

Community LTC



By Dan Osterweil,
MD, CMD

Will We Better Manage Chronic Disease?

To paraphrase an old car commercial, this is not your father's medical care system. Meeting the needs of tomorrow's seniors will require a lot of things currently in short supply or underdeveloped. These include interdisciplinary teamwork, with the active involvement of patients and caregivers; payment reform; effective models of chronic disease management; and related to this, research. Let's start with a discussion the last two, for as distant as research may seem from real life, to a large extent, it's the prerequisite to progress.

Three articles in the December 2009 issue of "The Journal of the American Geriatrics Society" analyzed the evidence for several chronic disease management strategies of current interest. Two of the articles review the scientific literature (J. Am. Geriatrics Soc. 2009;57:2328-37 and J. Am. Geriatrics Soc. 2009;57:2338-45). The third is an editorial response to these reviews (J. Am. Geriatrics Soc. 2009;57:2348-9). The report from the literature is both good and bad.

With sponsorship from the Institute of Medicine, Chad Boulton, MD, director of the Lipitz Center for Integrated Health Care at the Johns Hopkins Bloomberg School of Public Health, Baltimore, and his colleagues set out to identify models of comprehensive care needed to keep an aging population well enough to stay out of hospitals and nursing homes.

Ideally, according to Dr. Boulton's team, such models would improve patients' quality of life, quality of care, functional independence, and survival, all the while lowering costs and health care usage. Searching the medical literature, the team identified 123 "high-quality research" articles containing 15 "successful" models of chronic disease management.

To be sure, the science was kind of messy: The researchers noted "considerable heterogeneity" among models. But each of the 15 "was deemed successful, because at least one high-quality study reported that at least one version of the model is capable of improving the quality, outcomes, or efficiency of care." The table here presents the successful models.

Half Full or Half Empty?

But that's only half the story. Robert Kane, MD, professor of long-term care and aging at the University of Minnesota School of Public Health, Minneapolis, also reviews the chronic-care literature, dividing his report into three approaches: disease-specific management programs, care coordination (also known as care or case management), and chronic disease self-management programs.

His conclusion is decidedly less sanguine than that of Dr. Boulton's team: "The report card for chronic care treatment approaches is not stellar," writes Dr. Kane. On the whole, he finds disease-specific management approaches "better at improving processes of care than outcomes. Effect on utilization seems to go in both directions. (And) it is not clear just what interventions work for which conditions." Findings for care coordination are "also mixed." He finds the most support for self-care programs, though even here, he reports "substantial variation" among programs.

So is the glass half-empty (Dr. Kane) or half-full (Dr. Boulton and his colleagues)? The answer is beside the point, for what's noteworthy is the lack of consensus. The fact that these highly respected researchers reach different conclusions indicates weakness in the evidence base. A less than impressive research base, in turn, suggests a need for more research. Here, Dr. Kane quotes that "great American philosopher Davy Crockett: 'Be sure you are right, then go ahead.'"

When pressed in interviews for next steps, Dr. Kane and Dr. Boulton seemed less and less different in their views. For his part, Dr. Kane recommended taking a good look at current health care systems that are reporting promising outcomes in their chronic disease management programs.

For best results, he believes that system-wide reform is needed, including financial incentives to prompt substantial behavior change on the part of physicians. Fee-for-service payment, he says, is "the anathema" of effective chronic disease care.

Primary care delivery must change, he asserts. "We need to track the status of patients, get them actively involved in their own care, and intervene when [a patient's] clinical trajectory is different from what you expect it to be."

There are special points of vulnerability in the current nonsystem, said Dr. Kane, such as transitions between health care settings, when a little attention can pay big dividends. But, he added, some findings defy logic, such as activity programs with ostensibly well people.

Dr. Boulton highlighted a few chronic care models with especially positive findings and potentially huge impacts. Interdisciplinary primary care is one, for recent evidence has shown that some of these models, including the Guided Care model that Dr. Boulton pioneered (see "Experiments in Coordinated Elder Care," July 2009 CARING FOR THE AGES), are associated with cost savings, quality-of-care improvements, and physician satisfaction.

Another model that provides "fertile ground for further work" is transitional care. Here, Dr. Boulton explained, "we have good data on an important problem [rehospitalizations] that has far ranging economic implications." He also agreed with Dr. Kane that chronic disease self-management is critical to improving outcomes. So is payment reform, Dr. Boulton added, although rather than eliminate fee-for-service payments, he advocated supplemental per-patient payments to support interdisciplinary teamwork.

The Answer: Yes and No

In his editorial, David Reuben, MD, director of the Multicampus Program in Geriatric Medicine and Gerontology at the University of California, Los Angeles, steers the discussion to where we now see growing consensus: payment reform to support new models of chronic-disease management. He proposes paying primary care physicians a "suitable amount per patient" to provide all

appropriate and needed care.

Such a system, he argues, would provide incentives for more rapid innovation in services and allow the health care system to set prices for provider payments.

Is there a bottom line here? Look closely, and you can see two. First, progress is occurring. Remarkably, the vast majority of the 123 articles reviewed by Dr. Boulton and his team were published in the past decade (though their search looked back 20 years). In research time, this body of work is still in its infancy—but developing rapidly. That's good news, for the second bottom line is this: No matter how you look at it, we have our work cut out for us.

DR. OSTERWEIL is medical director of S+AGE at Sherman Oaks Hospital near Los Angeles. He also serves as clinical professor in the division of geriatrics at the University of California, Los Angeles, David Geffen School of Medicine. He expresses thanks to Ms. Annie Rahman for her assistance with this column.

Models of Disease Management

Interdisciplinary primary care: A team (a physician plus other health care professionals) communicates frequently to provide comprehensive primary care to patients.

Care or case management: A nurse or social worker helps patients and family members assess and resolve health-related problems.

Disease management: Nurses or other health professionals provide patients with disease-specific information in writing or by phone.

Preventive home visits: A multidimensional home assessment leads to recommendations for treating and/or preventing health problems.

Outpatient comprehensive geriatric assessment (CGA) and geriatric evaluation and management (GEM): An interdisciplinary team assesses patient problems and develops, and in some cases, implements, a treatment plan.

Pharmaceutical care: Pharmacists provide patients or interdisciplinary care teams with medication information and advice.

Chronic disease self-management: Health professionals lead structured, time-limited programs that provide health information and engage patients in self-management.

Proactive rehabilitation: Rehabilitation therapists provide outpatient assessments and interventions to help

disabled patients maximize their functional ability and stay at home.

Caregiver support: Nurses or social workers provide caregiver education and support. There is "strong evidence" that these programs can delay nursing home placement significantly.

Transitional care: A nurse or advanced practice nurse works to ensure a patient's smooth, safe transition from the hospital to the next site of care. This intervention "is clearly capable of reducing hospital readmission rates and costs."

Hospital-at-home: Patients receive care at home for certain acute conditions typically treated in the hospital.

Nursing home: An advanced practice nurse or physician assistant evaluates the patient every few weeks, trains the nursing home staff to better manage care, and treats residents.

Prevention and management of delirium: These programs usually provide staff training, prevention interventions, and routine patient screening to identify underlying risk factors.

Comprehensive hospital care: Included here are such models as interdisciplinary geriatric consultation teams, acute care for elders units, and inpatient CGA and GEM units.

Source: J. Am. Geriatrics Soc. 2009;57:2328-37.