Improving Health

Care for

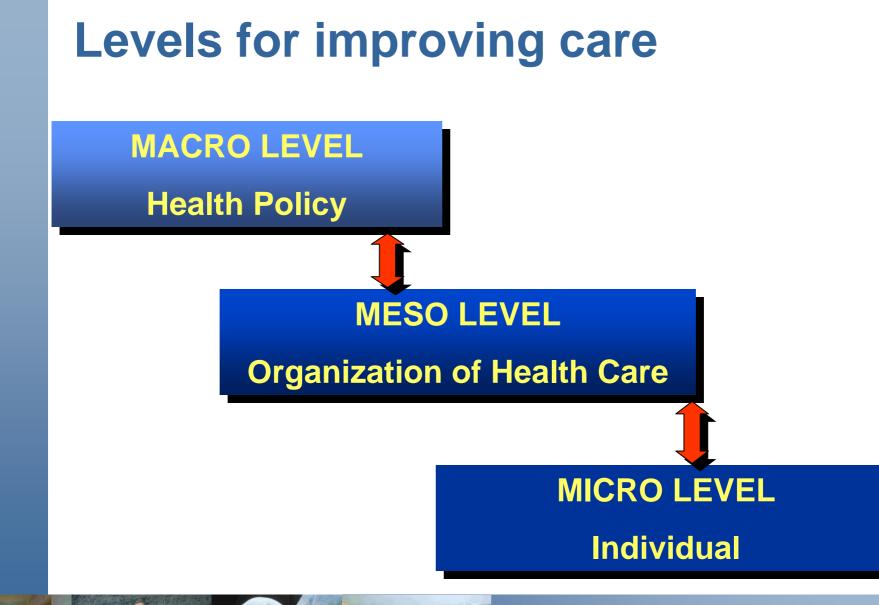
Chronic

Conditions



JoAnne Epping-Jordan, PhD Coordinator Health Care for Chronic Conditions World Health Organization 26 March 2004







Presentation outline

Typical care
Innovative Care
Accelerating implementation



Presentation outline

1 Typical care2 Innovative Care3 Accelerating implementation

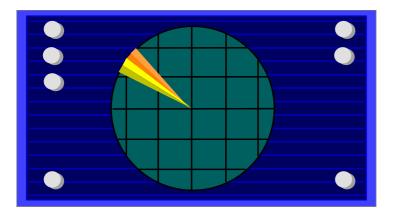


Health care for chronic conditions: What do we know?

- 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 selfmanagement, prevention and follow-up*.
- Chronic conditions require a different kind of health care (*mismatch*).



TYPICAL CARE The Radar Syndrome



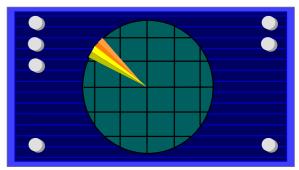
- ☆ Patient appears
- Patient is treated "find it and fix it"
- Patient is discharged

... 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 healthrelated 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

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%)



Who suffers as a result?





Health care workers



Insurers

Governments



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Chronic conditions require an evolution of health care

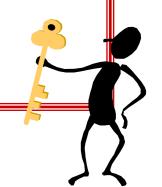
from typical (radar care) to achievable "Innovative Care"



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.







• Strengthen partnerships

- Integrate policies
- Promote consistent financing

- Support legislative frameworks
- Provide leadership and advocacy

Links

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• Develop and allocate human resources

Community

- Raise awareness and reduce
- Encourage better outcomes through leadership and support Community Partners
- Mobilize and coordinate resources
- Provide complementary services

Health Care Organization

- Promote continuity and
- Encourage quality through leadership and incentives
- Organize and equip health care teams
- Use information systems
- Support self-management and prevention

