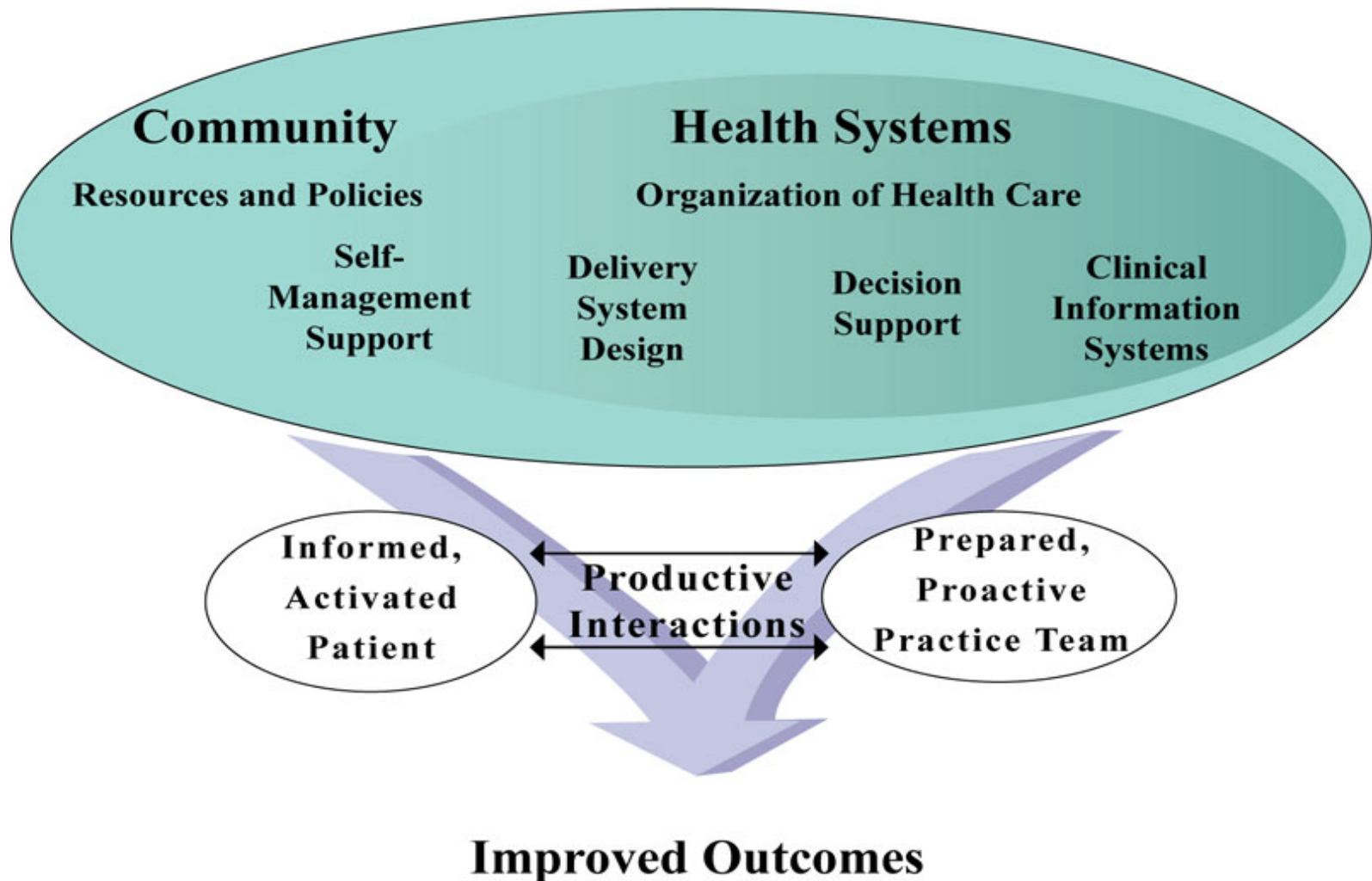
Annual Cost of Tobacco in US

- Cigarette smoking results in 5.1 million years of potential life lost
- \$96B in direct medical spending due to smokers
- \$97B in lost productivity from our national workforce in preventable deaths



http://www.cdc.gov/tobacco/data_statistics/fact_sheets/economics/econ_facts/#costs

