

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

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Improving Chronic Illness Care

A national program of the Robert Wood Johnson Foundation

Step 1: End the complacency!

- U.S. 30th in life expectancy (Cuba is 29th)
- 40-50% more expensive than any other country
- Quality mediocre and unrelated or negatively correlated with cost
- Nearly 1 in 6 have no health insurance and they have a 25% greater mortality rate
- Tragic racial, ethnic and income disparities
- Survival of primary care in question



Johns Hopkins U.S. Survey about Chronic Care: % Agreeing With

	Public	MD's	Policy-makers
People with chronic conditions usually receive adequate medical care	48%	45%	22%
Gov't programs are adequate to meet the needs of people with chronic conditions	38%	20%	16%
Health insurance pays for most of the services chronically ill people need	37%	28%	23%

Why focus on chronic illness care?

- **Primary care dominated by chronic illness care**
- **Clinical and behavioral management increasingly effective, but complex and expensive**
- **Inadequate reimbursement forcing primary care to increase throughput while limiting clinical staff—the hamster wheel**
- **Roughly 50% of Americans not receiving evidence-based chronic illness care (Quality Chasm) and only 25-40% have their condition under good control**
- **Trainees choosing other specialties**
- **Loss of confidence in primary care by policy-makers and funders**
- **Talk of the “demise of primary care”**

Step 2 – Don't wait for federal healthcare reform



Step 3: Find the causes of inadequate care.

IOM Quality Chasm Report:

“The current care systems
cannot do the job.”

“Trying harder will not work.”

“Changing care systems will.”



What's Responsible for the Quality Chasm?

- **A system oriented to acute disease that isn't working for patients or professionals**



Crossing the Quality Chasm Recommendations

- **Redesign care delivery**
- **Build organization support for redesign**
- **Improve information and measurement systems**
- **Change payment so that it encourages quality care and improvement**

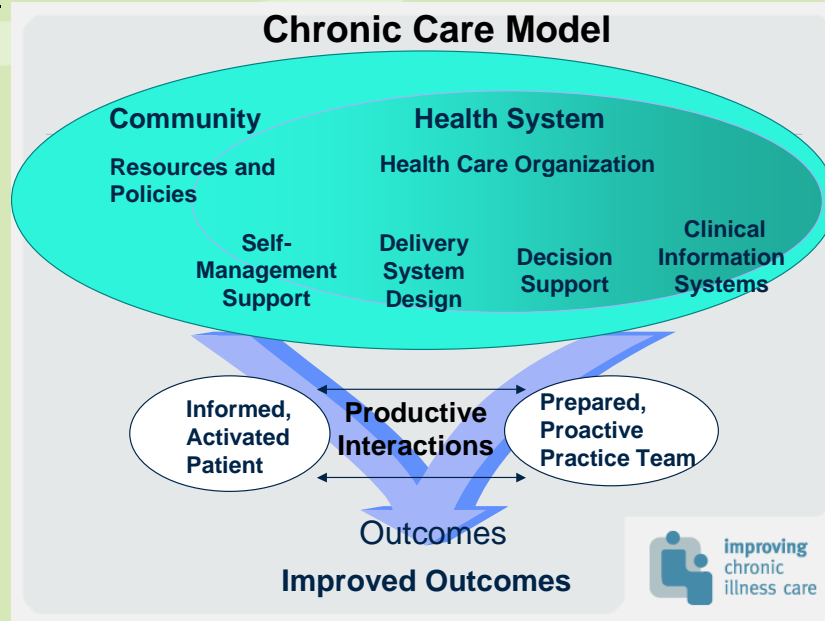
Step 4: Select a strategy

Three Options:

1. Assume that competition and computers will improve care
2. Direct to patient disease management
3. Improve medical care by changing care systems

What kind of changes to practice systems improve care?

- better use of non-physician team members,
- planned encounters,
- modern self-management support
- Care management for high risk
- Links to effective community resources
- guidelines integrated into care
- enhancements to information systems (registries)



Lessons learned in chronic illness care improvement

- **Chronic care collaboratives have demonstrated that practices can make these changes and improve care**
- **Mostly reaching early adopters**
- **Practice redesign is very difficult in the absence of a larger, supportive “system”, especially for smaller practices**
- **How to help isolated small practices where 80% of Americans receive their care?**

Step 5—Reach the Majority of Practices

- **It will take more than collaboratives**
- **Are there lessons from successful large systems like the VA or regions of Kaiser Permanente?**
- **If so, might they be applicable to communities?**

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**
- **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**

***King's Fund Study**

But, the VA and Kaiser are organizations with leaders, money, fairly clear business goals, and staff who share those goals. Is there anything analogous in the community?

Step 6—Build a regional healthcare “system”



But, who might do it, and what would they do?

Regional coalitions have been a common American response to regional problems.

“Americans are a peculiar people. If in a local community a citizen becomes aware of a human need that is not met... suddenly a committee comes into existence...and a new community function is established. It is like watching a miracle.”

de Tocqueville, 1840

Regional coalitions tackling health issues are not new or uncommon. Lasker et al. identified over 400 Coalitions in 1997.

The Regional Framework

- Data sources were a literature review, interviews with leaders of major coalitions directed at quality, and lessons learned in helping launch the PSHA
- The goal is to provide a visual summary of what we leading coalitions were doing—i.e. not an evidence-based guideline or model

To improve care and reduce costs the goal must be to transform health care delivery everywhere healthcare is delivered



**Transformed
Health Care Delivery**

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- **Care will not improve unless we change the systems of care**

Payers

Providers

Plans

Patients

Collaboration among Stakeholders

- **Major stakeholders need to be involved and committed to improvement**
- **Refusal of a stakeholder group to participate is ominous**

Leadership

- **Someone needs to take and then assure leadership**
- **But long-term success depends on three-tiered leadership**
 1. **Organizational manager & staff**
 2. **Respected home base for coalition**
 3. **Stakeholders involved in program development**

Shared Data and Performance Measurement

- Is primary goal data exchange or performance measurement?**
- Need data on performance to plan, motivate, monitor, and reward**
- Need data on all patients—health plans and providers must share**

Shared Data and Performance Measurement

- **What to measure?**
- **Data sources**

Question: Do claims data validly reflect care quality and efficiency?

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

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QI Strategies

Are there promising QI strategies besides collaboratives? Some evidence supports practice coaching. Is there anything else on the horizon?

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QI Strategies

The isolation and resource limitations of small practices must be addressed. Practice networks may be an answer.

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IT Tools

Mounting evidence suggests that it is registries, not other EMR features, that improve care. What can a regional initiative do to assure that practices have registries?

Improving Health Care Delivery

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Care Management

There is strong evidence that many high risk patients benefit from clinical care management by nurses, pharmacists, and other clinical staff. Can we make care management a community resource?

Engaging Consumers

- Public disclosure
- Consumer education

- **More activated and informed consumers may help push improvement.**
- **No evidence that it changes provider choice.**
- **Public disclosure of performance data may spur improvement**
- **But may also lead to negative provider behaviors**

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

Question: Is the bloom off the P4P rose, or is the jury still out?

•Create benefit plans that reward consumers for making cost-effective choices

A Framework for Regional Quality Improvement