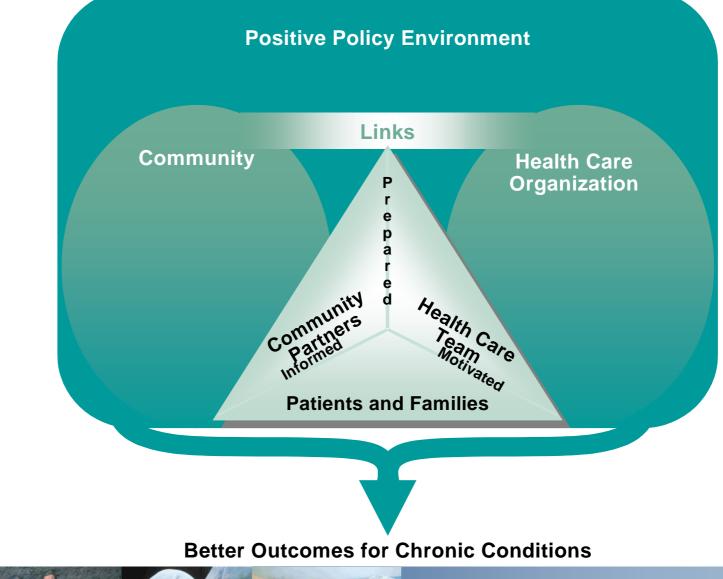
Patients and Families

Informed

Health Care Team Care Molivated

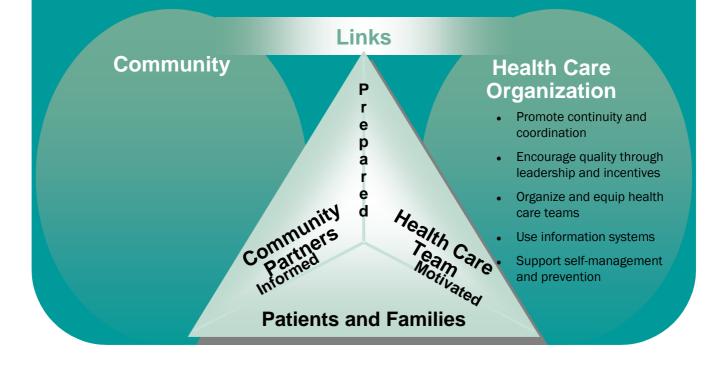
Better Outcomes for Chronic Conditions



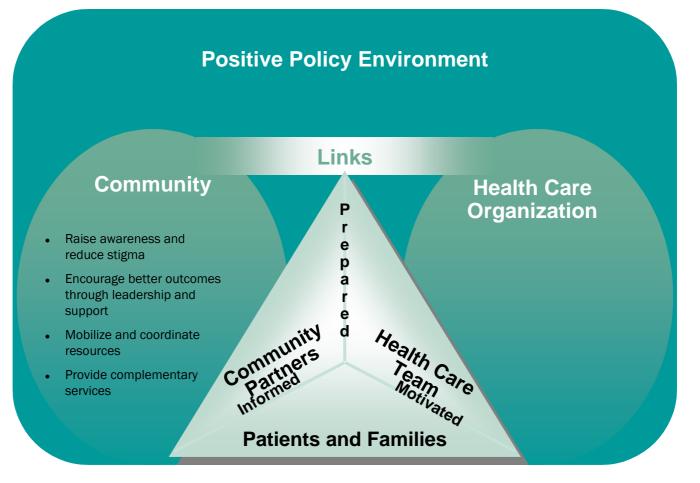




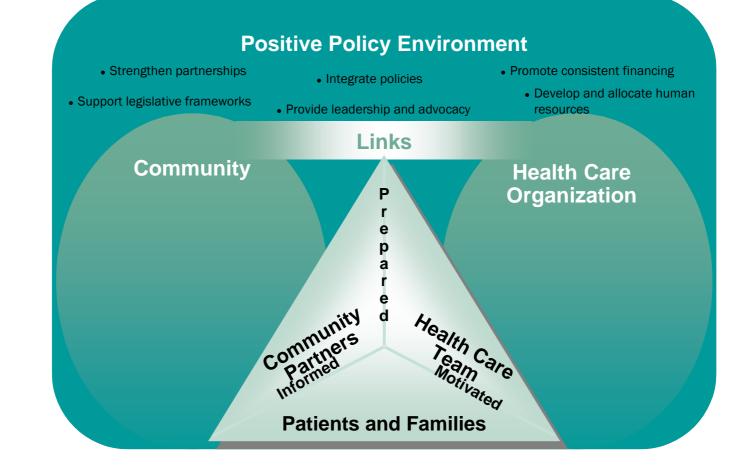
















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Better Outcomes for Chronic Conditions



