Improving Health Care for Chronic Conditions

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… committed to health care improvement

Levels for improving care

MACRO LEVEL

Health Policy

MESO LEVEL

Organization of Health Care

MICRO LEVEL

Individual




Presentation outline

1 Typical care

2 Innovative Care

3 Accelerating implementation




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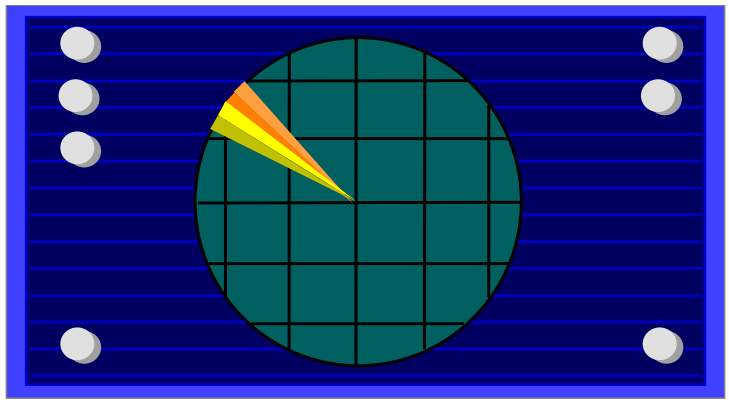
Health care for chronic conditions: What do we know?

- **Disease burden has changed towards chronic conditions world wide. *Health systems haven't*.**
- **Highly effective interventions exist for most chronic conditions, *yet patients do not receive them.***
- **Current health systems are designed to provide episodic, acute health care and *fail to address self-management, prevention and follow-up*.**
- **Chronic conditions require a different kind of health care (*mismatch*).**




TYPICAL CARE

The Radar Syndrome



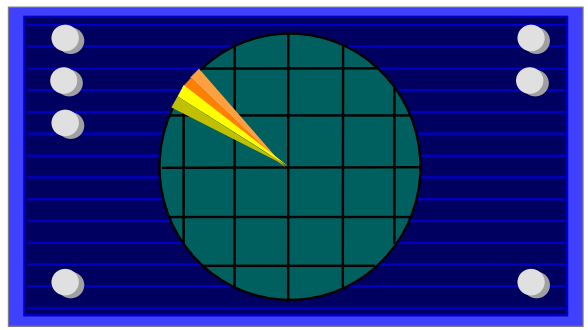
- Patient appears
- Patient is treated "find it and fix it"
- Patient is discharged

... then disappears from radar screen



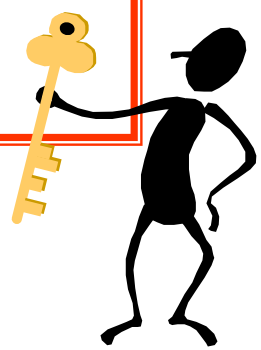

Radar logic = inappropriate care for chronic conditions

- System oriented to acute illness
- Patient's role not emphasized
- Follow-up sporadic
- Prevention overlooked






All systems are perfectly designed to produce exactly the results they achieve.






Missed opportunities for clinical prevention: What is the impact?

- **Tobacco smokers have 18% higher medical charges than non-smokers**
- **A one-unit increase in BMI raises medical charges by 1.9%**
- **Each additional day of physical activity per week reduces medical charges by 4.7%**

Study conclusions:

"Health plans that do not systematically support members' efforts to improve health-related behaviors may be incurring significant short-term health care charges that may be at least partly preventable."

JAMA. 1999; 282: 2235-9




Health Care Experiences in Five Countries

- 3,849 “sicker patients” across 5 countries
- Despite differences in health systems, large proportions of patients report errors, poor communication, faulty care coordination
- Focusing on high utilizers has the potential to both control costs and improve care

Blendon et al., Health Affairs 2003; 22(3):106-21




Across the five countries

"My regular doctor or health professional DOES NOT …"

- make clear specific treatment goals (20-38%)
- help me understand what needs to be done for my health (12-26%)
- ask for my ideas or opinions about treatment (47-67%)
- keep me motivated (28-43%)
- provide advice on weight, nutrition, exercise, smoking, drinking (33-49%)
- discuss the emotional burden of the condition (51-66%)

Blendon et al., Health Affairs 2003; 22(3):106-21




Who suffers as a result?

- Patients
- Families
- Health care workers
- Employers
- Insurers
- Governments

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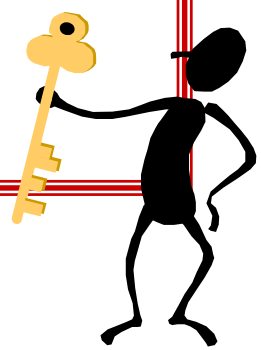
Chronic conditions require an evolution of health care ….

from typical (radar care) to achievable "Innovative Care"

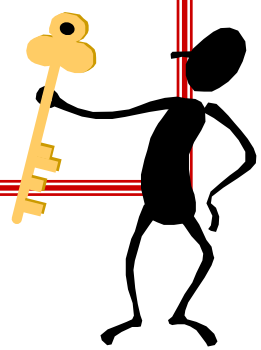



No longer is each risk factor and chronic illness being considered in isolation. Awareness is increasing that *similar strategies* can be equally effective in treating many different conditions.



