Improving Chronic Disease Care

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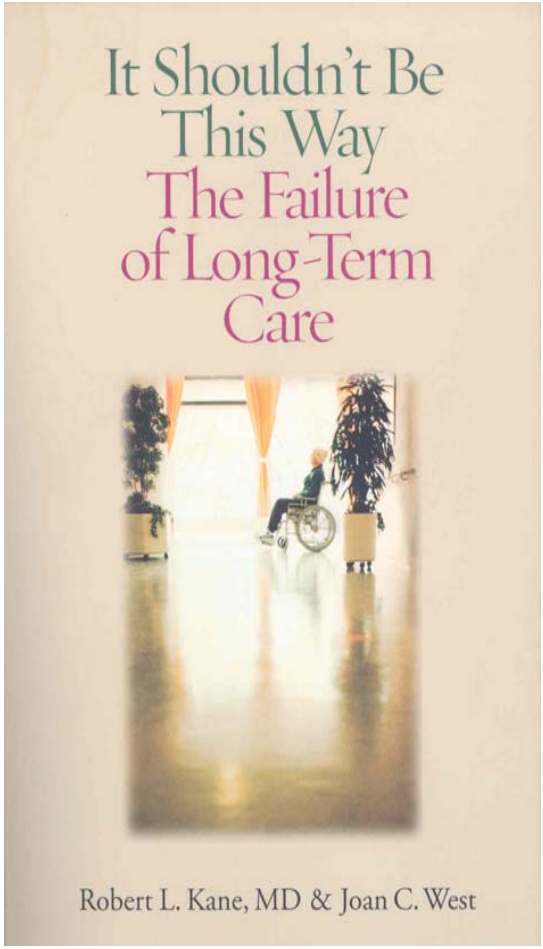
It Shouldn't Be This Way: The Failure of Long-Term Care

Robert L. Kane
Joan West

Vanderbilt University Press, 2005



Goals of Chronic Disease Care

1. Manage the disease to reduce exacerbations.
2. Prevent the transition from impairment to disability, and from disability to handicap.
3. Encourage patient to play an active role in managing his/her disease but avoid allowing the disease to dominate the person's life.
4. Provide care in a culturally sensitive manner.
5. Integrate medical care with other aspects of life without medicalizing those aspects.

Patients' Roles

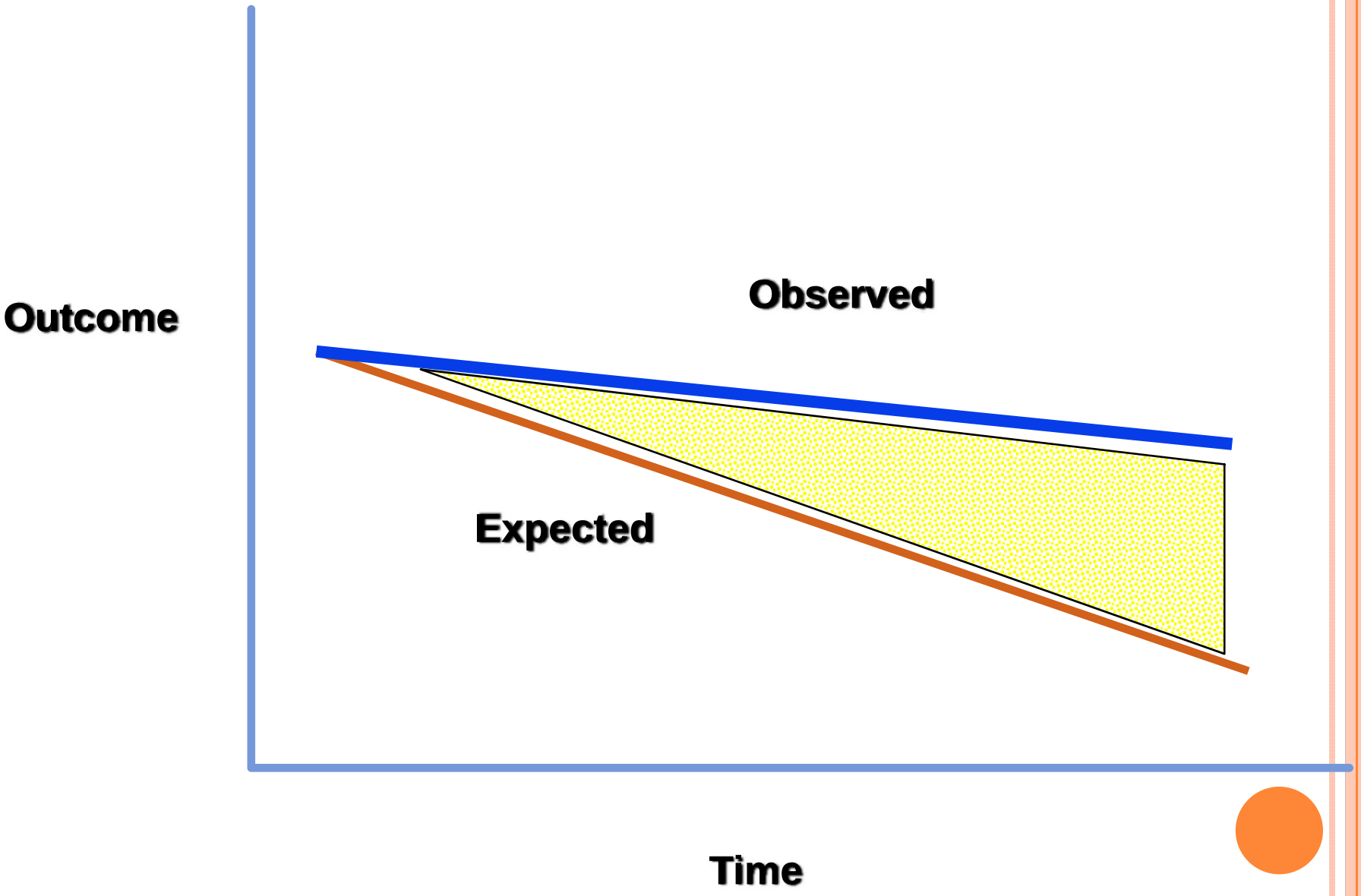
- 365/24/7
  - Shared responsibility
  - Shared risk
- Ongoing communication
- Shared decision making
  - Need better information
  - Need time

