

5

Conclusions and Policy Recommendations

Better Knowledge

Better Tools

Better Incentives



Chronic illness is rising among people ages 50+, and with age come multiple chronic conditions. These conditions can have a profound effect on people's lives, increasing their use of health care services and eventually leading to serious consequences, such as disability and death. People with chronic conditions and their family caregivers describe many challenges in managing the condition, and some of them point to shortcomings in the health care and social support system that make coping with chronic conditions even harder.

A serious problem for people with chronic illness is the loss of critical information as patients transition among settings, such as hospitals and emergency rooms. These settings are not organized around patients and their needs, but instead according to long-standing institutional practices. Care coordination requires that patients with chronic conditions understand their role in self-care and medication management, and that their preferences be incorporated into the care plan. Patients and caregivers should know whom to contact if individuals develop new symptoms or their condition worsens.

“Changes in the delivery of health care are needed to better support people with chronic conditions.”

Our survey finds that during transitions from health care facilities to other settings, some patients need more support than others. Patients at high risk for a poor transition include those with more than five chronic conditions, numerous office visits, poor health status, limitations on daily activities, need for assistance with patient care coordination activities, and a low level of engagement in their care.

The numbers of people with chronic illness grow each year, and people 50+ are more likely to have these conditions than younger people. In part, these conditions have become more visible because we have more ways to treat them; however, a sedentary lifestyle and poor diet are contributing

factors. Further, with improved treatment of acute conditions, we are leading longer lives—and the longer we live the more likely we are to experience these conditions. Indeed, older Americans are more likely to have multiple chronic diseases. Side effects and harmful drug interactions also increase with multiple medications for multiple conditions. For healthier people, chronic disease can be manageable, and people can take a primary role in taking care of their conditions. For people with multiple chronic conditions, the “oldest old,” and those approaching the end of life, the challenge is greater, and both these people and their caregivers need more support. Many studies have shown that important clinical information needs to flow among care settings, among providers, and to the patient and any caregivers. Changes in the delivery of health care are needed to better support people with chronic conditions. Barriers to improvements in care for people with chronic disease include the fragmentation of care delivery, poor transitions among settings, and misaligned payment incentives that fail to value better integration of services. Poor information systems make these problems worse because it is difficult for providers to track patients over time. Medications are a key component of effective

chronic care management—taking medications can slow the progression of many conditions, but multiple medications can interact and create dangerous side effects.

RECOMMENDATIONS

Experts agree there are large gaps in the quality and delivery of health care for people with chronic illness. An important goal is to improve the care and quality of life for people with chronic disease and those who care for them.

Ideally, our extensive review of the issues around chronic care would lead us to recommend specific models of care, interventions, and financing that both improve the patient’s care and experience and reduce spending. However, while purchasers and plans are trying approaches that have had some promising results, the evidence is inconclusive about what will work in all circumstances, although the recommendations that follow point to program elements for which there is consensus.

Even though we know what good care for chronic conditions should look like, widespread, sustained improvements are unlikely until we address the barriers to good care discussed in the previous chapter. Addressing these barriers requires a multi-pronged strategy that includes better knowledge,

better tools, and better incentives. For each of these strategies, our recommendations are for changes aimed at providers, family caregivers, and patients—who play a critical role in managing their own care.

BETTER KNOWLEDGE

Expand testing of care delivery models to find out what works.

Recognizing the need for better care delivery for patients with chronic conditions, the Centers for Medicare & Medicaid Services (CMS) has sponsored many demonstrations of programs with differing features and differing target populations. The goal of these programs is to figure out what improvements in the delivery of care will enhance the patient’s experience and clinical outcomes. Other purchasers, including the Department of Veterans Affairs, Medicaid programs, and employers and health plans, also have experience with chronic care coordination programs, case management programs, and disease management programs. The medical home concept (called “health care home” in some states) is catching on among private and public payers at the state and federal levels. For example, CMS is piloting a medical home model in Medicare for coordinating care, with provider recruitment in 2009 and payment for services starting in

2010. A program using multispecialty physician group practices as the locus for chronic care management is still in progress.