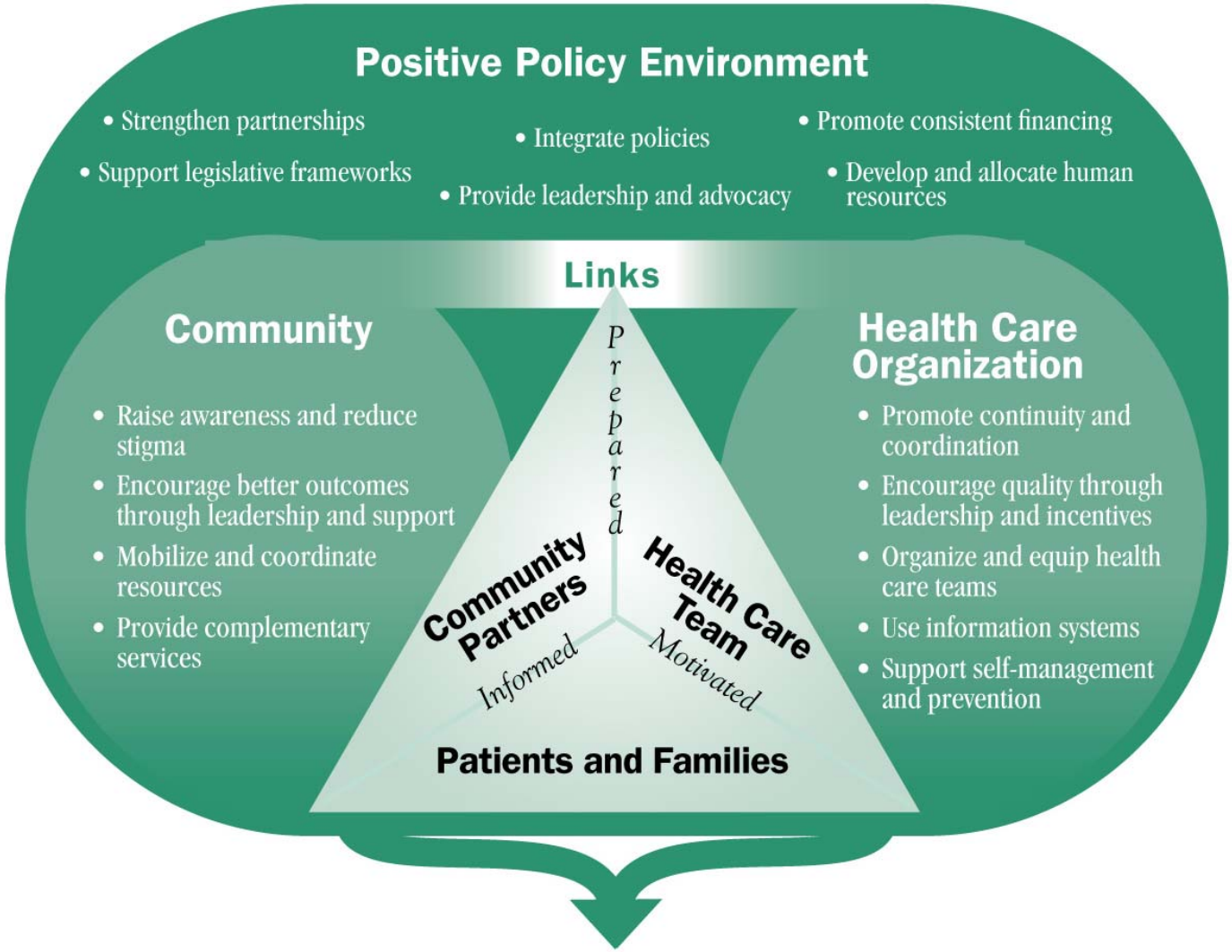



Organized systems of care, not simply individual health care workers, are essential in producing positive outcomes.






Innovative Care for Chronic Conditions Framework



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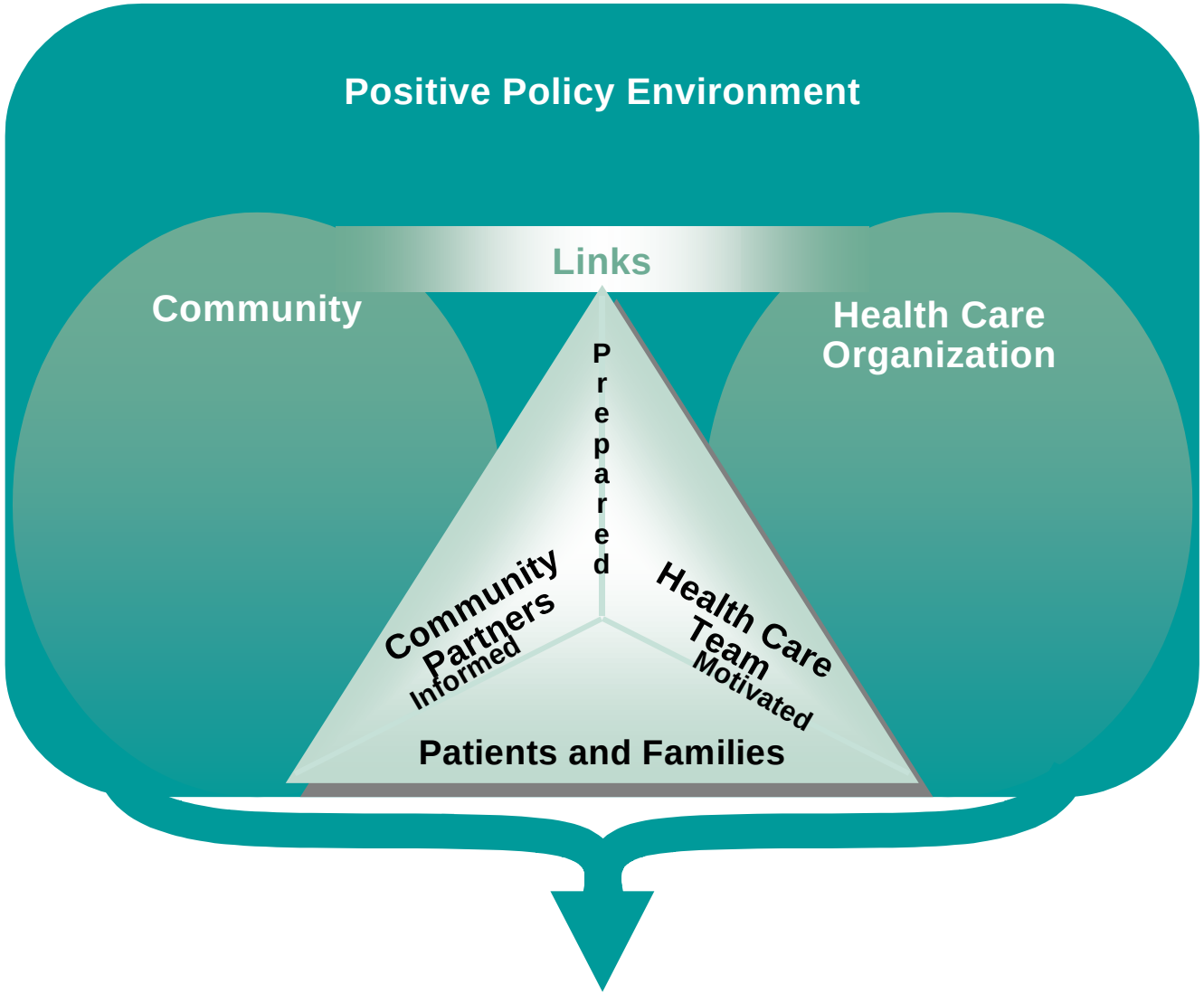
Innovative Care for Chronic Conditions Framework



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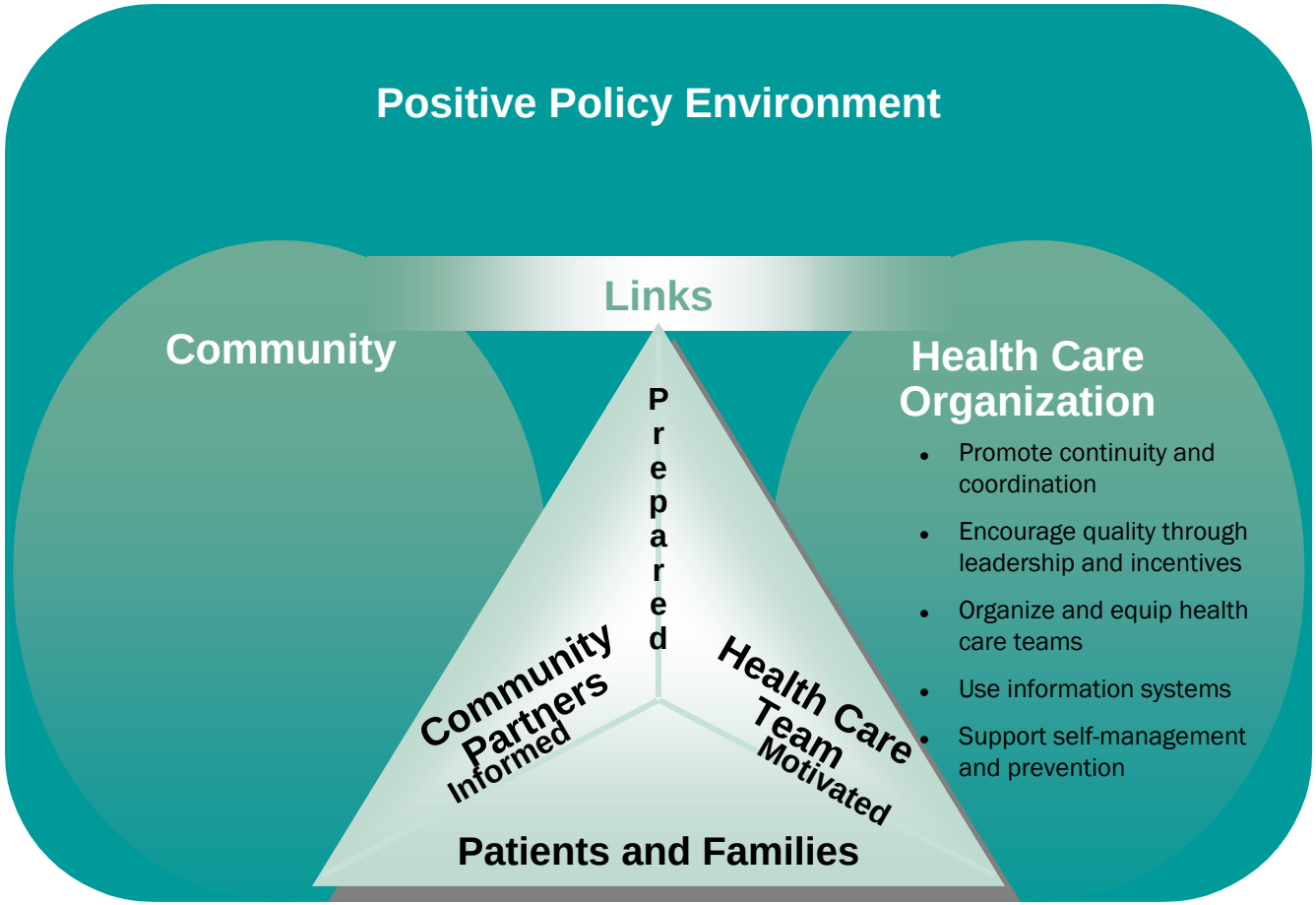