Time

- Episode vs. Encounter
- Pay-off horizon
  - Up-front investment recovered over time
- Manage by change, not routine
  - Scheduling appointments
  - Length of appointments

Expectations

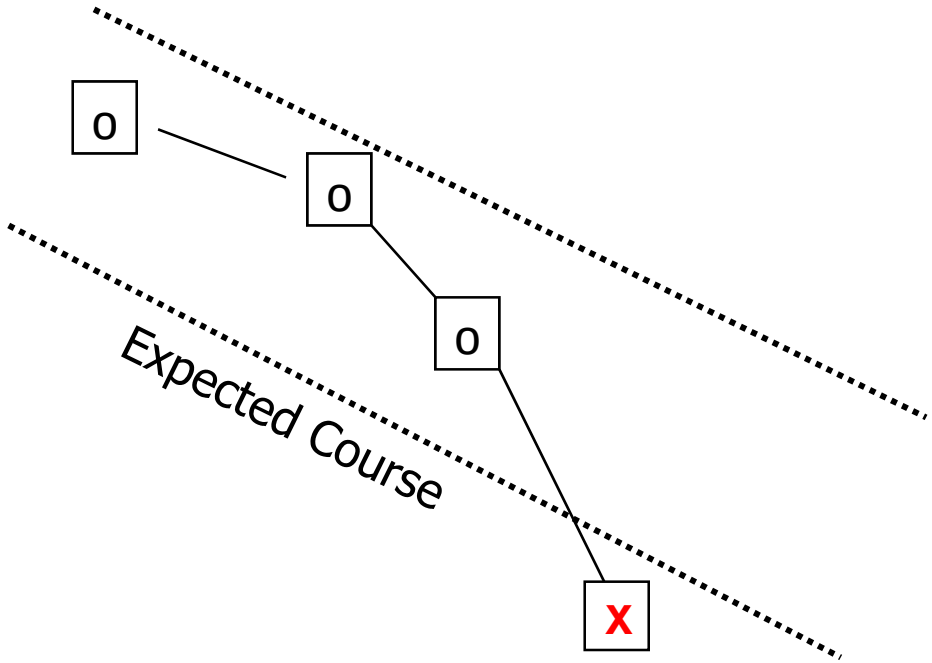
- Cure vs. Management
- Measuring success
  - actual vs. expected


Outcome
Observed
Expected
Time

Clinical Glidepath

- **A Clinical Glidepath is a way to observe one or more parameters of a patient's condition on a regular basis to be able to compare the observed state with the expected state.**
- **It is a tool to improve communication between patients and primary care providers.**
- **If the patients stays within the expected course, nothing need be done.**
- **But if the patient's clinical course deviates, this change should trigger immediate closer attention to ward off a problem while it is early.**

Clinical Glidepath



Theories of reducing chronic disease burden and costs

- Prevention
  - Drugs (e.g., polypill)
  - Health behavior
  - Primary care
  - Better management (e.g., HIT)
- Substitution
  - Personnel
  - Site of care
- Efficiency

Strategies for Improving Primary Care

- Reorganizing care delivery system
  - Proactive primary care
  - Quality Improvement
  - Electronic Health Record
  - New duties
- Decision support
- Disease management (independent)
- Care coordination (medical home)
- Patient empowerment

Approaches to Care

- Disease based
- Treatment defined
  - Inpatient
  - Outpatient
  - Home
  - Nursing home
- Service based
- Patient based

The Business Case for Better Chronic Disease Care

- Aggressive primary care reduces hospital and ER use
- More available primary care facilitates substitution of secondary care at cheaper sites (e.g., NH)
- Would like to see support for the former but latter more effective, at least in the short term

Chronic Disease Business Case

- Capitation rates
  - Case mix adjustments
  - Law of large numbers
  - Non-voluntary enrollment
- Return on investment
  - Pay-out window

Disease Management Observations

- Multiple definitions
- Small number of well designed studies
  - Variable content, setting, duration and intensity of intervention
- Evidence weak
  - Better for process than outcomes
  - Utilization effects in both directions
- Not clear which DM elements work

Disease Mangement Conclusion

"The prevailing evidence appears to be that while disease management programs improve adherence to practice guidelines and lead to better control of the disease, their net effects on health care costs are not clear."

