What can states do to improve chronic illness care?

National Conference of State Legislatures
October 5, 2007
Presentation Overview

- The problem of chronic disease
- One solution: transforming medical care for the chronically ill
- Research, experience, and lessons learned
- Going the next step: regional collaboratives
- Lessons learned from state-based efforts
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 nearly $1 trillion and significant advances in care, one-half or more of patients still don’t receive appropriate care.
- Gaps in quality care lead to thousands of avoidable deaths each year.
- Patients and families increasingly recognize the defects in their care.
### Johns Hopkins U.S. Survey about Chronic Care: % Agreeing

<table>
<thead>
<tr>
<th>Statement</th>
<th>Public</th>
<th>MD’s</th>
<th>Policy-makers</th>
</tr>
</thead>
<tbody>
<tr>
<td>People with chronic conditions usually receive adequate medical care</td>
<td>48%</td>
<td>45%</td>
<td>22%</td>
</tr>
<tr>
<td>Gov’t programs are adequate to meet the needs of people with chronic conditions</td>
<td>38%</td>
<td>20%</td>
<td>16%</td>
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<tr>
<td>Health insurance pays for most of the services chronically ill people need</td>
<td>37%</td>
<td>28%</td>
<td>23%</td>
</tr>
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</table>
# Chronic Conditions per Medicare Beneficiary

<table>
<thead>
<tr>
<th>Number of Conditions</th>
<th>Percent of Beneficiaries</th>
<th>Percent of Expenditures</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>18</td>
<td>1</td>
</tr>
<tr>
<td>1</td>
<td>19</td>
<td>4</td>
</tr>
<tr>
<td>2</td>
<td>21</td>
<td>11</td>
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<tr>
<td>3</td>
<td>18</td>
<td>18</td>
</tr>
<tr>
<td>4</td>
<td>12</td>
<td>24%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>21</td>
</tr>
<tr>
<td></td>
<td></td>
<td>66%</td>
</tr>
<tr>
<td>5</td>
<td>7</td>
<td>18</td>
</tr>
<tr>
<td>6</td>
<td>3</td>
<td>13</td>
</tr>
<tr>
<td>7+</td>
<td>2</td>
<td>14</td>
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</table>
Medicaid as a % of state budgets

<table>
<thead>
<tr>
<th></th>
<th>Mississippi</th>
<th>Ohio</th>
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</thead>
<tbody>
<tr>
<td>Lowest</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicaid</td>
<td>6</td>
<td>39</td>
</tr>
<tr>
<td>Elementary &amp; Secondary</td>
<td>50</td>
<td>27</td>
</tr>
<tr>
<td>Higher Education</td>
<td>18</td>
<td>10</td>
</tr>
<tr>
<td>All Other</td>
<td>26</td>
<td>24</td>
</tr>
</tbody>
</table>

Mississippi

Ohio
The IOM Quality Chasm Report

Conclusions:

“The current care systems **cannot** do the job.”

“Trying harder will not work.”

“Changing care systems will.”
To Change Outcomes Requires Fundamental Practice Change

Reviews of interventions in several conditions show effective practice changes are similar across conditions.

Integrated changes with components directed at:

- influencing physician behavior
- better use of non-physician team members
- enhancements to information systems
- planned encounters
- modern self-management support, and
- care management for high risk patients
Informed, Activated Patient

Productive Interactions

Prepared, Proactive Practice Team

Improved Outcomes

Chronic Care Model

Community

Health System

Resources and Policies

Health Care Organization

Self-Management Support

Delivery System Design

Decision Support

Clinical Information Systems
Can Busy Practices Change in Accord with the CCM?

- 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- 600+ 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
CCM Developments

• Guides several state programs

• Adaptations undertaken by U.K.’s National Health Service, World Health Organization, and several Canadian provinces.

• Foundation for NCQA and JCAHO certification for chronic disease programs.

• Part of new Models of Primary Care proposed by AAFP and ACP.

• Several practice assessment tools now available for large and small practices.

• Assessments now used in some pay for performance programs (NCQA).
Challenges Remaining

Early Adopters

Try less time-intensive learning

Target small practices

Create supportive systems
What will it Take to Improve Care for Chronic Illness for the Population?

Three Options When Selecting a Strategy

1. Assume that competition, financial incentives and computers will improve care.
2. Rely on direct to patient disease management.
3. Improve medical care by changing care systems.
King’s Fund Study of Organizations with Best HEDIS Chronic Illness Scores

Organizational factors supportive of high quality chronic care:

• Strategic values and leadership support long-term investment in managing chronic diseases

• Well-aligned goals between physicians and corporate managers

• Investment in information technology systems and other infrastructure to support chronic care

• Use of performance measures and financial incentives to shape clinical behavior

• Active programs of Quality Improvement based on explicit models

BMJ 2004;328:223-225
What’s needed to improve chronic illness care for the population?