The Chronic Care Model



Developed by The MacColl Institute
® ACP-ASIM Journals and Books

Chronic Care Model (CCM)

- The CCM identifies 6 essential elements of a health care system that encourage high-quality chronic disease care:
 - Community Resources and Policies
 - Health system
 - Self-management support
 - Delivery system design
 - Decision support
 - Clinical information systems
- Evidence-based change concepts foster productive interactions between informed patients and providers with resources and expertise
- Implementation of the CCM in health care settings results in healthier patients, more satisfied providers and cost savings

AAFP Web site. <http://www.aafp.org/online/en/home/practicemgt/quality/qitools/quality/chroniccare.html> Accessed February 15, 2011.

AAFP Web site. http://www.improvingchroniccare.org/index.php?p=Model_Elements&s=18 Accessed February 15, 2011.

Pennsylvania Chronic Care Initiative

- The Chronic Care Commission - strategic plan for implementing the chronic care model in all primary care practices across the Commonwealth.
- Involve strong collaboration by providers, payers, and professional organizations.
- Incorporates the PCMH standards as a validation tool that practices are transforming their care delivery to effectively manage chronically ill patients.
- Seven regional learning collaboratives underway across the Commonwealth.

<http://www.pcpcc.net/content/pennsylvania-chronic-care-initiative>

Pennsylvania's Statewide Diabetes Initiative

- In May 2007, the Pennsylvania Governor's Office of Health Care Reform established the Chronic Care Management, Reimbursement and Cost Reduction Commission
- The Commission is responsible for broad-scale implementation of CCM
 - Motivated by use of new primary-care reimbursement model
 - Incentive payments in some regions linked to National Committee for Quality Assurance patient-centered medical home certification
- CCM elements are to be implemented in 20 to 50 practices in 4 regions over a multiyear period
- Learning collaboratives will be the principal vehicle to spread CCM knowledge

Siminero L et al. *Clin Diabetes*. 2009;27(4):153-159.

Chronic Care Management in Primary Care

- Need to go from a system that reacts to an acute illness to one that is proactive in preventing disease
- Old model is “Tell the patients what to do and it is up to them to follow my advice”
- New model is “What can I do to involve my patients in their care and empower them to manage their disease”

Change in Chronic Care Management

- The goal is function and comfort, not cure
- The role of the health care provider changes from principle care giver to teacher and partner
- The sites of care change from clinic and hospital to community
- The role of the patient changes from passive to active participant

Patient Self-Management

Self-management is defined as the task that individuals must undertake to live with one or more chronic conditions. These tasks include having the confidence to deal with medical management, role management and emotional management of their conditions.

Institute of Medicine 2004

Self-Management Support

- Engages patients in the active self-management of their disease
- Customizes care to engage patients in setting goals that change their behavior
- When informed patients take an active role and providers are proactive, their interaction is likely to be productive
- Recommendations for diabetes care:
 - Clinicians should explore every opportunity to engage patients with diabetes in the provision of self-care
 - Implement strategies to support behavior change