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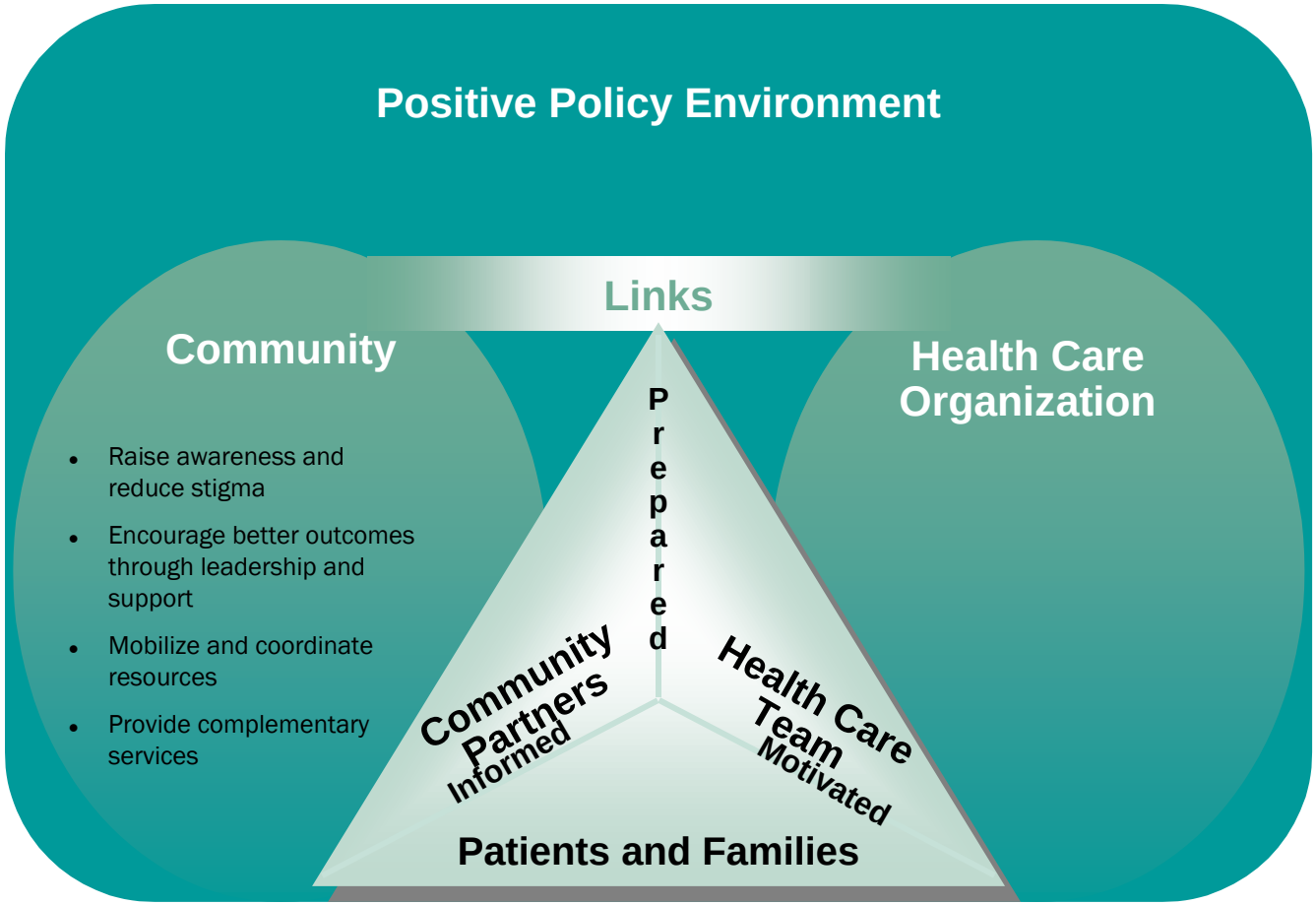




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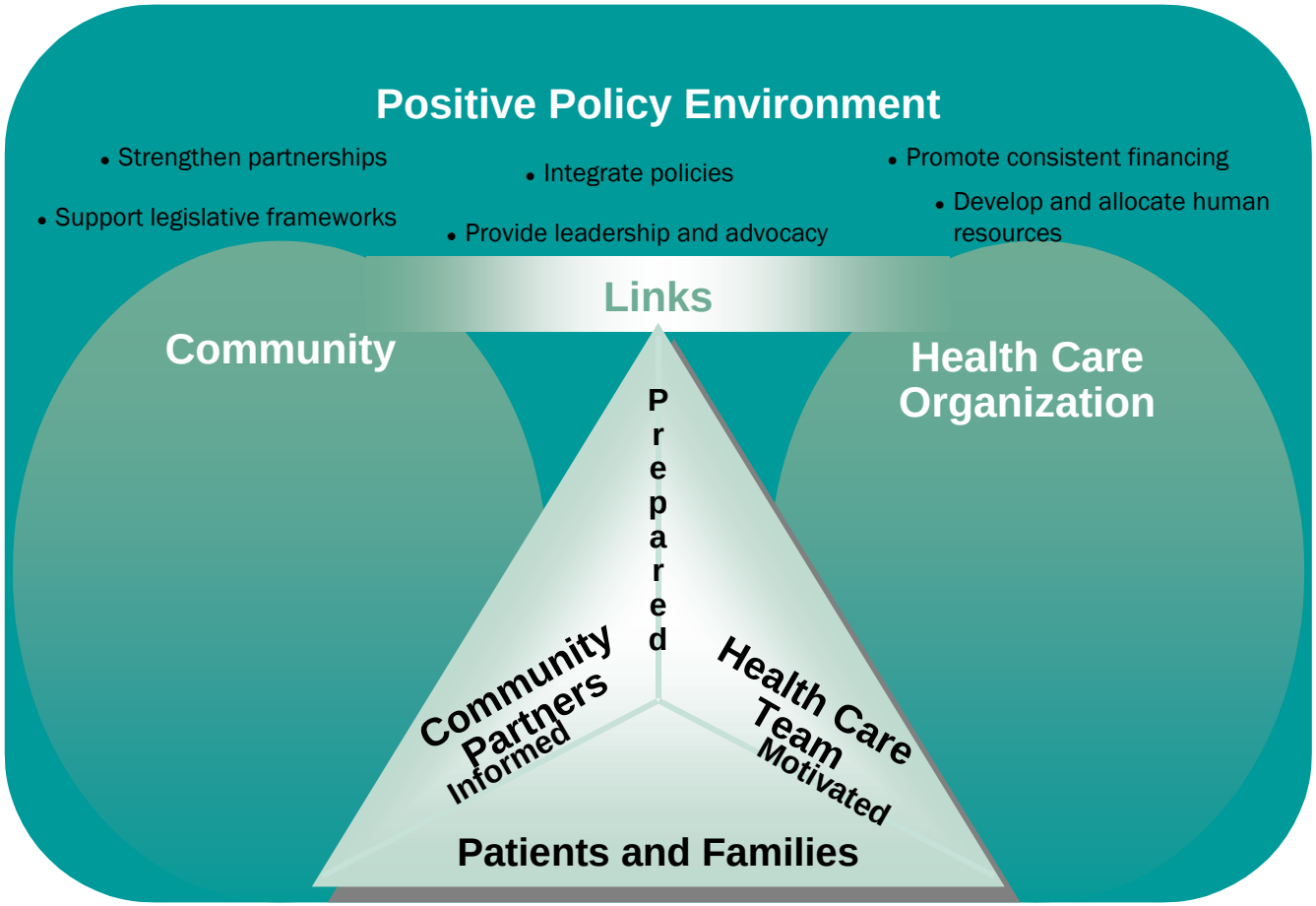