CBO, 2004

Shared Care

- Joint participation of PCPs and specialists in planned delivery of care
- Cochrane review, 2007: 19 RCTs, 1 CBA
  - Physical health: 7 studies
  - **No signif impact except 1 showed impr FEV1 in mod/sev COPD**
  - Mental health: 8 studies
  - **3/6 Signif improvement in depression**
  - **4/5 Recovery from depression or maintaining remission**

Shared care 2

- Psychosocial: 7 studies
  - 2/4 Signif improvement well-being/QOL
  - 1/1 Signif improvement physical QOL
  - 2/4 Signif improvement function:
- Hospital admissions: 7 studies
  - 2/2 Signif reduction bed days: 1/1, readmissions
  - 1/1 Signif reduction mental health readmissions
- Satisfaction w treatment: 9 studies
  - 4/5 favored intervention; 1/5 favored control
  - 4/4 no difference in mean satisfaction scores
- Service utilization: 9 studies
  - 3/6 Signif increase disease-related visits
  - 4/5 Signif improvement medication adherence
  - 4/8 Signif improvement medication prescribing

Self Management

- Lorig RCT (heart dis, lung dis, stroke, arthritis): 6 mos
  - Improved aerobic & stretching exercise, cognitive symptom management, communication with MDs
  - Improved SR health, disability, social role, energy, health distress
  - Decreased hosp stays & days
  - Sustained at 2 yrs
  - Repeated with minority patients

Self Management 2

- DeWalt RCT (CHF)
  - Decreased hospitalization or death
  - No difference in cardiac hospitalization of HF related QOL
  - Improved HF knowledge, self-efficacy, daily weight measurements

Self Management COPD

- **Bourbeau, 2003, 2006**
  - **Decreased hospital admissions for COPD and overall**
  - **Improved QOL**
- **Coultas, 2004**
  - **Improved perceived illness intrusiveness**
  - **No effect on QOL**
  - **No difference in ER, hospital use**
- **Monnikhof, 2003**
  - **1/8 improve HRQOL (physical activity)**
  - **0 /2 no difference in COPD symptoms**
  - **1/1 increased use of steroids**
  - **1/1 increased use of antibiotics**

Conclusions

- Empirical basis for chronic disease interventions is not strong
- Several strategies show promise
  - Integrated care, collaborative care (extra personnel)
  - Follow guidelines
    - BUT guideline conflicts (Boyd, JAMA 294: 716, 2005)
- System changes required
  - Clinicians need to be committed
  - Do enough of it to make a behavior change
- New strategy needed
  - Triage targeting
  - Individualized approach

New Strategic Thinking

- P(better outcomes) = f(care, patient, care*patient)
- Good primary care should make a difference
- Patient = f(need, likelihood of benefit, willingness to participate)
- Targeting criteria have focused on need
- Should include likelihood of benefit
  - Susceptibility to treatment

Triage Targeting

Need

- Multiple comorbidities
- High utilizers
- Transitions & hand-offs

Potential for Benefit

- Motivated patients & family
- Involved staff
- Committed leadership
- Available resources

Individualized Medicine

- Genotype
- Psychotype

Modified Prochaska Model for Patient Commitment to Disease management

Stage	Response
Committed	**Work with them now Provide tools**
Motivated	**Educate them about the advantages of proactive primary care**
Interested	**Educate them Motivate them**

Getting Clinicians Involved in Chronic Disease Management

- Remove barriers
  - Fee-for-Service payment is the enemy of chronic disease care
  - Add staff
- Create incentives for doing the right thing
  - Financial
  - Recognition
  - Practice satisfaction
- Increase efficiency
  - Eliminate scheduled return appointments
    - Revisits based on clinical trajectories

Payment Issues

- Providers expect to be paid for what they do
- Who will invest in primary care
- How to cover new services
  - Monitoring
  - Counseling
- Payment strategies
  - Share savings from decreased inpatient/ER utilization
  - Pay more per visit for fewer visits
  - Pay for episodes instead of incidents
  - Pay for outcomes

Conclusions

- Chronic disease is here to stay
- More must be done to bring the health care system into alignment
- There is some evidence to show better care is possible; but still a mixed picture
- Innovations must address rebuilding the care infrastructure
- Changing the payment system is necessary but not sufficient
  - Payment should re-enforce not drive reform