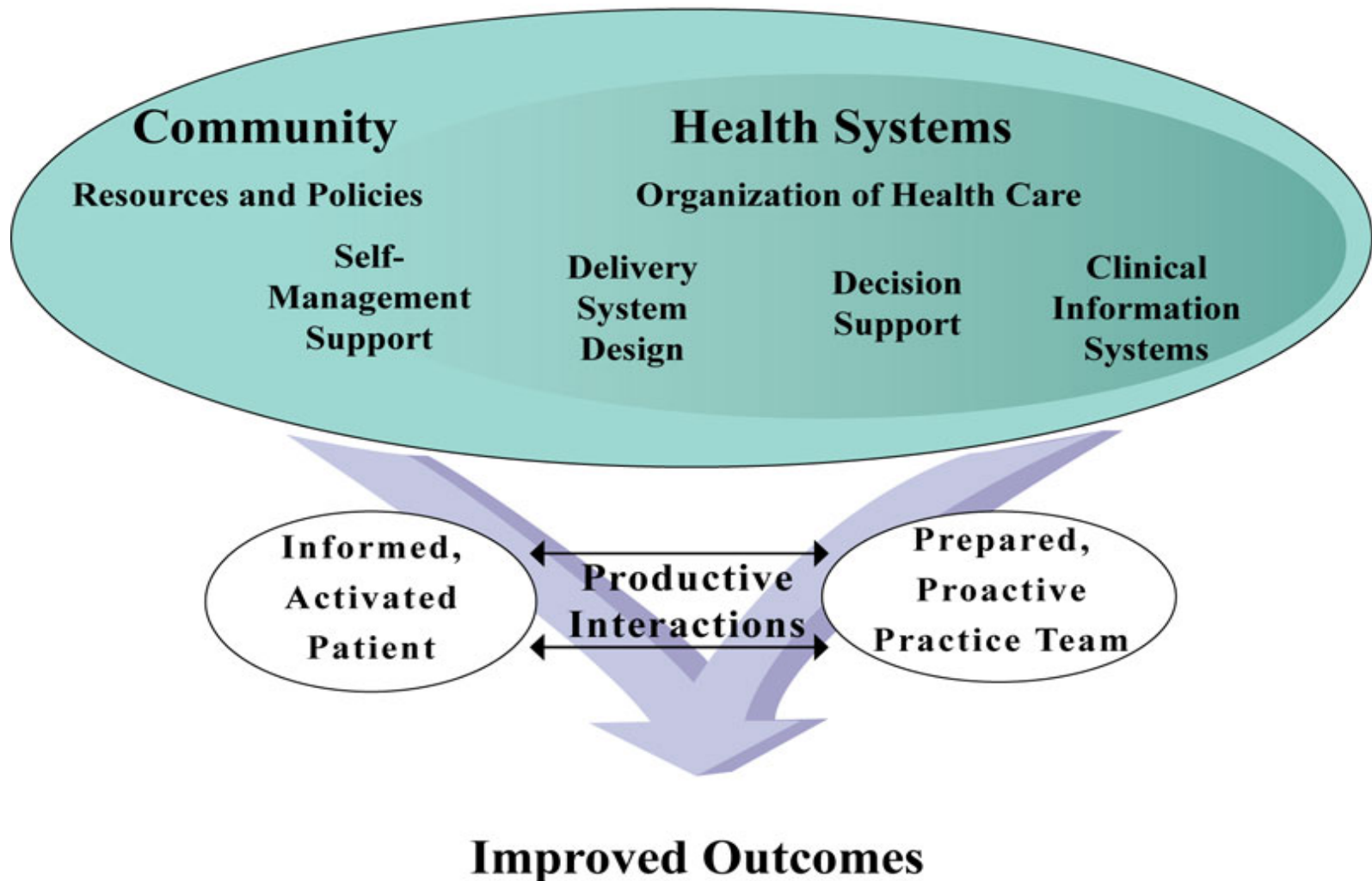
AADE. *Diabetes Educ.* 2008;34(3):451-456.