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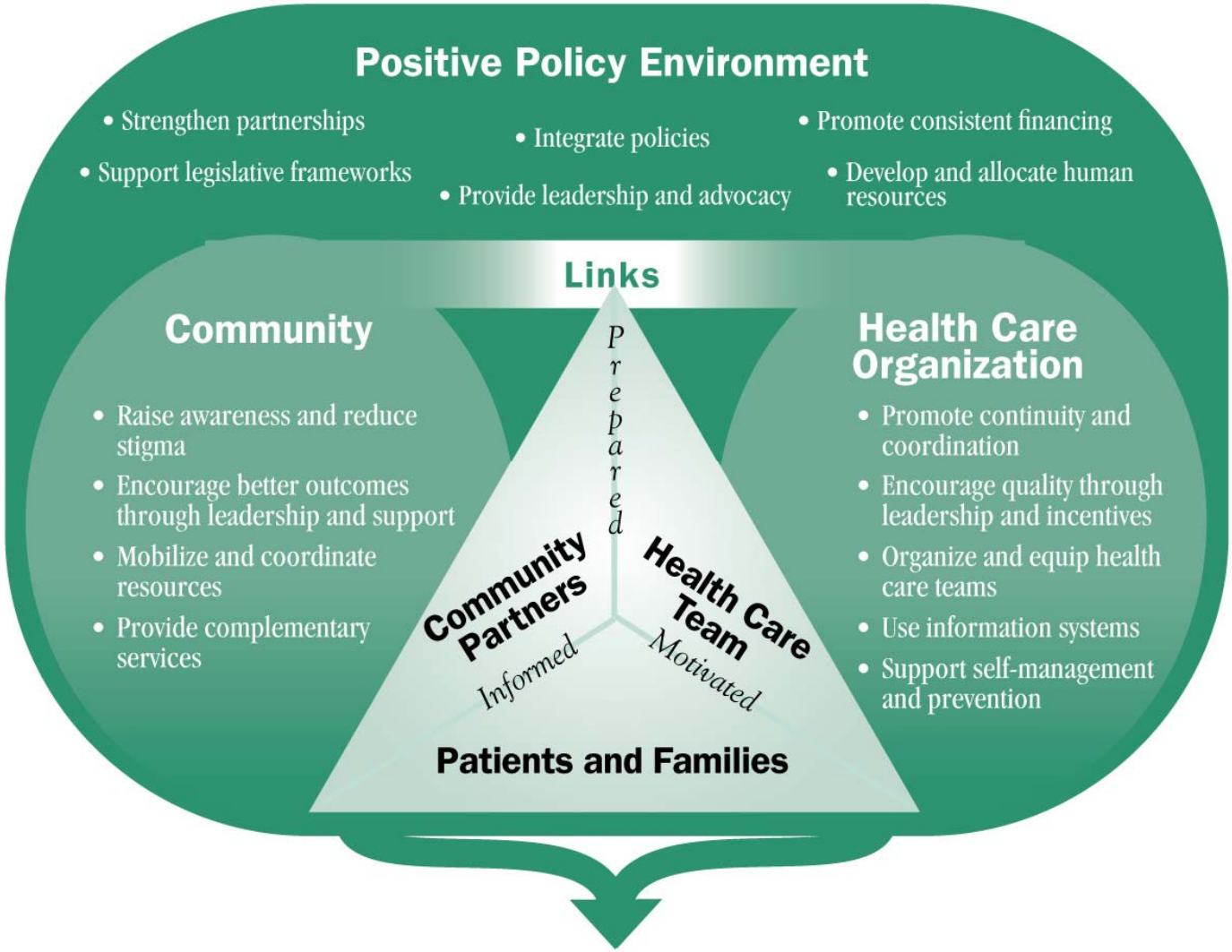




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"The WHO strategy for chronic disease management in resource poor countries could provide a model for delivering comprehensive services to people infected with HIV, who have similar healthcare needs."

MM Kitahata, MK Tegger, EH Wagner & KK Holmes

BMJ, October 2002




It CAN be done ...

Examples from innovative programmes

- Cancer: saves 400 years of waiting time
- Diabetes: quadruples foot exam rates (18% - 82%)
- Asthma: reduces hospital admission costs from $18,488 to $1,538 per patient
- Coronary artery disease: reduces deaths by 41%
- Congestive heart failure: reduces hospital admissions by 56%
- Nicotine dependence: produces 70% cessation

For details ...




… in developing countries

Rural South Africa

- Integrated, nurse-led PHC for hypertension, diabetes, asthma and epilepsy
- Introduced registries, diagnostic and treatment protocols, patient self-management support, and planned follow-up. Reconfigured health care personnel.
- Results: nurses could successfully manage > 90% of patients with minimal to no MD support
- Adherence rates significantly improved

R Coleman, G Gill & D Wilkinson,

Bulletin of the WHO, 1998




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Diffusion

…”The process by which an innovation is communicated through certain channels over time among the members of a social system”…