"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 <u>CAN</u> 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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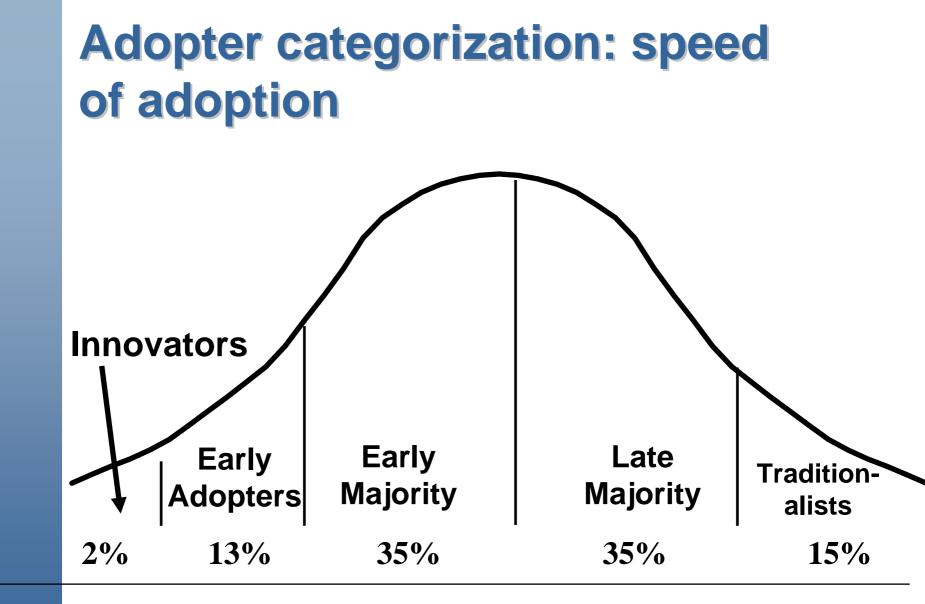


Diffusion

..."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







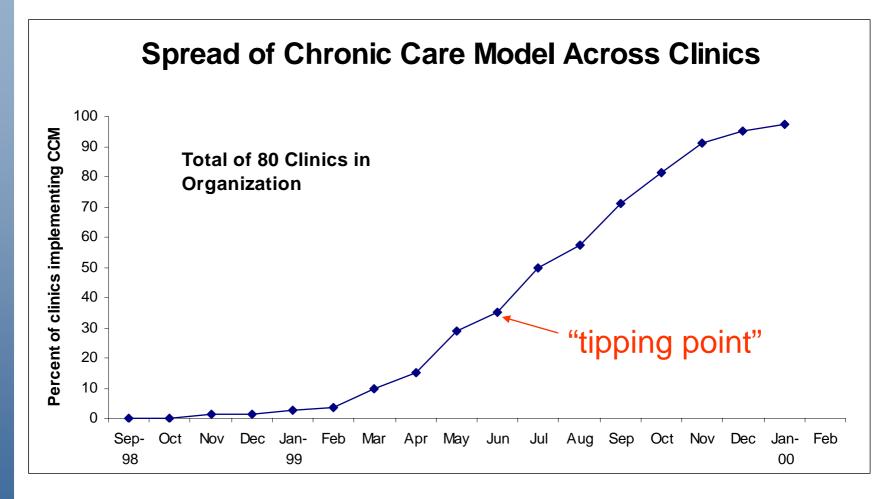
Momentum for spread

... "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"



