



Building Bridges

Integrative Solutions for Managing
Complex Co-Morbid Conditions

What is Multi-Morbidity?

- A patient with multiple medical problems
- A patient requiring a complex system response
- A patient with multiple diagnoses and limited agreement on which issue is the most important/pressing

Why “Building Bridges?”

For every complex problem, there is a solution that is simple, neat, and wrong.

-*HL Mencken*

Why “Building Bridges?”

- Multiple Chronic Disease States
- Mental Illness
- Substance & Alcohol Abuse
- Poverty / Safety / Environmental Issues
- Disability
- Lack of Strong Social Networks
- Lack of Coordinated Access to Appropriate Medical Care
- Lack of Coordinated Access to Appropriate HCBS Services

Participants

- Agency for Healthcare Research & Quality (AHRQ)
- Center for Health Care Strategies (CHCS)
- National Center for Chronic Disease Prevention and Health Promotion (CDC)
- Permanente Federation; Kaiser Permanente
- Johns Hopkins University Medical School
- American College of Medical Quality
- Health Research Center of the Park Nicollet Institute
- Society of General Internal Medicine
- University of California, San Diego
- Schaller Anderson, Inc.

Presentation Guidelines

- Define the Problem
- What Motivates You to Care About the Problem?
- Are there Effective Strategies or Opportunities?
- What are the Gaps in Research & Policy?
- What are the Next Steps?

Define the Problem

- Prevalence of Multi-Morbidity is increasing.
- Determining the highest priorities for a patient is a complex juggling of competing demands.
- There is a proliferation of guidelines and quality indicators.
- Our current understanding regarding the effectiveness of interventions is limited.
- There have been many studies of “slices” of the problem, with outcomes that have limited generalizability.
- There are no good models for integrating BH and physical health management. Often, policy places barriers to sharing information between providers.

Define the Problem

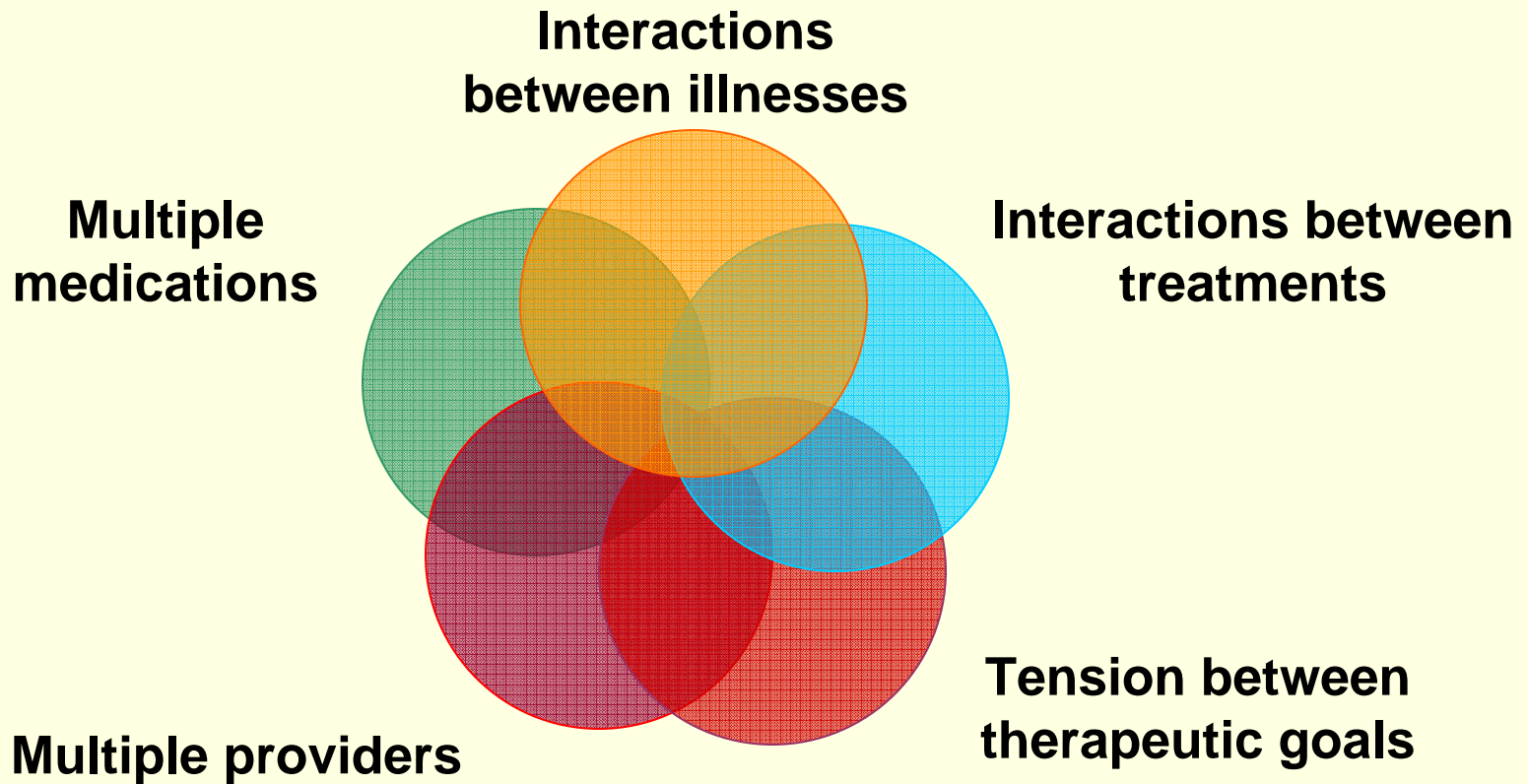
- There are multiple conflicting agendas:
 - Generalists vs. Sub-specialists
 - Patient vs. family
 - Personal vs. society: Futile Care
 - Healthcare vs. Profit
- There is a temptation to think mainly of “Management” and not “Prevention”
- There is a temptation of wanting “Perfection” vs. “Continual Improvement”