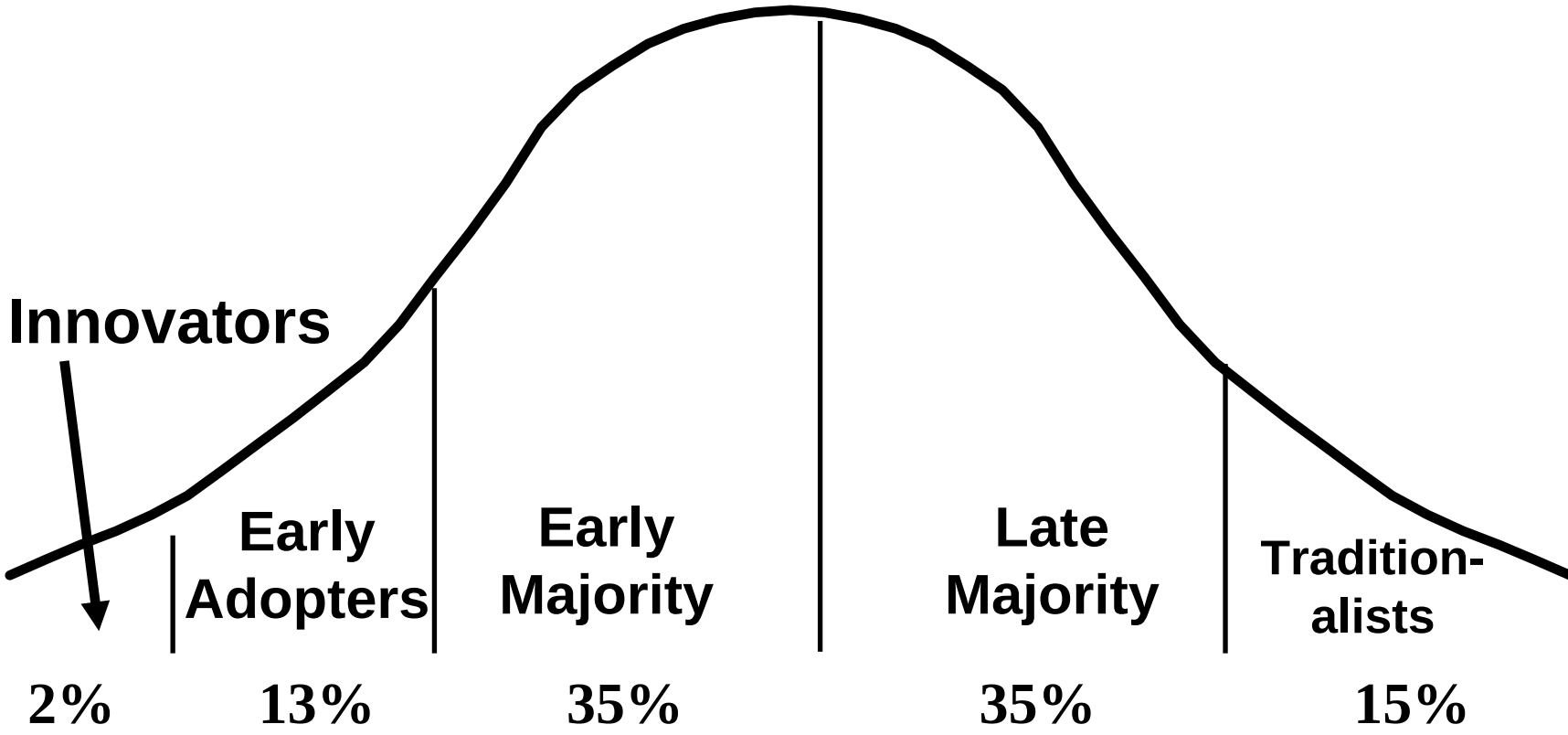
Everett Rogers

Diffusion of Innovations

1995




Adopter categorization: speed of adoption





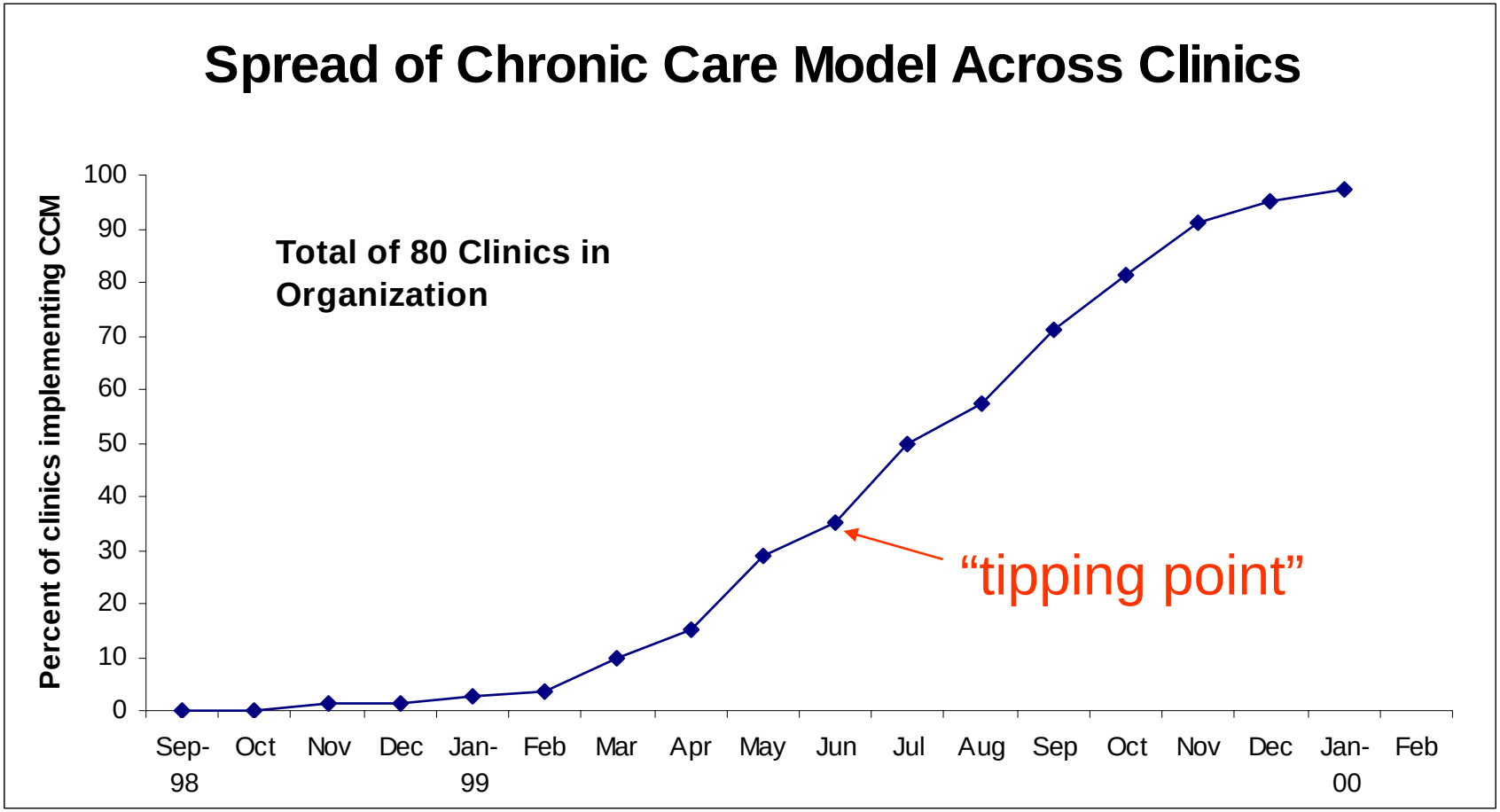

Momentum for spread

...“The part of the diffusion curve from about 10% to 20% adoption is the heart of the diffusion process. After that point, it is often impossible to stop further diffusion of a new idea, even if one wished to do so”...

