

# Innovations in Care

## for Chronically Ill Patients

Caring for patients with one or more long-term health conditions is the bread and butter of our health care system; yet innovations in care for the chronically ill do not always receive the attention they deserve. In this Issue Focus, some of the most promising paths to care improvement being forged with the support of health philanthropy are described. Additionally, critical outstanding challenges and promising areas for future exploration are discussed.

### THE NEED TO IMPROVE CHRONIC CARE MANAGEMENT

Although Americans are living longer, it is far from clear that we are living better in terms of our health and functional well-being. The rising prevalence of chronic conditions—including illnesses like diabetes, cardiovascular disease, and cancer, with potentially debilitating and life-threatening impact—has major implications for our health and our health care. More and more patients are being treated for conditions that require close monitoring and careful management to avert or slow disease progression and to ensure that they attain their best possible health, functional status, and quality of life.

The toll on our health and health spending is great and growing. A full three-quarters of health spending is attributable to chronic conditions, a tally that does not take into account the burden of illness on patients and their families (CDC 2009). Half of all adults are living with at least one chronic condition, and more than one in five have more than one chronic condition (Wu and Green 2000; Vogeli et al. 2007). About one-quarter of those with a chronic condition also experience limitations in one or more activities of daily living (Anderson 2004). The rate of childhood affliction has grown from fewer than 2 percent of children in the 1960s to more than 7 percent in recent years (CDC 2009).

This epidemic demands at least two major lines of response (IOM 2012). First is an investment in prevention, to reduce risk factors like poor nutrition, inactivity, smoking, and alcohol abuse, and to take other steps to cut the rate at which chronic conditions are acquired. Second is meaningful innovation in approaches to care for patients who are chronically ill, particularly for those with complex conditions whose care involves ongoing efforts by multiple health care professionals.

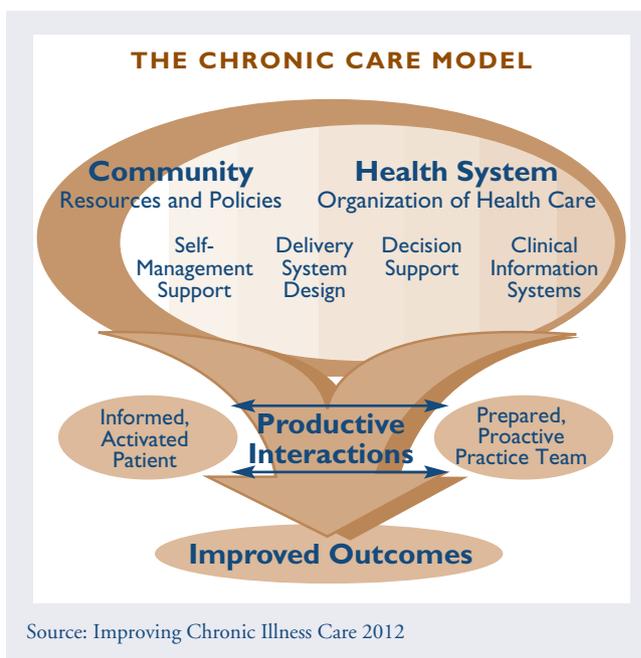
Better care for patients living with chronic conditions—in particular for those patients with multiple or complex conditions—is an alluring goal that promises better outcomes at lower cost. Proper care means maximizing patients' health and functioning, ensuring that the right care is provided at the right time, and doing what it takes to steer clear of avoidable

hospital admissions. Achieving this goal will require coordinated, patient-centered care from health care professionals who operate as a team, using information technology to share data, avoid duplication of effort, ensure continuity at care transition points, and involve the patient in care decisions and condition management. Yet attaining these instrumental objectives has proved very elusive.

### THE CUTTING EDGE

In its work to strengthen delivery of chronic disease care, the California HealthCare Foundation began by strengthening the capacity for improving care for this population via such steps as creating disease registries (Chang 2012). A subsequent focus on redesign of primary care included team building, fostering patient self-management, adoption of electronic medical records, introducing standardized work processes, and employing systems of measurement and reporting. In the third phase of its work, the foundation is focusing on care for patients with complex chronic diseases, putting in place population management programs and efforts to engage the patient's family in care, for example. Areas of current attention include a focus on vulnerable points of transition or hand-off, such as hospital discharge, and making good use of technologies, such as telemedicine, that can support more efficient care delivery.

The Commonwealth Fund has advocated for better chronic



care management and identified a range of successful models for emulation and adaptation. Chronic care demonstration projects with innovations, such as identification and targeting of patients who can benefit from focused attention, outreach programs, health system navigation aides, use of nurse extenders and same-day appointment scheduling, have yielded impressive reductions in hospital admissions, emergency room visits, and skilled nursing facility use, along with reduced mortality and costs. Key factors for success in improving outcomes and lowering costs of caring for chronically ill patients include creation of teams that span multiple sites of care, development of information systems to include components such as patient registries and telehealth, and coherent payment systems that give providers the incentives to make needed changes (Schoen 2012).

In August 2012 the Robert Wood Johnson Foundation (RWJF) published a review and assessment of its work to improve care for chronic illness, which has included work to develop, test, and disseminate the influential Chronic Care Model (see figure). The review authors observed that many RWJF programs had had important positive effects for patients and some had made an impact on the field of chronic care management. Few of the programs, however, produced change outside of the scope of the programs themselves, despite a sizeable overall investment of resources, attributable to lack of synergy across the programs and to the scope of the problem (Showstack and Wolfe 2012).

### SEIZING OPPORTUNITIES, OVERCOMING OBSTACLES TO PROGRESS

Today's health care environment and policy context suggest a number of specific opportunities for foundations to engage in work to foster and support innovation in care for chronically ill patients. Notably, ongoing implementation of Affordable Care Act provisions is helping develop an environment that favors innovation—for instance, through support for accountable care organizations with both the incentives to focus on improving care for the chronically ill and the capacity to achieve the triple aim of better health, better care, and lower costs. New demonstration projects will assess ways to care for the population dually eligible for Medicare and Medicaid, disproportionately patients with multiple complex chronic conditions. Meanwhile, public programs and private employers faced with unsustainable increases in costs of health care are looking for ways to reduce the cost impact of care for chronic conditions.

Without improvements in prevention, the number of people affected by chronic illness will escalate, augmenting the demand for more effective and efficient care delivery for chronically ill patients. At the same time, a number of very significant challenges to making that vision a reality are evident. State budget crises pose risks to the safety net in many communities, and shortages of primary care providers are

expected to increase in the short term. Methods used to reimburse health care providers still fail to incentivize investment in prevention, evaluation and management, communication outside the office visit, and holistic approaches to care (Tynan and Draper 2008). In such an environment, it will be ever more difficult to make the big changes that are needed to restructure care delivery and engage patients and providers in new care paradigms.

### RESOURCES

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