The War on Chronic Disease: How We Can Turn Back the Tide

By Lisa Yarkony
An 85-year-old woman lives alone and struggles with multiple chronic conditions. She has COPD, high blood pressure, chronic back pain, and chronic kidney disease. She’s also a heavy smoker with a past history of congestive heart failure. A bout of pneumonia puts her in a hospital bed and she returns home with new medications, bringing her total number of meds up to 20. She is oxygen dependent and can’t climb the steps to her bedroom and bathroom. She is also short of breath at rest and at risk of falls when she walks. She’s too tired to cook or to do household chores, and she still smokes one or two packs of cigarettes a day though hospital staff tried hard to help her stop.1

She has real problems. Yet she’s far from unique since a tidal wave of chronic disease threatens to drown the U.S. More than 25 percent of Americans now have two or more chronic conditions that require ongoing medical care and make it hard for them to have independent lives. These conditions include heart disease, diabetes, obstructive lung disease, high blood pressure, kidney disease, osteoporosis, arthritis, asthma, HIV, mental illness, and dementia. When the ailments pile up, so do the costs. And they’re growing as our country grays. Two thirds of Americans over 65 and three-fourths of those over 80 have multiple chronic diseases, and 69 percent of Medicare dollars go to people with five or more chronic conditions.2

These costs have shot up, according to a national survey from the Centers for Disease Control and Prevention (CDC). So have the number of adults with multiple chronic conditions. During the decade ending in 2010, the percentage of seniors with both high blood pressure and diabetes jumped from 9 to 15 percent. Those with high blood pressure and heart disease went from 18 to 21 percent. The extent of high blood pressure and cancer climbed from 8 to 11 percent. And the increases should only grow as the baby boomers retire.3 By 2020, the number of people with multiple chronic conditions is expected to be 81 million, up from 57 million in 2000. “With an aging population, the persistence of risk factors for disease, and the marvels of modern medicine, more people are living with multiple chronic conditions,” said Dr. Anand K. Parkh, deputy assistant secretary for health at the Department of Health and Human Services (HHS). “New care models are needed to provide coordinated care.”

The need is especially great because Americans are living longer. In 2009, American life expectancy at birth reached 78.2 years, the longest in our history. Since 2000, life expectancy has increased by 1.8 percent (or about 17 months) for the general population. That, along with the aging of the baby boomers, should more than double the number of Medicare beneficiaries over the next 40 years, with a greater percentage of beneficiaries age 85 and up. By 2020, the number of people over 85 will likely reach 6.6 million, up from 5.5 million in 2010.4

In addition, the overall risk of mortality in the U.S. dropped by 60 percent between 1935 and 2010. People who would have died of heart disease, kidney disease, cancer, or diabetes a generation ago now live longer thanks to new medical and surgical interventions. For instance, between 2000 and 2008, the age-adjusted risk death rates for heart disease declined by 28 percent and that for cancer dropped by 12 percent.5 As a result, many more Americans survive into old age, leading to new patterns in the use of health care. Most U.S. health care costs now arise in the final years of life, when patients with chronic disease incur the most intense treatment and highest expenses. Unfortunately, neither the health care system nor Medicare has kept pace with the changing needs that underlie these costs.6

The problem stems from a reimbursement system and culture that reward caregivers for treating a specific disease rather than tending to the patient’s general health and well-being, says the Institute of Medicine (IOM).8 This approach hurts patients because all chronic illnesses have the potential to limit a person’s functional status, productivity, and quality of life. The health care system suffers, too, since the medical costs of people with chronic illnesses represent 75 percent of the $2 trillion in U.S. annual health care spending. And these costs — both personal and financial — have led to a call for public action. So the CDC and the Arthritis Foundation asked the IOM to help identify public health actions that will reduce disability and improve the quality of life for people with chronic disease.9

The IOM committee appointed to study the issue presented its findings in Living Well with Chronic Illness: A Call for Public Action. The report sounded an alarm by stating, “The epidemic of chronic illness is steadily moving toward crisis proportions, yet maintaining or enhancing quality of life for individuals living with chronic illnesses has not been given the attention it deserves.”10 One reason for this disregard is that the medical system is designed to reward people for services provided, not for patient health, said Dr. Patrick Remington a member of the committee that oversaw the report. “The health care system doesn’t really mind more people with chronic disease. That’s the elephant in the room. That is one of the reasons why health care costs are skyrocketing.” Clinicians and administrators want to provide appropriate care, but the system doesn’t encourage it, Remington said. “We’re trying to figure out how to purchase health and not pay for disease care.”11

Getting over that roadblock is among the goals of the IOM report, which supports greater use of new economic models in making policy decisions that will promote living well with chronic disease. The report advises more study
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and assessment of evidence-based interventions — ending smoking, eating nutritious food, and limiting weight gain — in people with one or more chronic diseases. It encourages the public health, health care, and community non-health care sectors to collaborate more on prevention and treatment options for people with chronic disease. And it advises HHS to support the states in developing comprehensive, population-based, strategic plans with specific goals, time frames, and resources that focus on managing chronic illness. Among them were community-based efforts to address the health and social needs of people living with chronic illness and experiencing disparities in health outcomes.