Everett Rogers
Diffusion of Innovations
1995




The “Diffusion Curve”



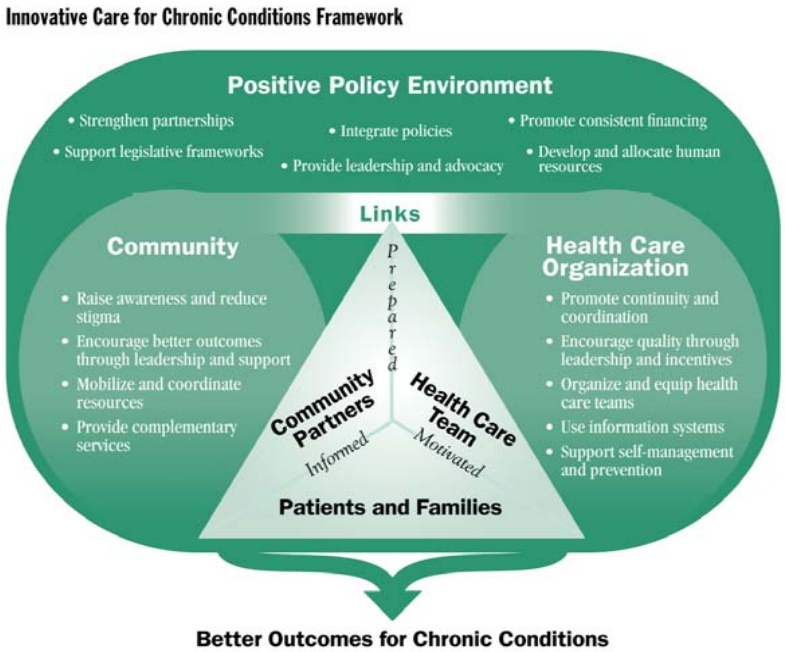


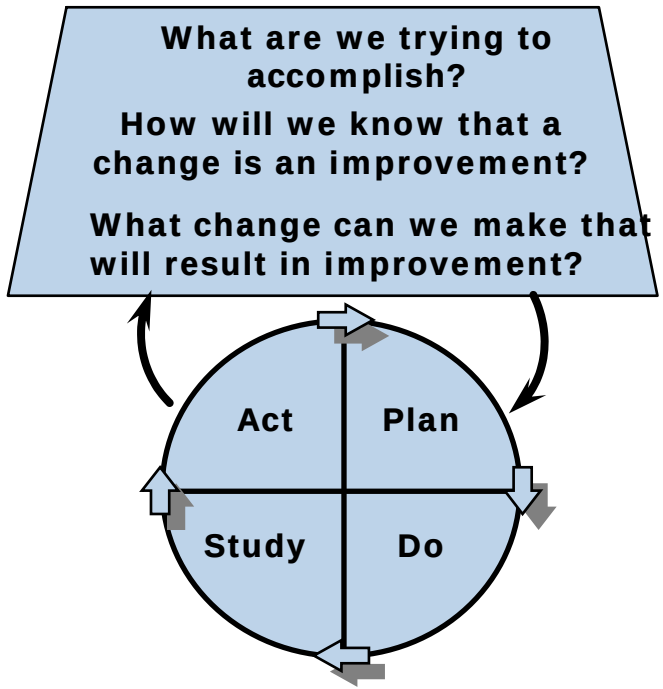

The implementation model

What to do: The ICCC Framework

+

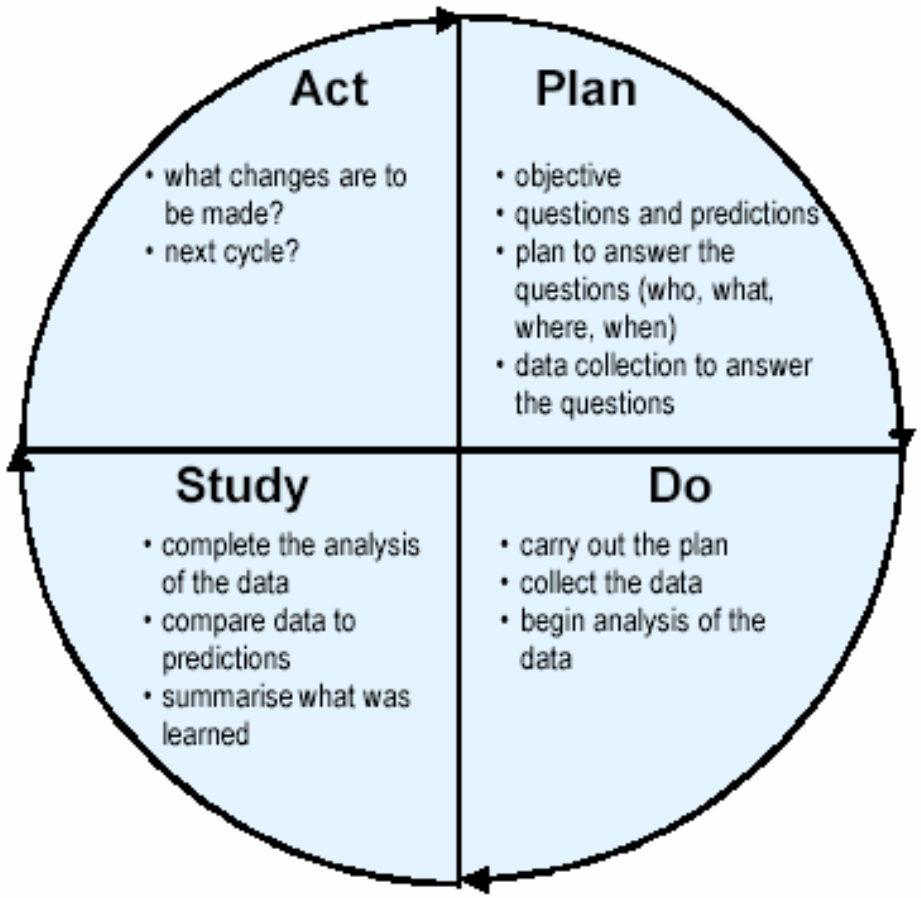
How to make it happen: The Model for Improvement