Build a regional healthcare “system”

- Commitment and Leadership
- Measurement (& incentives)
- Infrastructure
- Active program of practice change
• Care will not improve unless we change the systems of care

• The goal is to transform health care delivery everywhere healthcare is delivered
• Someone needs to take and then assure leadership

• Major stakeholders need to be involved and committed to improvement
• Need outcome and patient experience data as well as process data to assess effort, performance, and improvement

• Practices will have to be able to provide valid and complete data on these indicators; claims will not suffice

• Practices should be able to use these data in clinical care, not just periodically send them off

• Smaller practices need info. and technical support to develop such data systems
Improving Health Care Delivery

- Information technology tools
- Quality improvement strategies
- Consensus guidelines
- Care management
- Provider networks

Need strategies and infrastructure to help ALL practices change their delivery systems

- Strategies – QI methods, Provider networks
- Infrastructure—IT, guidelines, care managers
**Engaging Consumers**

- Public disclosure
- Consumer education

- More activated and informed consumers may help push improvement
- Public disclosure of performance data may spur improvement
Aligning Benefits/Financing

- Incentives for cost-effective care
- Performance measures and rewards

- Create incentives for providers to make the investments needed to improve chronic care
- Create benefit plans that reward consumers for making cost-effective choices
A Framework for Regional Quality Improvement

Leadership

Collaboration among Stakeholders

Shared Data and Performance Measurement

Engaging Consumers
- Public disclosure
- Consumer education

Improving Health Care Delivery
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- Quality improvement strategies
- Consensus guidelines
- Care management
- Provider networks

Aligning Benefits/Financing
- Incentives for cost-effective care
- Performance measures and rewards

Transformed Health Care Delivery

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Is geographic improvement possible? State efforts
Is geographic improvement possible?

Indiana

• Health Commissioner and Medicaid Director to improve care for 80,000 chronically ill Medicaid recipients

• State leadership and money creating a Medicaid care system

• Statewide Collaborative Program PLUS
  - call center
  - community-based nurse care managers linked to practices
  - statewide Web-based patient registry
  - registry updated with claims data
  - considering performance incentives
  - embedded RCT

• Reported cost-savings to the Governor
A Framework for Regional Quality Improvement

Collaboration among Stakeholders

Leadership

Shared Data and Performance Measurement

Engaging Consumers
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- Consumer education

Improving Health Care Delivery
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- Quality improvement strategies
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- Incentives for cost-effective care
- Performance measures and rewards

Transformed Health Care Delivery

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Is geographic improvement possible?

North Carolina

- State leadership and money has created a visionary Medicaid care system
- Measurement system, Guidelines, Physician networks, Care Managers, Collaboratives
- Financial rewards for participating
- Early results promising
- Plans to extend to include all patients regardless of insurance coverage
Is geographic improvement possible?

Washington State

- Diabetes Surveillance
- Regional Collaboratives
- Standard guidelines & payment reform
- Laid groundwork for PSHA
Is geographic improvement possible?
Pennsylvania

NEWS ◆ NEWS ◆ NEWS ◆ NEWS ◆ NEWS

OFFICE OF THE GOVERNOR
COMMONWEALTH OF PENNSYLVANIA

FOR IMMEDIATE RELEASE:
Sept. 17, 2007

GOVERNOR RENDELL APPOINTS MEMBERS TO CHRONIC CARE COMMISSION AS PART OF HIS PRESCRIPTION FOR PENNSYLVANIA

HARRISBURG – Governor Edward G. Rendell has appointed 37 Pennsylvanians to a commission that will work to improve how Pennsylvania with chronic disease receive health care in the future. The initiative is part of the Governor’s Prescription for Pennsylvania health care reform plan.

“About 78 percent of all health care costs in Pennsylvania are attributable to 20 percent of all patients — those with chronic diseases,” Governor Rendell said. “The members of the Chronic Care Management Commission will be responsible for developing the process to effectively manage chronic disease across the state. We can’t reduce the occurrence and cost of chronic diseases without aggressively addressing prevention, detection and treatment in a comprehensive, pro-active way.”

• Started at the National Governors Association
• All the major players at the table
• Timeline & budget to make it happen
## Lessons Learned

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<thead>
<tr>
<th>State</th>
<th>Lesson</th>
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<tbody>
<tr>
<td>Indiana</td>
<td>Make your effort bipartisan &amp; protect it from political winds</td>
</tr>
<tr>
<td>Rhode Island</td>
<td>Bring all the “p”s to the table: providers, purchasers, payers, patients, policy-makers</td>
</tr>
<tr>
<td>Colorado</td>
<td>Connect with local foundations and groups already doing the work</td>
</tr>
<tr>
<td>New York</td>
<td>State involvement can take efforts to the next level</td>
</tr>
<tr>
<td>Maine/California</td>
<td>Organizing diffuse efforts is a big but important job</td>
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## More Lessons Learned

<table>
<thead>
<tr>
<th>State</th>
<th>Lesson</th>
</tr>
</thead>
<tbody>
<tr>
<td>North Carolina</td>
<td>Reach out! Provider networks can engage small practices in quality improvement</td>
</tr>
<tr>
<td>Vermont</td>
<td>Putting dollars on the table facilitates the work</td>
</tr>
<tr>
<td>Washington</td>
<td>A charismatic leader with vision can make things happen</td>
</tr>
<tr>
<td>Pennsylvania</td>
<td>Take advantage of opportunities like the NCSL &amp; NGA to jumpstart innovative ideas</td>
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Contact us at:

www.improvingchroniccare.org