Collaborative Care Givers Reinforce Patient Self-Management Skills

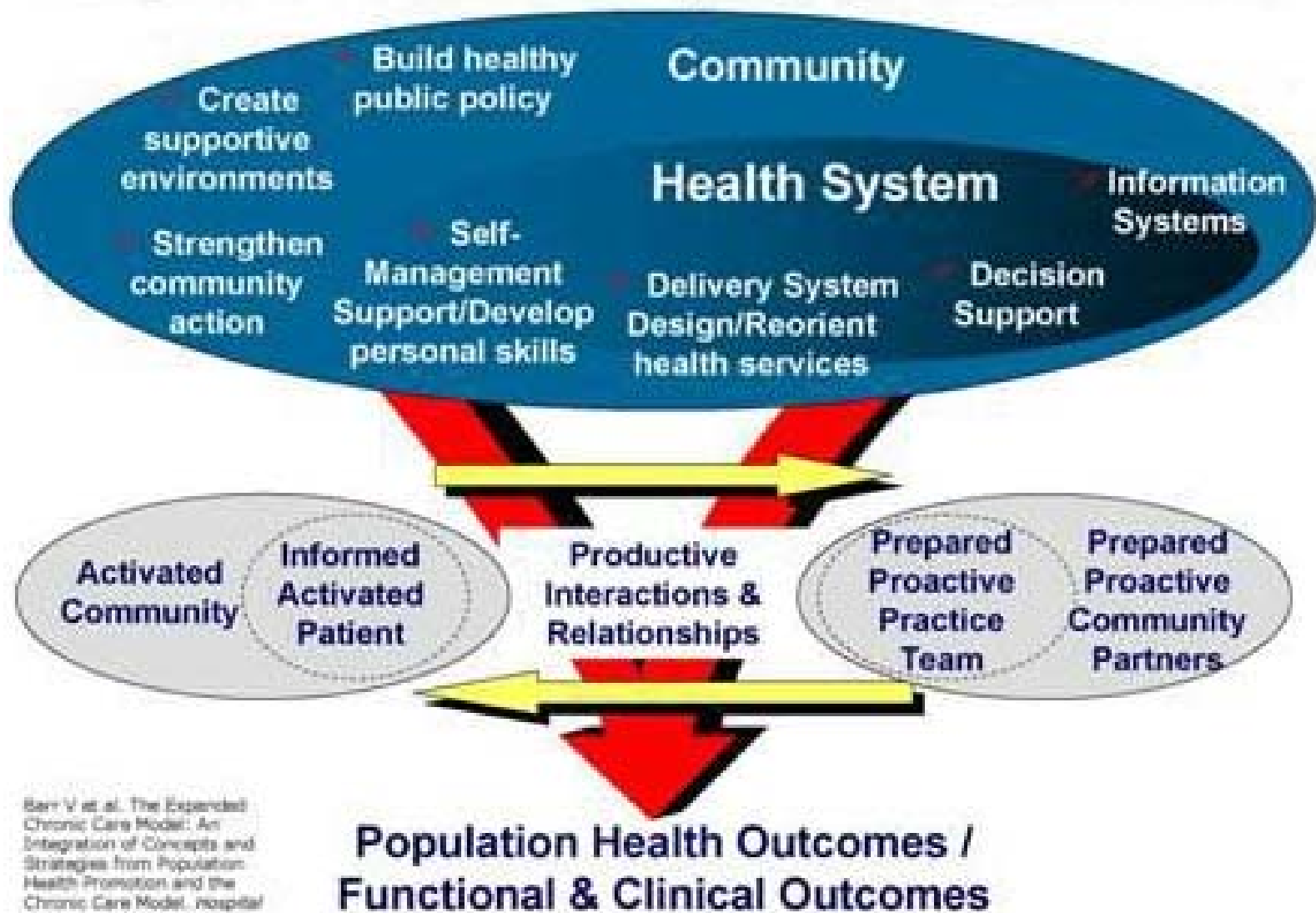
Issue	Usual Care	Patient Self-Management
Relationships	Professionals are expert; Patients are passive	Shared expertise with active patients; Patient expert in their experience of disease
Needs Assessment	Provider defines what patients need to know	Patient defined problems
Content	Disease management	Disease, role, and emotional management
Process	Prescribed behavior change; Provider solves problems; External motivation; Didactic presentations	Patient sets goals and learns problem-solving skills; Focus is on internal motivation and self-efficacy
Outcomes	Knowledge and behavior	Health status and appropriate utilization

Adapted from Bodenheimer T, et al. *JAMA* 2002;288:2469-2475.