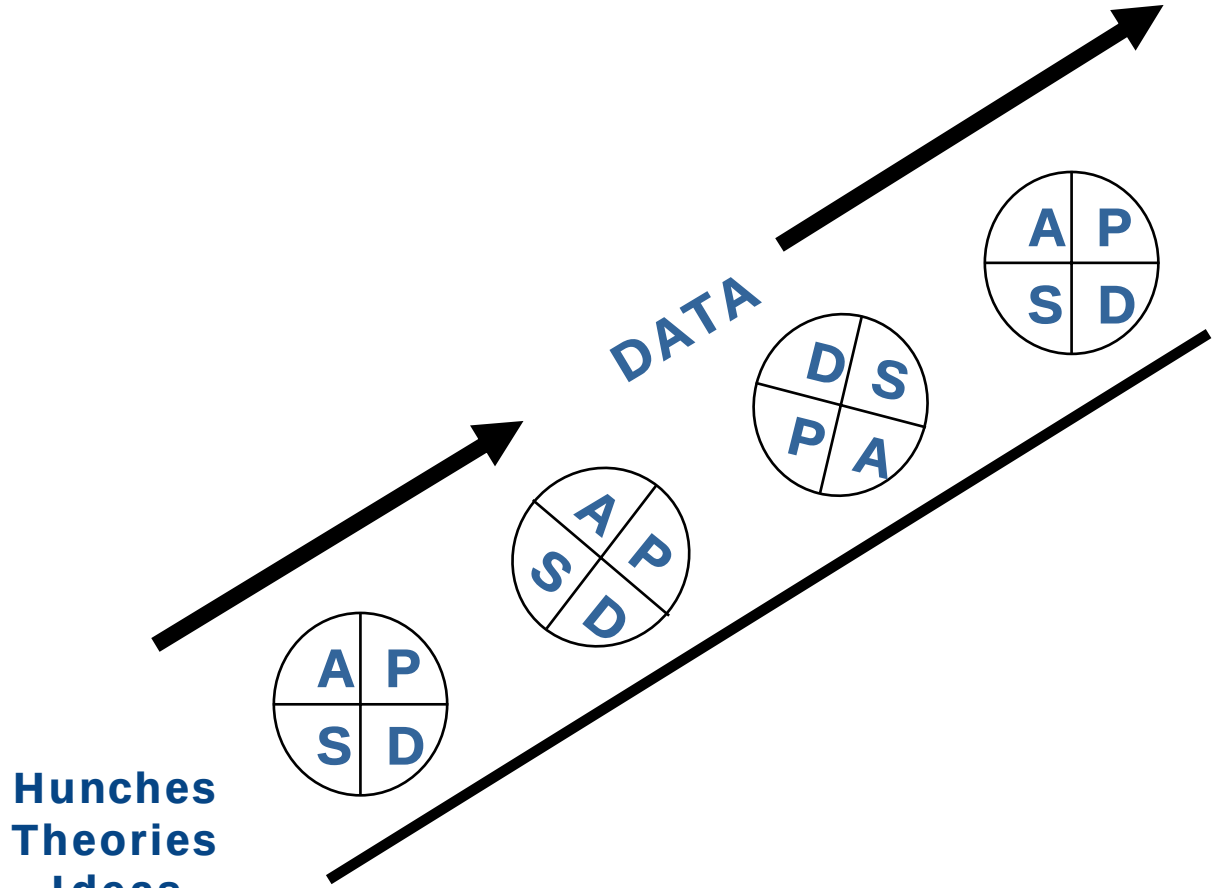



Plan-do-study-act



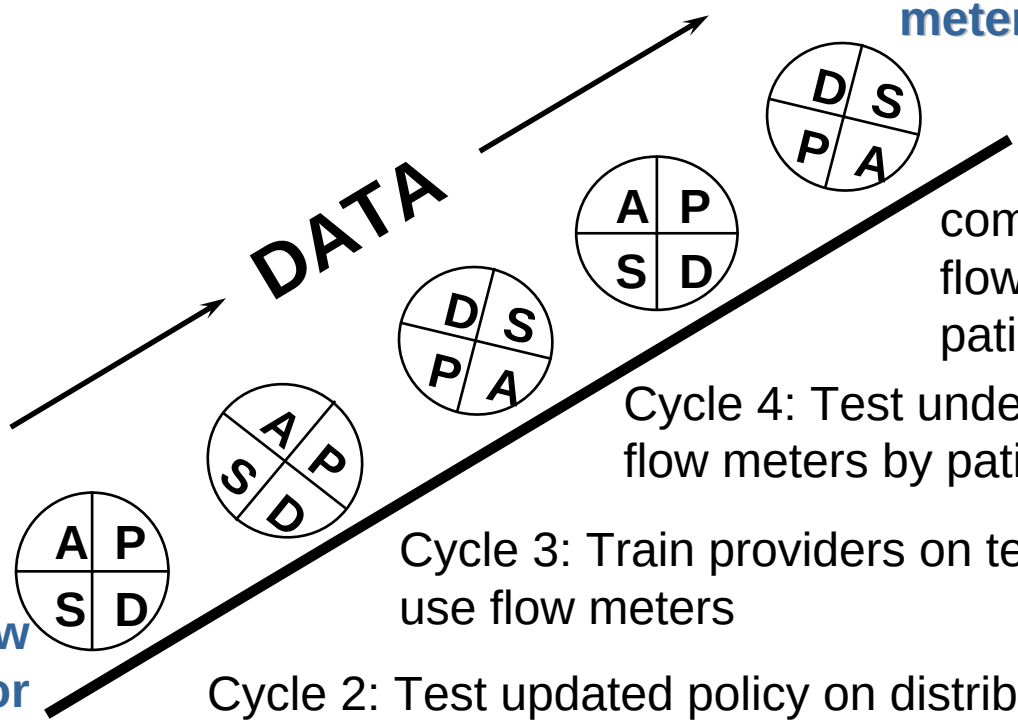



Repeated use of the cycle






Focus: Improve assessment and care of high-risk asthma patients



Routine use of flow meters by high-risk patients

Cycle 5: Monitor communication and use of flow meters with high-risk patients

Cycle 4: Test understanding of use of flow meters by patients

Cycle 3: Train providers on teaching patients to use flow meters

Cycle 2: Test updated policy on distribution of flow meters

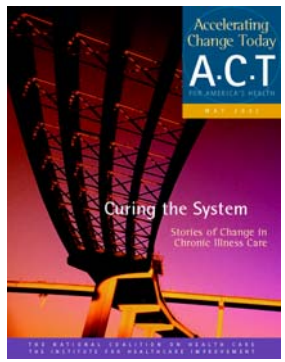
Cycle 1:Test communication on use of flow meters with providers

Peak flow meters for high-risk patients




Sample Results: Clinica Campesina

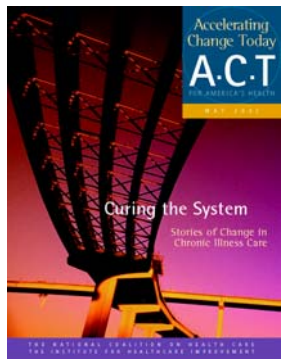
Measure	Initial rate	Improved rate
Average HbA1c	10.5%	8.7%
At least 2 HbA1c/year	15%	45%
Eye exams	7%	27%
Foot exams	15%	56%
Collaborative self-management goal	0%	46%






Sample results: Premier Health Partners

Measure	Initial rate	Improved rate
HbA1c < 7%	42%	70%
At least 2 HbA1c/year	67%	90%
Foot exams	61%	78%
Annual urine protein	52%	78%
ACE inhibitors with positive urine protein	38%	80%

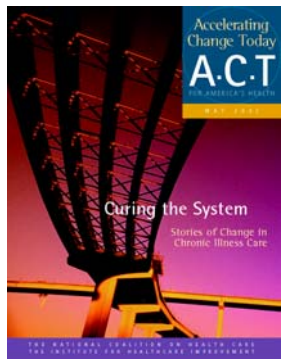





Sample results: High Plains Community Center

Measure	Initial rate	Improved rate
BP < 140/90	35%	62%
At least 2 BP checks/year	47%	87%
Documented self-management goal	34%	59%
Hyperlipidemia screening	70%	82%