Define the Problem

It's better to do something than to do nothing.

-Melanie Bella, CHCS

Challenges in Addressing Multi-Morbidity



Challenges in Addressing Multi-Morbidity

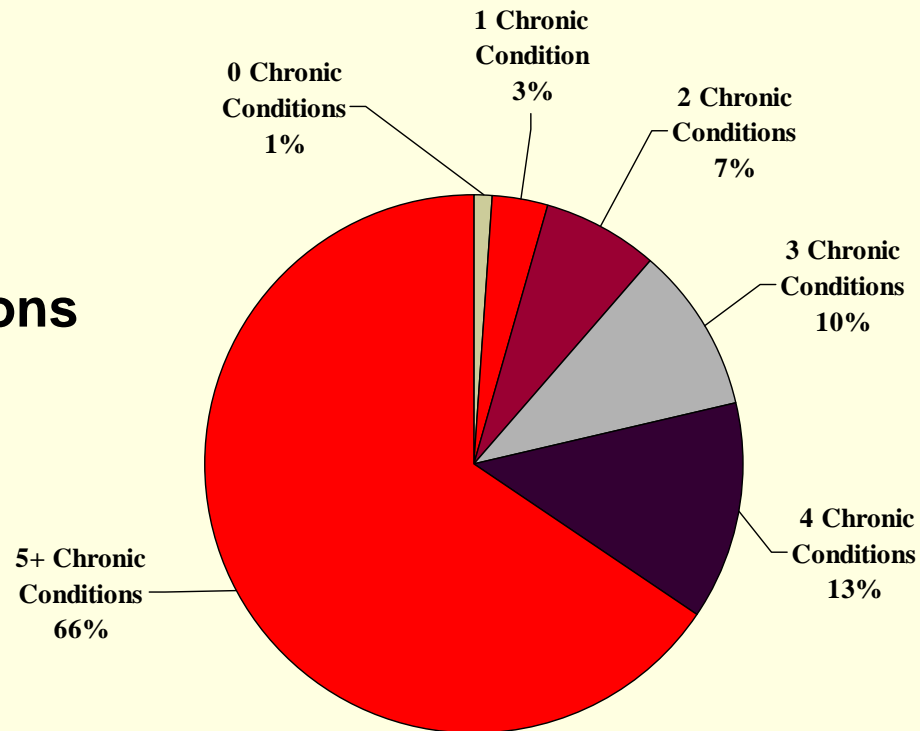
Case Study

79 year old woman with 5 chronic conditions of *moderate severity*: COPD, HTN, DM, OA, Osteoporosis