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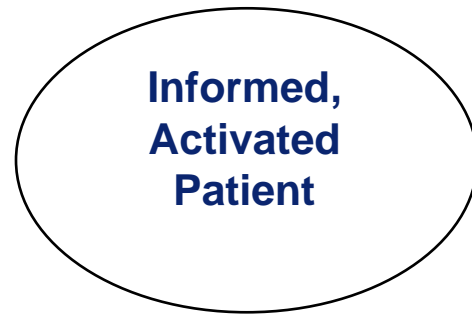


Ben V et al. The Expanded Chronic Care Model: An Integration of Concepts and Strategies from Population Health Promotion and the Chronic Care Model. *hospital/Quarterly* 2003;7(11):73-82

Chronic Disease Prevention

- Chronic care will be less costly & more effective if clinical prevention & management of chronic disease use similar strategies for improvement
- Expanded Chronic Care Model integrates population health promotion into prevention & management of chronic disease
- Support people & communities to be healthy; greater focus on:
 - Determinants of health
 - Delivering high quality healthcare services

What characterizes an “informed, activated patient”?



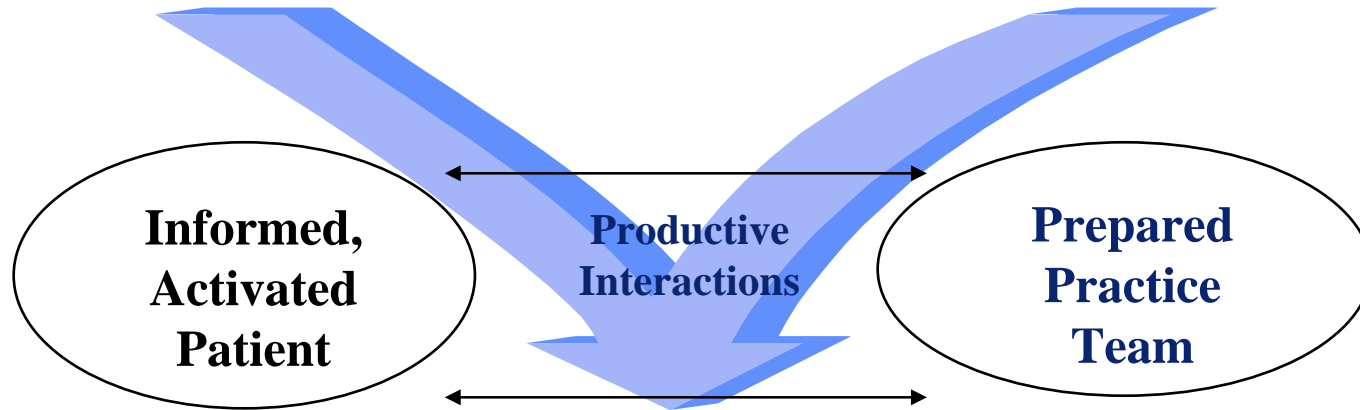
They have the motivation, information, skills, and confidence necessary to effectively make decisions about their health and manage it.

What characterizes a “prepared” practice team?



At the time of the interaction they have the patient information, decision support, and resources necessary to deliver high-quality care.

How would I recognize a productive interaction?



- *Assessment of self-management skills and confidence as well as clinical status.
- *Tailoring of clinical management by stepped protocol.
- *Collaborative goal-setting and problem-solving resulting in a shared care plan.
- *Active, sustained follow-up.