Improved rate = results after 7 months





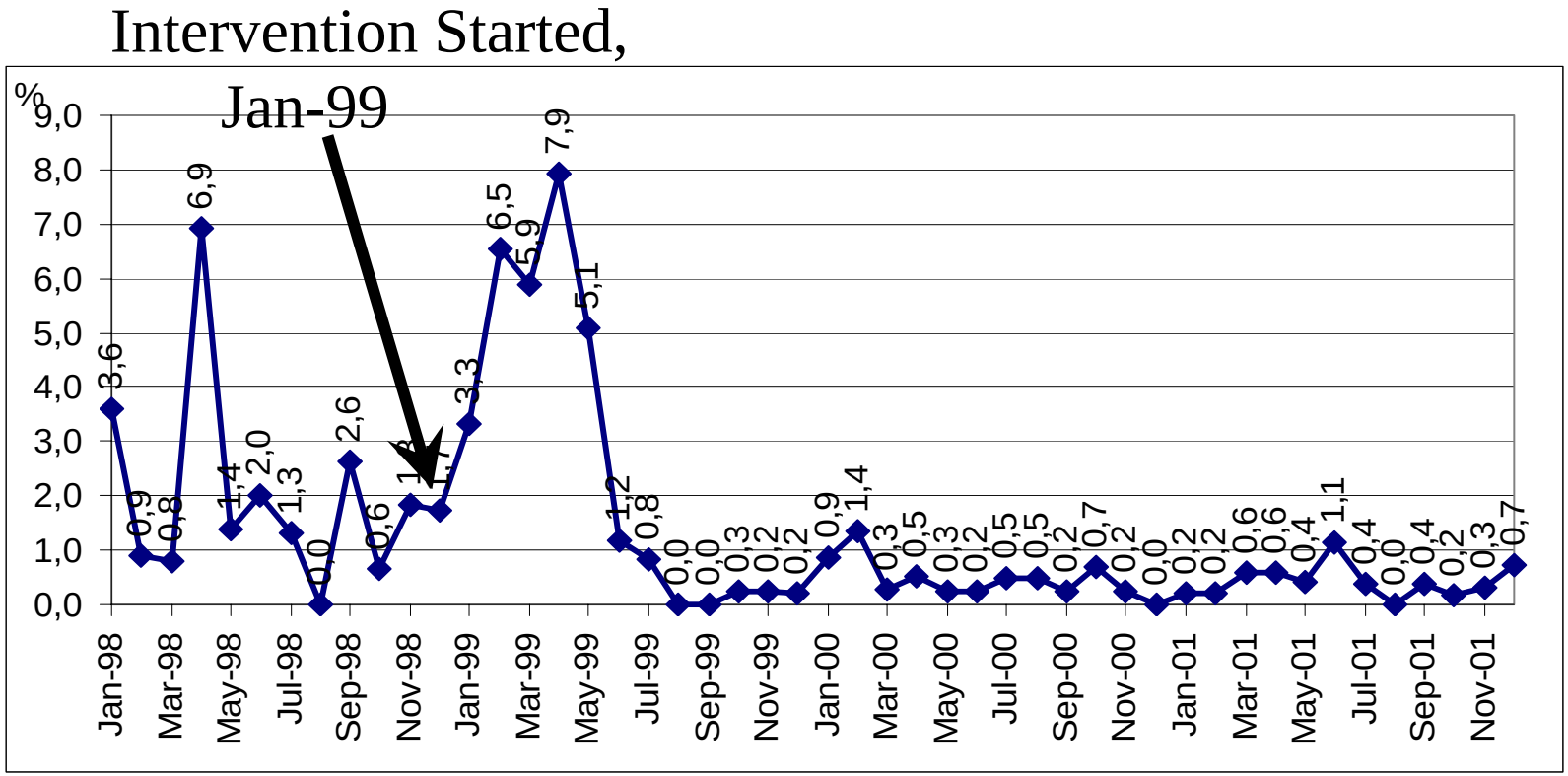

Improving the system of hypertension care in Tula Oblast, Russian Federation (1998-2000)

- Number of patients managed at the primary care level increased by 7.6 times
- BP stabilization achieved in 69.4% of patients
- Hypertension related hospitalizations decreased by 85%
- Hypertensive crises decreased by 60%

University Research Corporation, USA




Hospitalization due to AH



University Research Corporation, USA

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Organization of Tula intentional spread (2000 - 2002)

University Research Corporation, USA



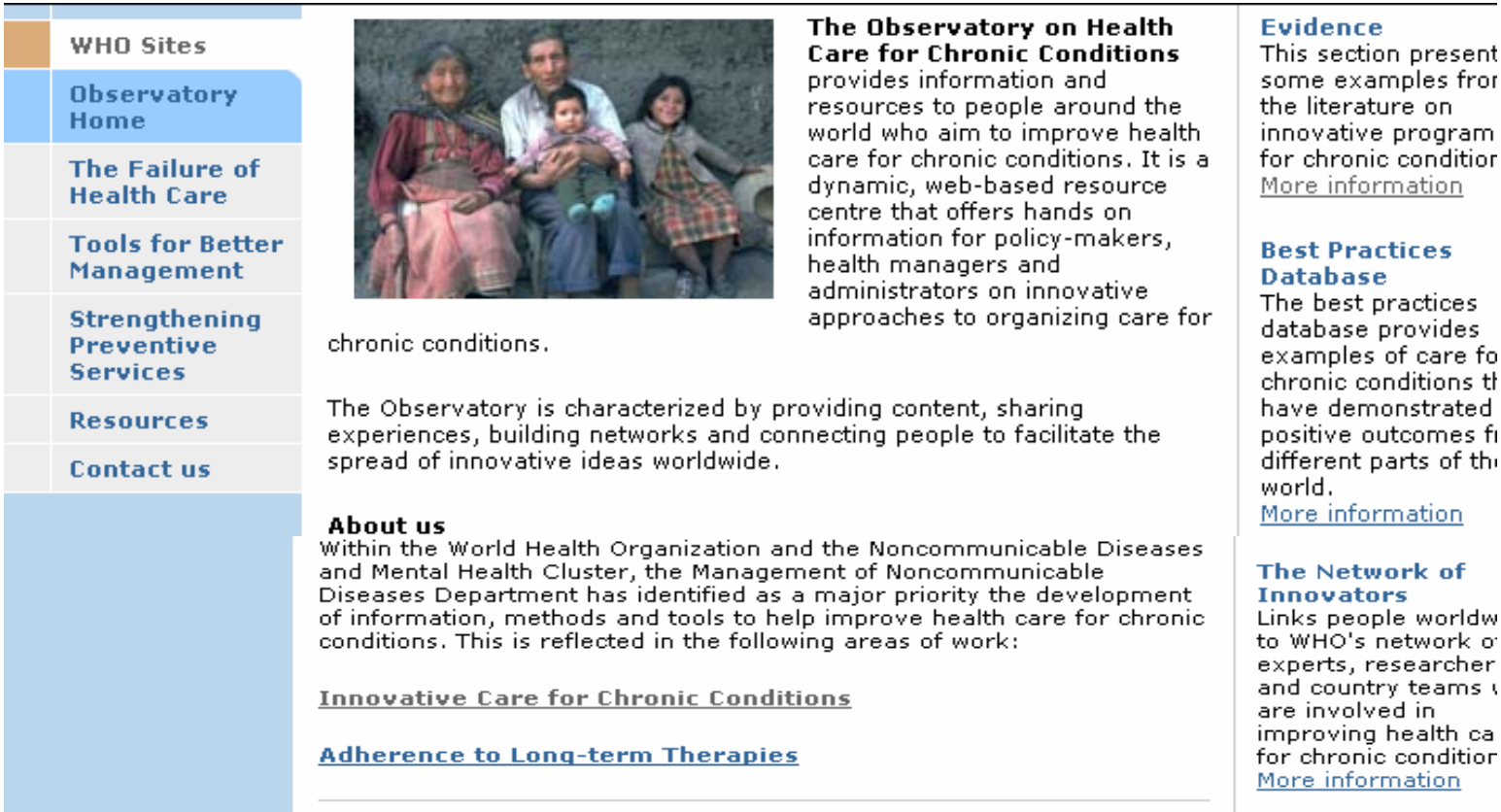

Summary

- The disease burden has changed towards chronic conditions world wide. The health system hasn't.
- Effective prevention and management of chronic conditions requires an evolution of health care, away from a model that is focused on acute symptoms towards a coordinated, proactive system of care.
- Evidence shows that integrated approaches result in improved efficiency and better outcomes.




For more info: Observatory on Health Care for Chronic Conditions

A forum for both *content* and *process*



http://www.who.int/chronic_conditions/en/

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"Trying harder will not work. Changing systems of care will."

Crossing the Quality Chasm, Institute of Medicine, 2001