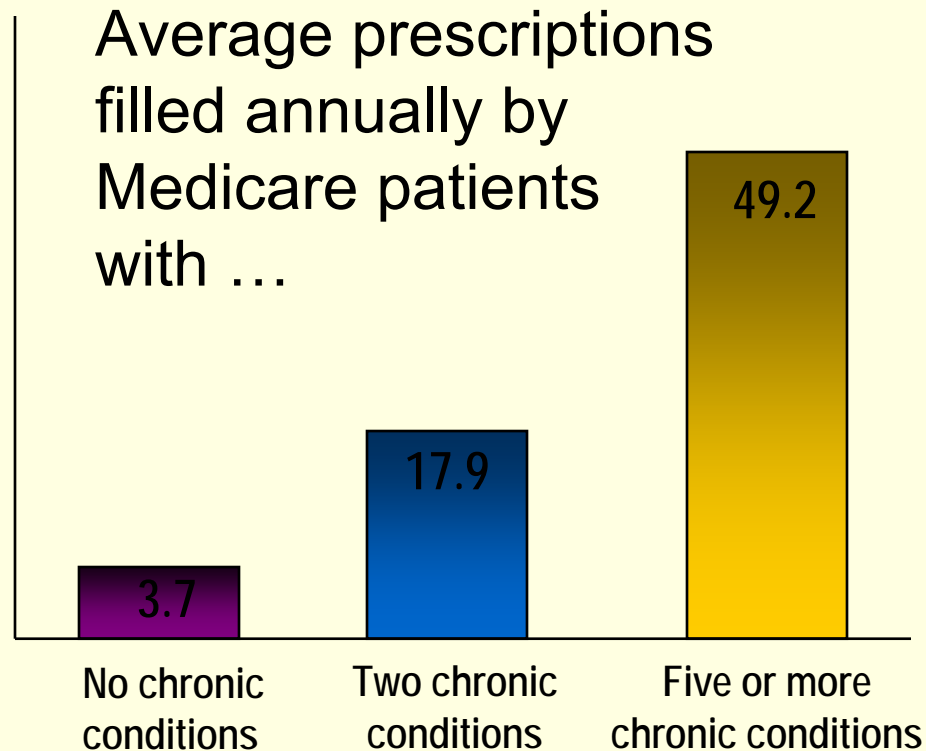
Time	Medications	Non-pharmacologic Therapy	All Day	Periodic
7 AM	Ipratropium MDI Alendronate 70mg weekly	Check feet Sit upright 30 min. Check blood sugar	Joint protection Energy conservation	Pneumonia vaccine, Yearly influenza vaccine
8 AM	Eat Breakfast HCTZ 12.5 mg Lisinopril 40mg Glyburide 10 mg ECASA 81 mg Metformin 850mg Naproxen 250mg Omeprazole 20mg Calcium + Vit D 500mg	2.4gm Na, 90mm K, Adequate Mg, ↓ cholesterol & saturated fat, medical nutrition therapy for diabetes, DASH	Exercise (non-weight bearing if severe foot disease, weight bearing for osteoporosis) Muscle strengthening exercises, Aerobic Exercise ROM exercises Avoid environmental exposures that might exacerbate COPD	All provider visits: Evaluate Self-monitoring blood glucose, foot exam and BP Quarterly HbA1c, biannual LFTs Yearly creatinine, electrolytes, microalbuminuria, cholesterol <u>Referrals:</u> Pulmonary rehabilitation Physical Therapy DEXA scan every 2 years
12 PM	Eat Lunch Ipratropium MDI Calcium+ Vit D 500 mg	Diet as above	Wear appropriate footwear Albuterol MDI prn Limit Alcohol	Yearly eye exam Medical nutrition therapy <u>Patient Education:</u> High-risk foot conditions, foot care, foot wear
5 PM	Eat Dinner	Diet as above	Maintain normal body weight	Osteoarthritis COPD medication and delivery system training Diabetes Mellitus
7 PM	Ipratropium MDI Metformin 850mg Naproxen 250mg Calcium 500mg Lovastatin 40mg			
11 PM	Ipratropium MDI			