Levels of Prevention

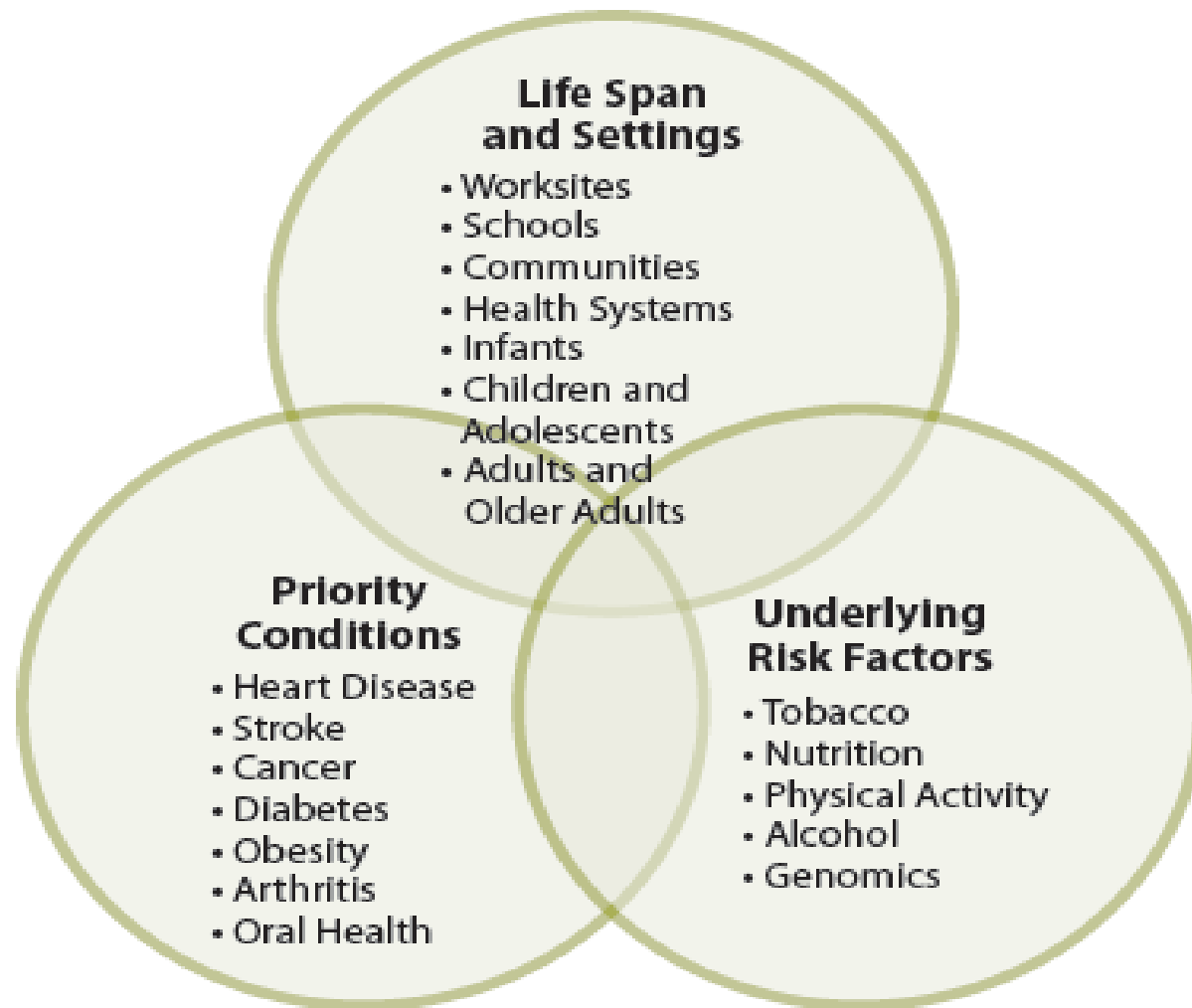
Preventive medicine strategies are typically described as taking place at the primary, secondary, tertiary and quaternary prevention levels.