To date, some of the programs have improved outcomes, though cost containment has been less consistent. More information is needed to identify the elements of programs that work best and how to target the right interventions to the patients who will benefit most so that resources are used most effectively. Different strategies may work for different patients; strategies could target people with different types of diseases, constellations and progression of disease, and abilities to actively manage disease. Once information is available on what elements of programs work best, it should be disseminated to all payers and providers. A national clearinghouse for information on chronic care and care coordination might be a useful way to learn from the many experiments by private payers, Medicare and Medicaid, and the Department of Veterans Affairs.

Although no one model or set of models is definitive in providing the best approach for all patients, some specific interventions are widely viewed as effective, such as a discharge checklist for patients leaving a health care facility. Health care facilities should use this list as part of their discharge procedure and share it with patients and caregivers to improve their preparation and understanding of what they should expect as they leave the hospital. Discharge information should go to the patient's primary provider, along with medical records from the admission.

Include best practices from chronic disease care in clinical preparation and training. As we learn more about what works in care for chronic conditions, educators should incorporate those findings into curricula for physicians, nurses, pharmacists, social workers, and other health care professionals. For example, multidisciplinary teams appear to be a feature of successful programs; this suggests using a model of team practice to educate and train students so they are prepared to practice in teams. The Institute of Medicine recently called for development of interdisciplinary teams in its report on building the health care workforce.

Today's health care workforce lacks key competencies needed to work in interdisciplinary teams. New multidisciplinary collaborations will be needed to provide patient-centered care (Sievers & Wolf, 2006). Another needed competency will be the use of quality improvement skills to reduce errors. Over the coming decade, health care and education for the health professions will be called upon to change dramatically. Medicare is one potential change agent, as it explicitly funds medical education.

Clinical education calls for interdisciplinary experiences, rather than education isolated in individual silos. Health care professionals will need to learn to lead interdisciplinary teams and implement evidence-based practices (Benedict, Robinson, & Holder, 2006). Providers will need to be trained to work in interdisciplinary teams, and financing and delivery systems should support this interdisciplinary approach.

Providers in practice also need to continue their education and learn from best practices in chronic care. Maintenance of certification programs and continuing education should include demonstration of competency in the care of older adults, family caregiver support, and new multidisciplinary chronic care

management approaches. These programs can disseminate findings to encourage providers to adopt innovations that improve care. Specialty societies can incorporate into practice guidelines the most effective practices in the management and coordination of care for chronic conditions.

Engage patients by giving them information they will understand and act on. One of the salient features of chronic disease care is that some patients and their caregivers can take steps to participate in their own care. For example, lifestyle choices like diet and exercise can help a diabetic avoid acute manifestations of the disease, and taking blood pressure medications regularly can keep hypertension under control. Recognizing and acting on warning signs and symptoms can avoid the need for emergency care later. Not all patients are able or willing to become effective managers of their own care owing to dementias or functional limitations, but many are.

Support family caregivers and engage them as partners with professionals. Family caregivers not only provide the vast majority of long-term services and support (LTSS) in the United States but also provide many health care services. And by default, they often serve as “care coordinators” of chronic health and LTSS services. Caregivers need information and skills to help them provide safe and appropriate health care and LTSS to care recipients; backup support, including respite; and assessment of their own needs and health risks. New models of “family-centered” care are beginning to emerge, in which nurses and social workers actively collaborate to improve support for family caregivers and work in partnership with them to improve quality (*American Journal of Nursing*, 2008).

Encourage wise use of pharmaceuticals in managing chronic conditions. Virtually all older adults seeking care for chronic conditions have prescriptions for medicines that help alleviate symptoms and maintain quality of life. Appropriate medication use is an essential part of slowing the progression of illness and avoiding side effects. Prescribers who care for people with many chronic conditions should take care to sort out all the medications to avoid harmful interactions. The dosages should be checked regularly, as people’s metabolism can change over time.

Once the optimal set of medications is found, clinicians should encourage patients to take them regularly by educating the patient and caregiver, using reminder systems, and tracking use over time. Counseling, reinforced with clear, written instructions, helps the patient understand the value of the medications. Affordable prescriptions are also critical to encouraging patients to use these therapies.