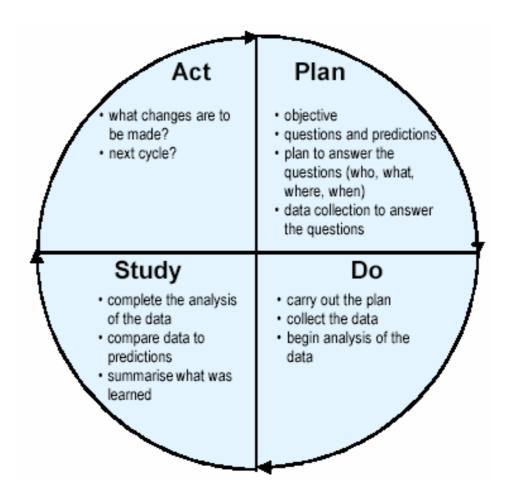


The implementation model

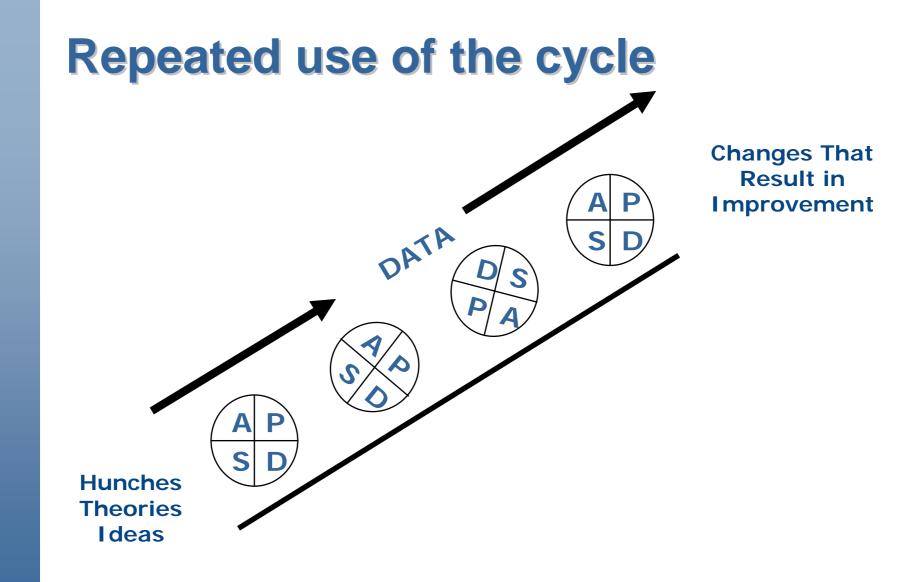
How to make it happen: What to do: The Model for The ICCC Framework Improvement **Innovative Care for Chronic Conditions Framework** What are we trying to **Positive Policy Environment** accomplish? · Strengthen partnerships · Promote consistent financing Integrate policies How will we know that a Develop and allocate human resources Support legislative frameworks · Provide leadership and advocacy change is an improvement? Links What change can we make that Community Health Care Organization will result in improvement? Promote continuity and Encourage better outcomes through leadership and support Encourage quality through leadership and incentives Community Health Care Partners Act Plan Support self-management **Patients and Families** Study Do **Better Outcomes for Chronic Conditions**



