

# The National Landscape for Chronic Care Improvement



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Improving Chronic Illness Care  
A national program of the Robert Wood Johnson Foundation

# The Sins of American Medical Care are Visited Upon the Chronically Ill

- Escalating prevalence of chronic illness and diminishing reimbursement threatening primary care
- The health impacts of uninsurance greatest for the chronically ill
- Clinical and behavioral management increasingly effective and increasingly complex but:
  - >only 50% of Americans are receiving evidence-based care
  - >high drug prices and limited benefits may make this worse
- “Chasm” between usual and best care is huge when measured by needless suffering

# Crises in American Primary Care

- Escalating prevalence of chronic illness has changed the work of primary care
- Clinical and behavioral management increasingly effective and increasingly complex
- Roughly 50% of Americans not receiving evidence-based chronic illness care (Quality Chasm)
- Unhappy clinicians leaving practice; trainees choosing other specialties
- Loss of confidence by policy-makers and funders “can’t change physician behavior”

# What's Responsible for the Crisis?

- A system that is not working for either patients or health professionals??



# What People with Chronic Illnesses Need

**Continuous primary care that can provide:**

- **Proven effective treatments**
- **Information and support for self-management**
- **Intensification of management when needed**
- **Coordination of care**

# Two Options For the Chronically Ill

- Improve Medical Care
  - IOM Report
- Take chronic illness care out of the hands of primary care –

“Changing care systems will” improve care

Direct to Patient Disease Management

## Does Direct to Patient DM Work?

- WE STILL DON'T KNOW!
- Because rigorous studies lacking.
- Most evaluations begin with “high utilizers” and compare those who agree to participate with those that don't
- This year's average high utilizer will be less costly next year **regardless**

# Is Option 1 Realistic?

## Can primary care improve chronic illness care?

- Many administrators are doubtful
- They cite:
  - physicians poorly prepared for planned, team-based care
  - limited frontline staff
  - inadequate or inappropriate IT
  - no financial incentive



# Toward a chronic care oriented system

THERE IS NOW LOTS OF EVIDENCE THAT  
CARE CAN BE IMPROVED BY:

Integrated changes with components directed  
at:

- better use of non-physician team members,
- planned encounters,
- modern self-management support
- Links to effective community resources
- guidelines integrated into care
- enhancements to information systems



# Chronic Care Model



# CCM developments

- Serves as guide to state programs in Indiana, Rhode Island, Vermont, Washington, Oregon, California, Indiana, Colorado and others
- CCM foundation for NCQA and JCAHO certification for chronic disease programs
- CCM part of new Models of Primary Care proposed by AAFP and ACP
- Several practice assessment tools now available for large and small practices
- CCM-based Assessments used in pay for performance programs

# **Can Busy Practices Change in Accord with the CCM?**

## **Chronic Conditions Breakthrough Series (BTS)**

- **Year-long collaborative improvement efforts involving multiple delivery systems and faculty**
- **Chronic Care Model guides system change**
- **Over 1000 different health care organizations and various diseases involved to date**
- **Began with national BTS but shifted to regional**
- **HRSA's Health Disparities Collaboratives- 500 community and migrant health centers**
- **External evaluations of early efforts by Chin et al., RAND**

# 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

# RAND Findings

- Organizations made average of 48 changes in 5.8/6 CCM areas
- IT received most attention, community linkages the least
- CHF pilot patients more knowledgeable and more often on recommended therapy, had 35% fewer hospital days
- Asthma and diabetes pilot patients more likely to receive appropriate therapy.
- Asthma pilot patients had better QOL
- Diabetes pilot and control patients had significantly better glycemic control (pilot>control); control improvement related to spread

# Do CCM system changes impact outcomes when implemented outside of collaboratives?

- Fleming et al. studied 134 managed Medicare organizations
- Collected Diabetes quality measures (HbA1c, LDL, microlabuminuria and eye exams)
- Compared top and bottom quartiles on quality (e.g., HbA1c>9.5– 20% vs. 50%)
- Assessed 32 care elements based on the CCM
- Top quartile more likely to employ CCM elements, especially:
  - computerized reminders,
  - practitioner involvement on QI teams,
  - guidelines supported by academic detailing,
  - formal self-management programs,
  - a registry

\*Fleming et al., AJMC 10:934, 2004

# Lessons learned in chronic illness care improvement

- Mostly reaching early adopters
- Regional or state-based collaboratives as effective, but offer added opportunities
- Practice redesign is very difficult in the absence of a larger, supportive “system”, especially for smaller practices
- Safety net providers (VA, BPHC, CA and NY Public Hospitals, HIS) and integrated care systems the vanguard

# What are the barriers?

- **Belief in the quality of one's practice – i.e. no meaningful measurement**
- **Multiple insurers with limited perspective on practice and influence**
- **Lack of well-functioning practice teams**
- **Inability to use information technology to support or improve patient care**
- **Lack of financial incentives**

# BUT

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

# King's Fund Study of Organizations with Best HEDIS Chronic Illness Scores

**Organizational factors supportive of high quality chronic care:**

- **Strategic values and leadership that support long term investment in managing chronic diseases**
- **Well aligned goals between physicians and corporate managers**
- **Integration of primary and specialty care**
- **Investment in information technology systems and other infrastructure to support chronic care**
- **Use of performance measures and financial incentives to shape clinical behavior**
- **Use of explicit improvement model—usually the Chronic Care Model**

# What's needed to improve chronic illness care for the population?

- Will and Leadership
- A commitment to raise the level of medical care in the state, not outsource it
- An active program of practice change
- Creating a state/regional health care “system”



# Will it save money?

- Maybe
- Drug costs can be substantially reduced without loss of effectiveness
- Transition care from hospital to home proven to save money for CHF and other patients

# Meta-analysis of Pre and Post-discharge Programs for Hospitalized CHF Patients

- **18 RCTS, 8 non-American (2 Australian)**
- **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 (43 to 35%)**
- **13% reduction in all-cause mortality**
- **Greater improvement in QOL**
- **Net cost savings \$536 per month**

Phillips et al. JAMA 2004; 291: 1358

# “Systemness” as a Community Property

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



# We are reaching the point where:

- One gets better care in a CHC than in an average medical practice
- One gets better care in a safety net hospital
- Keep it up!