There have already been steps in this direction, some of them based on the “Chronic Care Model” developed by the MacColl Institute for Healthcare Innovation. The model is based on productive interactions between patients and their care team, and it describes how the model elements join to create a patient-centered, proactive health care team. These elements are clinical information systems, decision support, delivery system design, self-management support, and community and organizational leadership.

Health care leaders have already adopted the model for use in various parts of the country. One of them is Paula Suter, director of chronic care management at Suter Care at Home in California. Suter drew on the Chronic Care Model to develop a home health care-based chronic treatment model that has resulted in the training of almost 4,000 clinicians at home health agencies in various states. At the center of the model, Suter explained, is a patient, who may have a low level of health literacy and may not get the help needed on the non-medical side of care. Patients need knowledge and self-confidence to self-manage chronic conditions, and medical caregivers often aren’t equipped to give them that, Suter admitted. As “clinicians, we’ve really been socialized to assume the role of authority. We’re very directive. When you’re dealing with a patient with a chronic condition,” she said, “that doesn’t always work.” In this case, it’s often better for caregivers to be collaborators, and collaboration is among the keys to the VNS CHOICE model for managing chronic conditions in elderly adults.

VNS of New York developed the program around five building blocks for managed long-term care: consumer choice, involving patients and their families in care planning, improving or stabilizing independence and functional status, and collaborating with community providers and facilities to provide coordinated care. These objectives drive all aspects of a patient’s care by a team that includes a care manager for life and a nurse consultant who serves as a contact point for all services provided. The care team philosophy includes concepts that put the focus on patients: comprehensive service delivery that addresses social, environmental, and medical needs while integrating both acute and LTC services; collaboration between interdisciplinary care team clinicians, patients, caregivers, and physicians; and continuous care coordination that addresses the multiple health and community services needs of patients — all tactics that cut costs by helping patients stay in their homes. Over a four-year period, hospital days per thousand decreased 15 percent and admissions per thousand fell by 10.8 percent.

Impressive cost savings have also come through the use of technology in home health. The Veterans Integrated Services Network of Florida launched a home care program some years ago, which used telehealth to improve outcomes for patients with chronic conditions. A six-month comparison of 600 patients found a total cost-savings of $26 million, and one group of 87 patients decreased its number of hospitalizations from 135 to 31, its total hospital days from 1,286 to 285, and its number of walk-in emergency visits from 268 to 114. Besides reducing costs, patient surveys showed that patients felt better and were very satisfied with the program. Similarly, a study by the Iowa Chronic Care Consortium and the Iowa Medical Enterprise found that technology-based remote monitoring reduced health care use and costs. Results
of the year-long study showed a 24 percent reduction in hospital admissions, compared to a 22 percent increase for the matched cohort; a 22 percent total bed days decrease, compared to a 33 percent increase for the matched cohort; and nearly $3 million in savings from reduced health care services use, compared to a $2 million increase for the matched cohort.16

Some of these savings ensue because technology helps patients with chronic disease to self-manage their conditions. Even the highest-quality care to individuals with multiple chronic conditions will not guarantee improved health outcomes for persons with multiple chronic conditions. Patients must be informed and involved as partners in their care.17 With the right motivation, they can head off risk factors that lead to the rise of added chronic conditions, as shown when New Jersey Visiting Nurse Association developed and tested a Web-based disease-management service for home care patients with diabetes, congestive heart failure, and/or obesity. The results showed that patients had 35 percent fewer hospital stays during the project than in the three prior years and they improved their self-monitoring skills. All patients reviewed their vital signs at least once a day, and they all scored 90 percent or better on key tests about their conditions and proper self-care.18

To see how much all this matters, let’s return to that 85-year-old woman who struggled with multiple chronic conditions. She was fighting a losing war, and didn’t have much to look forward to in years ahead. The next hospital stay seemed to be just around the corner, with all the personal and financial costs it entailed. But proper self-care, along with the right support, allowed her to fight back and manage to turn back the tide.

On her doctor’s recommendation, she received home health care services, including skilled nursing and physical and occupational therapy. The nurse found differences in the medications prescribed in the hospital and what she had been taking at home. The nurse worked with the patient’s primary care physician to get the drug regimen in order and then taught her patient how and when to take the medication. The nurse also educated and coached the patient on better management of her chronic illnesses, including quitting smoking. An occupational therapist worked with the patient so she could resume the activities of daily living. A physical therapist developed a home exercise program, taught her fall prevention techniques, and showed her how to combat back pain.19

These services led to terrific outcomes that allowed the woman to live more independently at home. By the time she was discharged from home care, she had been weaned off oxygen during the day and could safely engage in activities of daily living. She was able to prepare meals, bathe herself, reach her upstairs bedroom, and go outdoors. She had quit smoking, and she was able to take her medicines according to the doctor’s orders. She understood her conditions better and knew how to avoid unnecessary, costly hospitalizations.20 Home care had changed her life, and it’s been a lifesaver to million of patients like her. What’s the best way to answer the needs of this costly group with multiple chronic conditions? For multiple reasons, home care is the answer we need.

References
6. Ibid.
10. Ibid.
20. Ibid.