Challenges in Addressing Multi-Morbidity

2/3 of Medicare Spending is for People with 5 or More Chronic Conditions



Challenges in Addressing Multi-Morbidity



Source: House Ways and Means, Health Subcommittee
Hearing on Eliminating Barriers to Chronic Care and Care Management in Medicare
February 2003

Challenges in Addressing Multi-Morbidity: Health Literacy

- **Major Finding:** Adults with lower-than-average reading skills are less likely to get potentially life-saving screening tests (e.g., mammograms, Pap smears, flu and pneumonia vaccines)
- They are also more likely to be hospitalized; and have difficulty understand forms, children's diagnoses, and medical instructions
- They are less likely to know the health effects of behaviors and conditions, e.g., smoking, diabetes, asthma, AIDS, post-operative care
- Easy-to-read guides and other comprehension aids can help improve health outcomes

When Crossing the Bridge...



Have you ever noticed....anybody going slower than you is an idiot, and anyone going faster than you is a maniac?

-George Carlin

Strategies: What Would Success Look Like?

- Increased engagement of chronically ill
- Improved satisfaction of chronically ill
- Fewer potentially preventable hospital admissions
- Improved health status
- Equal or lower cost
- Broad replication

Integrated Care Model



Transparency: Cornerstones of Value-Based Health Care

Quality Standards

Design systems to collect quality of care information and define what constitutes quality health care

Price Standards

Aggregate claims information to enable cost comparisons between specific doctors and hospitals

Incentives

Reward those who provide and purchase high-quality and competitively priced health care

Interoperability

Set common technical standards for quick and secure communication and data exchange

Strategies: Medical Home

“Primary care practices have been described as complex adaptive systems. Complexity theory offers a way to make sense of occurrences that otherwise seem paradoxical. It focuses on multiple interactions and context rather than single cause and effect... and supports tailored interventions to improve non-linear processes of care.”

-Litaker, D. et al. JGIM, Feb. 2006

Translation...

One size does NOT fit all.

Strategies: Medical Home

Providers with intimate knowledge of specific complex members can participate in realistic patient-oriented guidance that takes into account:

- What is absolute risk reduction and what is the length of therapy necessary to achieve this degree of risk reduction?
- Is it known whether benefit increases or decreases in frail older people or co-morbid older people?
- What are highest priorities if it can't all be done in a frail or multi-morbid older person?
- What are goals of therapy?
- How should patient preferences be discussed and incorporated?
- What interactions are common or important given high prevalence of co-morbid conditions?
- What is the medication regimen complexity?
- What is the burden of therapy?

Strategies: QIO

- 2005 National Health Quality Report shows effectiveness of care improves faster in areas targeted by Medicare's Quality Improvement Organizations
- Example: Medicare's QIO measures for heart disease and pneumonia showed combined rate of improvement of 9.2%, four times the combined rate for all other measures
- When we focus on best practices, we can make rapid improvement, especially when results are publicly reported

Input From Research and QI Community

- Help transfer knowledge
 - Disseminate models of success
 - Connect partners, establish learning networks
- Bridge gap between Research/QI community
 - Help promote better reporting
 - Improve research methods, synthesis
- Research and Evaluation
 - Patient self-management

Challenges for Research

- How do we balance concerns about “internal validity” (does it really work) with “external validity” (is it relevant to the real world)?
- How do we better understand and reduce sources of bias in non-randomized studies
- How do we improve on combining clinical and economic outcomes to validate effects
- How do we predict which patients will become complex later in life?

Strategies: Social-Economics

“ Living with multiple co-morbidities is often a lifestyle - for the patient and for the patient’s household. They need a truly integrated system of care that address the patient's social network as well as medical care”.