Level	Definition
Primary prevention	Primary prevention strategies intend to avoid the development of disease. Most population-based health promotion activities are primary preventive measures.
Secondary prevention	Secondary prevention strategies attempt to diagnose and treat an existing disease in its early stages before it results in significant morbidity
Tertiary prevention	These treatments aim to reduce the negative impact of established disease by restoring function and reducing disease-related complications.
Quaternary prevention	This term describes the set of health activities that mitigate or avoid the consequences of unnecessary or excessive interventions in the health system

Health Promotion

- Health Promotion is “the process of enabling people to increase control over their health and its determinants, and thereby improve their health”
- Promote healthy living, especially for the disadvantaged and minorities
- Focus on the top priorities in terms of chronic diseases
- Take into account cultural differences
- Enable active participation in communities

Framework for Preventing Chronic Disease and Promoting Health



<http://www.cdc.gov/chronicdisease/index.htm>

Models for Lifestyle Changes

- 5 A's – behavioral counseling
- Transtheoretical Model (TTM) – Stages of Change
- Motivational interviewing
- Cognitive Behavioral Therapy (CBT)

5 A's of Behavioral Counseling

- **Assess** – ask about and assess behavioral health risks and factors that affect choice of behavior change goals and methods
- **Advise** – give clear, specific, well-timed, and personalized behavior change advice, including information about personal health harms and benefits
- **Agree** – collaboratively select appropriate goals and methods based on the patient's interest and willingness to change behavior
- **Assist** – using self-help resources and/or counseling, help the patient to achieve goals by acquiring skills, confidence, and social and environmental supports for behavior change
- **Arrange** – schedule follow-up (in person or by telephone) to provide ongoing assistance and support and to adjust the plan as needed, including referral to more specialized intervention