Plan-do-study-act

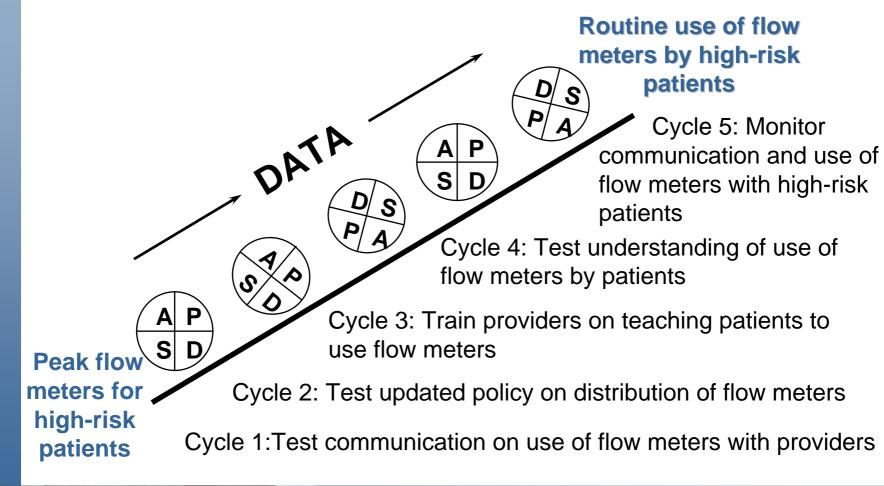








Focus: Improve assessment and care of high-risk asthma patients





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



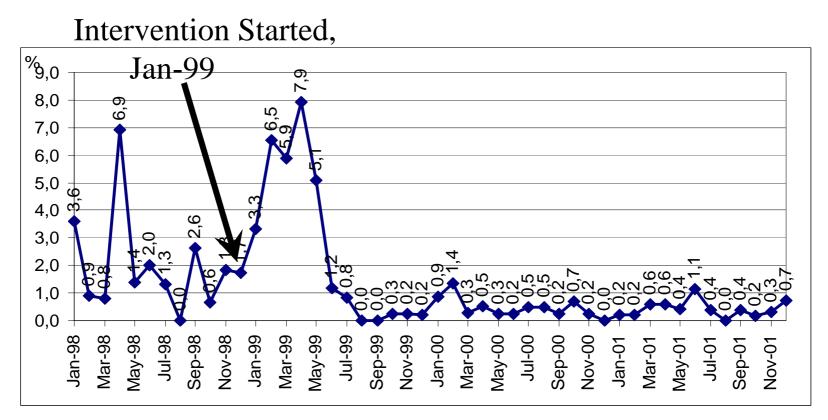
Improving the system of hypertension care in Tula Oblast, Russian Federation (1998-2000)

- 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



Organization of Tula intentional spread (2000 - 2002)



University Research Corporation, USA



Summary

- The disease burden has changed towards chronic conditions world wide. <u>The health system hasn't</u>.
- Effective prevention and management of chronic conditions requires an <u>evolution of health care</u>, 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*

WHO Sites

Observatory Home

The Failure of Health Care

Tools for Better Management

Strengthening Preventive Services

Resources

Contact us



The Observatory on Health Care for Chronic Conditions

provides information and resources to people around the world who aim to improve health care for chronic conditions. It is a dynamic, web-based resource centre that offers hands on information for policy-makers, health managers and administrators on innovative approaches to organizing care for

chronic conditions.

The Observatory is characterized by providing content, sharing experiences, building networks and connecting people to facilitate the spread of innovative ideas worldwide.

About us

Within the World Health Organization and the Noncommunicable Diseases and Mental Health Cluster, the Management of Noncommunicable Diseases Department has identified as a major priority the development of information, methods and tools to help improve health care for chronic conditions. This is reflected in the following areas of work:

Innovative Care for Chronic Conditions

Adherence to Long-term Therapies

Evidence

This section present some examples from the literature on innovative program for chronic condition <u>More information</u>

Best Practices Database

The best practices database provides examples of care fo chronic conditions th have demonstrated positive outcomes fi different parts of the world.

More information

The Network of Innovators

Links people worldw to WHO's network or experts, researcher and country teams (are involved in improving health ca for chronic condition More information

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



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

Crossing the Quality Chasm, Institute of Medicine, 2001