-Dave Ford, CEO, CareOregon

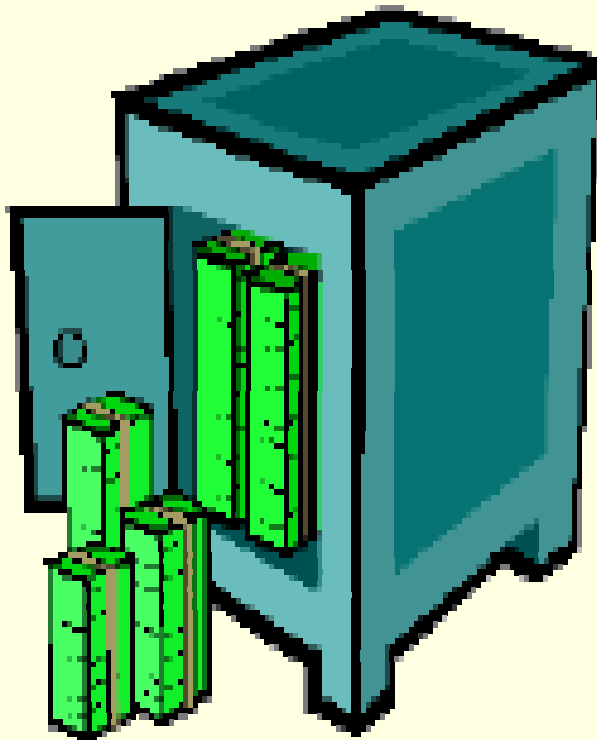
Strategies: Social-Economics

- Don't smoke. If you do stop or cut back.
- Eat a balanced diet, include fruits/vegetables.
- Keep physically active.
- If you drink, do so in moderation.
- Cover up in the sun and protect your children.
- Practice safe sex.
- Participate in appropriate health screening.
- Drive defensively; don't drink and drive.
- Manage your stress.

Strategies: Social-Economics

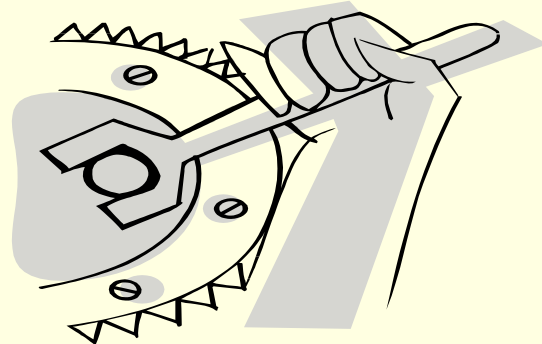
- Don't have poor parents.
- Don't live in a poor neighborhood.
- Practice not losing your job and don't become unemployed.
- Don't be illiterate.
- Don't be poor. If you can, stop. If you can't, try not to be poor for too long.

Strategies: Willy Sutton Social-Economics



THE “OFFICE:”

WHERE PEOPLE (INCLUDING CHILDREN)
LIVE, WORK, PLAY AND REFLECT!