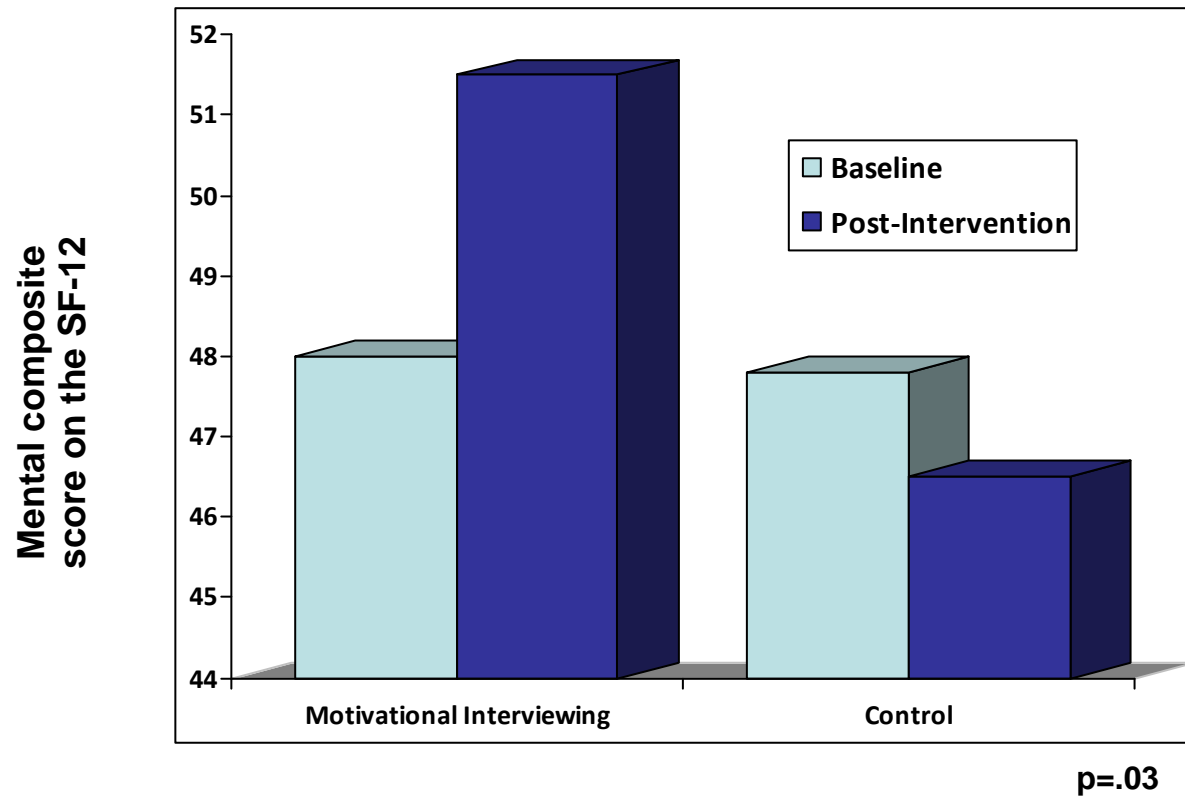
TTM

- Categorizes people based on where they are in the process
- 6 stages of change, 10 processes of change and decisional balance (pros and cons of changing)
- Stages of change
 - Precontemplation – no intention within the next 6 months
 - Contemplation – do intend to change in the next 6 months
 - Preparation – take action in the next month
 - Action – make specific overt modifications in past 6 months
 - Maintenance – working to prevent a relapse
 - Termination – no longer tempted
- Decisional balance – more pros; more likely change will occur

Motivational Interviewing and Collaborative Care

- Defined as a “*client-centered, goal-oriented method for enhancing intrinsic motivation to change by exploring and resolving ambivalence*”
- Encourages patients to engage in self-management by
 - Expressing empathy
 - Supporting their autonomy
 - Differentiating where they are and where they’d like to be
 - Exploring their ambivalence and identifying their need for change
 - Supporting the belief that they can make the change
 - Providing assistance with developing a realistic and sustainable action plan
- Philosophy and principles of Motivational Interviewing should be integrated into everyday use with emphasis on involving the entire care team.
Anderson B. *Am J Manag Care*. 2007;13(suppl):S103-S106.

Impact of Motivational Interviewing on Mental Health Status



The Mental Health Composite Score is derived from responses to questions in each of the following domains:

- Physical function
- Role limitations due to physical function
- General health perception
- Bodily pain
- Social functioning
- Energy/vitality
- Role limitations due to emotional functioning
- Mental health status

Butterworth S, et al. *J Occup Health Psychol.* 2006;11:358-365.

Patient Centered Medical Home (PCMH)

- The tenets of the PCMH are closely tied to that of the CCM
- Incorporates quality measures, patient self-management; lifestyle change theory; decision support, health information technology, and organization of the practice for efficiency.
- Physician led and includes all team members (nurses, medical assistants, social workers, receptionists, etc.)

Accountable Care Organizations (ACOs)

- ACA – January 2012
- High quality services, highly productive system, with shared-savings program for primary care, specialists, and hospitals
- Accountable for a patient population
- Fragmented to coordinated system of care
- Who should run ACOs – physicians, hospitals, ???

What's Next ?

- Critical information technology (EHRs, exchange data with other PCMHs or ACOs) for improvement in quality of healthcare delivery
- Health Care Navigators
- Primary prevention in communities
- Health promotion/Wellness programs
- Involvement of consumers in development of health care delivery systems

SUMMARY

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References

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- <http://www.hhs.gov/ash/initiatives/mcc/>
- <http://www.cdc.gov/chronicdisease/resources/publications/AAG/chronic.htm>
- http://www.improvingchroniccare.org/index.php?p=The_Chronic_Care_Model&s=2