Impacting Chronic Disease Care

California HealthCare Foundation’s Experience

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Evolution of Programs (short version)
Improving delivery of chronic disease care

- Phase I
  - Initial focus on prevalent conditions: diabetes, asthma
  - Expand capacity to improve care
    (learning to measure and improve)
    - Primary care focus
    - Disease Registries
    - PDSA (model for improvement)
    - IHI-style improvement collaboratives and trainings

Evolution of Programs (short version) Improving delivery of chronic disease care

- Phase II
  - Focus on primary care redesign
    - Team-Care
    - Patient Self-management
    - EMR adoption
    - Standardized work processes
    - Reporting of measures (and benchmarking)
    - Learning Communities
  - End of Life Care (including POLST)

Evolution of Programs (short version) Improving delivery of chronic disease care

- Phase III
  - Complex Chronic Disease
    - Population Management
    - Patient/Family Engagement
    - Management Approaches (e.g., Lean)
    - Data Transparency (to patient, public reporting)
    - Reducing Costs and Variation
  - Expanding Palliative Care

Themes in All Our Work

- Inclusion/engagement of the patient/family voice
- Team-based care (interdisciplinary, range from professional to peer/volunteer/family)
- Addressing diverse populations
- Effective use of health information and new technologies (user-friendly, cost-lowering)
- Focus on areas where triple aim is achievable: better care, better health, lower costs
- Attempting to support systematic approaches that can be sustained (better data, feedback mechanisms, strong leadership)

Opportunities driven by environment

- Management of the dually-eligible Medicare-Medicaid population (8 demo counties in CA)
- CMMI supported Accountable Care Organizations (8 Shared Savings + 3 Pioneer)
- Demand for new models—complex chronic through palliative care
- Need for more efficient safety net
- Continue to be challenged by better data (public programs, cost, etc.)

Current Program Opportunities:
Complex Chronic Disease Care

- Focus on handoffs, e.g., primary/specialty coordination, hospital discharge
- Use of technologies to support more efficient delivery
- Avoiding avoidable care
(Choosing Wisely and addressing variation)
- Wider adoption of shared savings programs that may support newer models of care delivery

Example: Care for Dual Eligible Population

- Work with county-based health plans, State and CMS to better identify heterogeneous population and areas of focus
  - Clinical subpopulation identification
  - Geomapping
- Inclusive processes for network and care model development
  - ‘Just in time’ information on existing models
  - Facilitated meeting with community and other agency (many non healthcare) stakeholders

For More Information

www.chcf.org

California
HealthCare
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California
Improvement
Network
Better Ideas
for Chronic
Disease Care

www.chcf.org/cin
(where many of the ‘better ideas’ are housed)