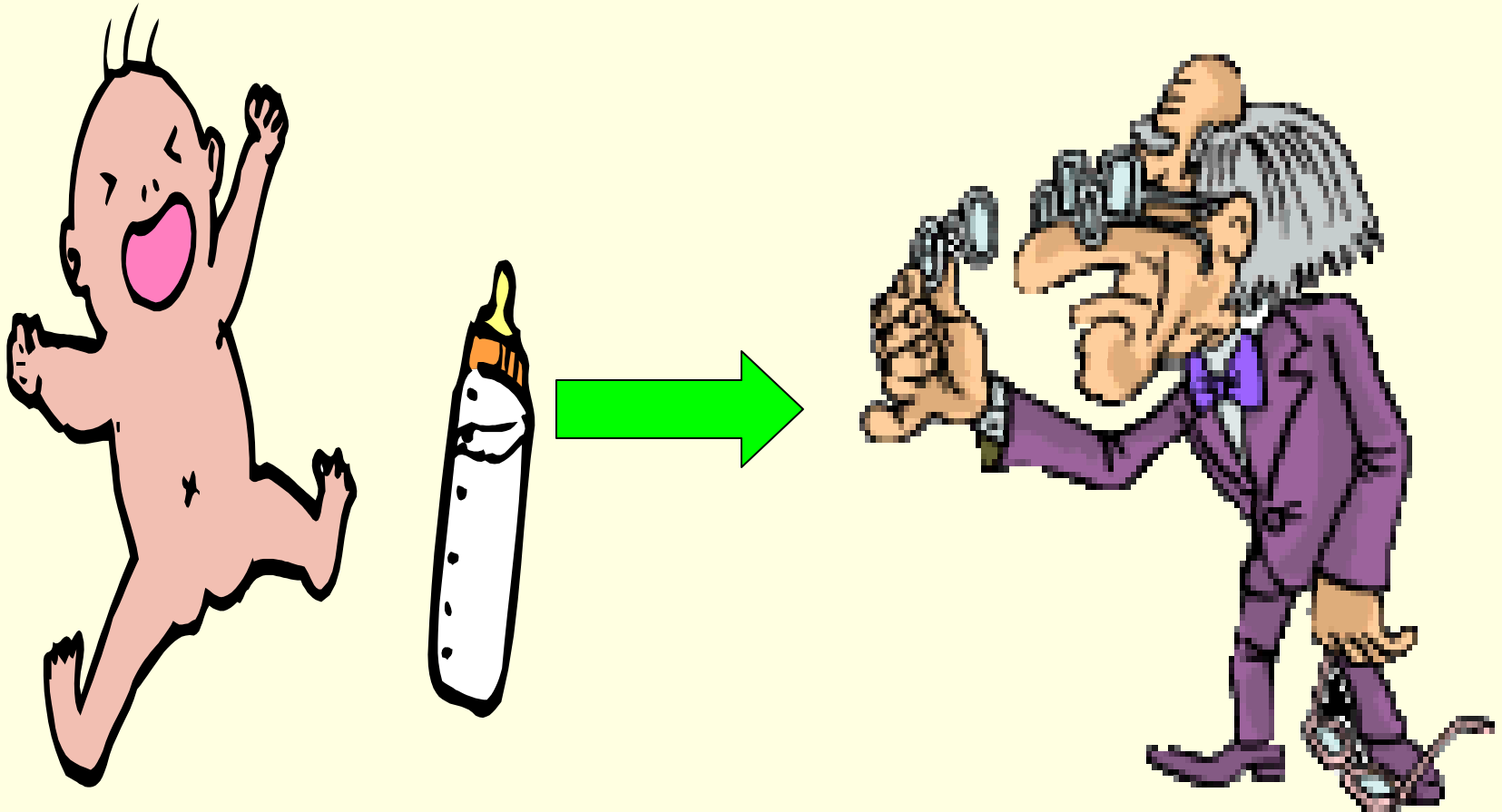
Strategies: Technical

- Assess and reward effective care coordination
- Increased application of health IT in small group practices (where majority of Americans still see their doctor)
- Expansion of telemedicine technology for remote patient monitoring
- Better linkages between clinicians and community resources
- Incentives / \$\$\$

Gaps in Research & Policy

- Few performance indicators developed in patients with multiple co-morbidities
- Weighting schemes are poorly developed
- Policy is too often determined by “experts” with insufficient input from practicing generalists
- RCTs often avoid subjects with co-morbidities and study narrow interventions that are isolated from the system in which it is provided.
- Care management studies of all types are often poorly designed or inadequately describe subjects (including co-morbidity patterns), interventions, and/or outcomes and, even if co morbidities are identified, do not provide sufficient power to study the effects of patterns of co-morbidity.
- With a few notable exceptions (e.g. CHF, diabetes), studies of complex case management produce a murky mix of results on the cost effectiveness of specific interventions.

“WISDOM!!”



***“I AM STILL
CONFUSED, BUT
AT A HIGHER
LEVEL!”***

The Next Steps

- Are we appropriately creating incentives for:
 - Wanting to care for multi-morbid patients
 - Attention paid to subsets of population
 - Processes (not all disease-specific)
 - Preferences
 - Coordination of care
 - Shared decision-making
 - Patient and caregiver empowerment and education

The Next Steps

- ***Vision and/or Action***
- ***Not Accepting the View that “We” Have “Failed” or that Further Improvement will be Rapid***
- ***Create Thought Leaders***

***“We must become
the change we seek in
the world.”***