Several practices and activities would improve information flow among patients, providers, and prescribers.

- Providers should fully inform patients about the purpose of each medicine, its effects, and side effects. Availability of lower-cost alternatives and the potential for drug interactions should also be part of the conversation.
- Patients or caregivers should keep an up-to-date personal medication list that includes a record of all the patient’s prescriptions, nonprescription medications, and dietary supplements. Sharing such a list is especially important when patients transition among sites of care, but it is also important when multiple prescribers are involved in the patient’s care.
- Patients and caregivers should follow up on any required laboratory work that gauges how a medicine is working.

- Patients should consider medication therapy management programs and drug reviews, which all Medicare plans offer to targeted patients with high drug costs. Some health plans and pharmacists also offer these services.

Improve research on disparities and dissemination of information in this area. As we discussed earlier in this report, minority populations suffer more from chronic disease, yet their quality of care is worse. As we take steps to improve chronic care generally, it is important to focus on strategies to narrow the gaps in prevalence and outcomes among populations. Measuring disparities in health care is integral to comprehensive performance improvement. A consistent and uniform method of collecting information on an individual's race and ethnicity, gender, age, socioeconomic status, and primary language is a fundamental tool to address gaps in care (Agency for Healthcare Research and Quality [AHRQ], 2006). The next steps are to identify where to focus the most attention and resources and learn how to close the gaps.

BETTER TOOLS

Increase use of health information technology. A key element to better coordination of care—in particular for chronic disease, whose care takes place over a long span of time, through many providers, and across multiple settings—is health information technology (HIT). HIT can fundamentally improve care, save lives, reduce errors (e.g., through e-prescribing), and conserve scarce resources across all health care settings. Electronic decision support, in the form of reminders, can help clinicians follow evidence-based guidelines that can warn of contraindications, reduce errors and duplicative services, enhance care coordination, and improve patient-provider communications. Information systems also permit the development of disease registries within health care practices, which most experts agree are essential for monitoring the care and status of patients with chronic disease and in helping providers communicate with each other.

Develop better tools for patients to manage their conditions. People with chronic illness should have information and training to help them manage their own disease. Good communication with and among providers is just the beginning, but it is a critical component. In addition, better communication between providers and family caregivers is essential, as are better tools and resources for caregivers. Some chronic care management programs organize meetings among people with the same health care condition to share information and provide motivation and support for maintaining healthy behaviors. Also important is offering patients and their caregivers access to and information about community resources, including LTSS that will help them maintain function and independence. Chronic disease management programs should focus on communication with patients and their families and provide them with information about community resources.

BETTER INCENTIVES

Make innovative changes to payment policy. A strategy to improve health delivery must include changes in reimbursement incentives if behavior is to change. As discussed earlier in this report, most payment approaches encourage the use of services over improving long-term outcomes. Payment systems that reward good chronic care would be better keyed to outcomes, including patient experience, and encourage ongoing management of the disease to improve care and reduce preventable emergency room visits and hospital care. The incentives should prompt providers to work together toward the same goals and reduce duplication.

Financial incentives (e.g., “pay-for-performance” plans) can foster the delivery of high-quality, cost-effective care. Innovative payment methods to promote better coordination of care should address incentives to provide care that results in the best outcomes and discourage perverse financial incentives that are barriers to improved care coordination, such as additional payments for preventable hospital readmissions. Innovations in payment for episodes of care, including for chronic conditions, should be tested. However, these programs should be designed to ensure that they do not create barriers to care or lead to reduced service. Competitive bidding for coordinated care services also is worth testing. Medicare and Medicaid should join funding streams to help bring together health and long-term care for beneficiaries enrolled in both programs, if patient protections are included.

We support expansion and adoption of tested models that work well in certain areas, such as transition from hospitals (http://www.caretransitions.org/intervention_design.asp, <http://www.nursing.upenn.edu/centers/hcgne/TransitionalCare.htm>). We also support rapid testing, expansion, and adoption of medical home (or health care home) models led by clinicians, including advanced practice nurses, which promise to be effective for improving care of beneficiaries, particularly those with chronic conditions, and increasing efficiency in the health care system. Care coordination programs, including medical/health care homes, should test the use of positive incentives to encourage patient and caregiver participation.

Some individuals with chronic conditions need both medical and non-medical services. People finishing their Medicare home health benefit would benefit from improved coverage for physical and other therapies to help them maintain function and independence. Another valuable benefit would be expanded respite services for family caregivers.

Maximize use of the health care workforce. A common feature in many chronic disease management programs is to use nurses and other providers to lead a team that helps patients and their families manage their care and navigate the health care system. Primary care outcomes in patients treated by nurse practitioners or physicians have comparable outcomes when the nurses have the same authority, responsibilities, productivity, administrative requirements, and patient population as physicians (Mundinger, 2000). Laws and regulations often inhibit the ability of health professionals to practice at the highest level of their licenses.

Professional licensing laws should allow nurses, nurse practitioners, and other qualified health professionals to perform duties for which they have been educated and trained. Broadening the pool of clinicians may expand access to primary care and providers who can care for patients with chronic illness, especially in light of the coming shortage of primary care providers.

Make medications and preventive care affordable. Difficulty affording medicines is a common deterrent to initial filling and subsequent refilling of prescriptions, and this becomes an even bigger problem when the patient takes multiple medications. More than one-third (35 percent) of persons ages 65 years and older with three or more chronic conditions say they do not take some or all of their medications because they are too expensive. This can result in serious medical complications that may require additional medical visits, emergency room visits, hospitalizations, or nursing home admissions. The wide availability of generics can make drug therapy more affordable; however, generics are not available for all drugs, particularly expensive biologics.

People with chronic conditions should receive recommended preventive care and screening. Access to preventive and screening care should be convenient and free of charge to patients, particularly those with chronic conditions, since it can dramatically increase use of these services.

REFERENCES

- Agency for Healthcare Research and Quality (AHRQ). National Healthcare Disparities Report, 2006. Rockville, MD: U.S. Department of Health and Human Services.
- American Journal of Nursing*. "State of the Science: Professional Partners Supporting Family Caregiving" (2008 Supplement), entire issue.
- Benedict, L., Robinson, K., and Holder, C. "Clinical Nurse Specialist Practice within the Acute Care for Elders Interdisciplinary Team Model." *Clinical Nurse Specialist* 20(5)(2006): 248–51.
- Institute of Medicine. "Performance Measurement: Accelerating Improvement." Committee on Redesigning Health Insurance Performance Measures, and Performance Improvement Programs. Washington, DC: National Academies of Science, 2005.
- _____. "Retooling for an Aging America: Building the Health Care Workforce." Washington, DC: National Academies of Science, 2008.
- Mundinger, M. "Primary Care Outcomes in Patients Treated by Nurse Practitioners or Physicians: A Randomized Trial." *Journal of the American Medical Association* 283(1)(January 4, 2000): 59–68.
- Sievers, B., and Wolf, S. "Achieving Clinical Nurse Specialist Competencies and Outcomes through Interdisciplinary Education." *Clinical Nurse Specialist* 20(2)(2006): 75–80.

AARP is a nonprofit, nonpartisan membership organization that helps people 50+ have independence, choice and control in ways that are beneficial and affordable to them and society as a whole. AARP does not endorse candidates for public office or make contributions to either political campaigns or candidates. We produce *AARP The Magazine*, the definitive voice for 50+ Americans and the world's largest-circulation magazine with over 34.5 million readers; *AARP Bulletin*, the go-to news source for AARP's 40 million members and Americans 50+; *AARP Segunda Juventud*, the only bilingual U.S. publication dedicated exclusively to the 50+ Hispanic community; and our website, AARP.org. AARP Foundation is an affiliated charity that provides security, protection, and empowerment to older persons in need with support from thousands of volunteers, donors, and sponsors. We have staffed offices in all 50 states, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands.



601 E Street, NW
Washington, DC 20049

D19176