

Healthy Aging v. Chronic Illness

Preparing Medicare for the New Health Care Challenge

by David B. Kendall, Kerry Tremain, Jeff Lemieux, and S. Robert Levine, M.D.

Medicare and modern medicine are badly unprepared to meet the nation's greatest contemporary health challenge: chronic illness. Diseases such as arthritis, coronary artery disease, diabetes, and asthma now afflict more Americans, cause more disability and death, and cost more money than any other health problem. Over three-quarters of the Medicare population suffers from one or more chronic conditions. In less than 20 years, care for these conditions will consume 80 percent of the nation's health care spending.¹

While modern medicine and public health have dramatically improved our ability to survive acute threats like heart attacks and infectious diseases, chronic conditions demand new and fundamentally different approaches than those currently offered. For well over a century, medicine has emphasized acute care. Doctors are trained to "find it and fix it."² A broken bone needs a cast. A heart attack leads to a bypass operation to correct a clogged artery. A badly infected foot is amputated.

While obviously necessary in many cases, these medical responses often represent a failure to act *proactively* against chronic illnesses, which are by definition ongoing and resistant to quick fixes. Osteoporosis, which weakens bones and makes them brittle and fragile, can be managed with diet and drugs, as can coronary artery disease. Properly fitted shoes and regular foot exams prevent disabling diabetic foot ulcers.

Expanding research demonstrates that so-called "care management" or "disease management" programs effectively and efficiently mitigate the disability, suffering, and cost associated with chronic illness. In care management programs, doctors detect and prevent deterioration and complications from chronic illnesses. Health professionals work

closely with patients to develop a treatment plan, monitor progress, and assess results in a continuously improving process.

Unfortunately, these programs remain stymied by the outmoded payment systems employed by Medicare and most private insurers. These systems reward doctors for doing things "to" patients—procedures like heart surgery or amputation—not for working "with" patients to coordinate their care, engage them in their own care, and monitor their progress. The lack of a drug benefit shows the absurd conclusion of this process. Medicare will pay once you've been hospitalized with a stroke, but will not pay for anti-hypertension drugs to prevent it. In the worst cases, Medicare writes checks for procedures that are not only unnecessary, but harmful.

The failure to pay for better chronic care reflects a larger failure to pay for quality improvement in health care. Medicare's Industrial Age regulatory machinery inhibits its ability to innovate and adapt, while inviting professionals, citizens, and political interests to spend their energy outwitting the system rather than outwitting illness. Entrenched attitudes, including the belief that poor health is an inevitable consequence of old age, further impede progress.

New research, new communications technology, and a new willingness on the part of individuals to participate in their own health care offer Medicare the best opportunity in a generation to redirect its energies toward the broad goal of healthy aging. By encouraging innovations responsive to the chronic care challenge, rather than just adding new benefits onto an outdated payment structure, Medicare can promote healthy aging, reduce disability, and produce better value for beneficiaries and taxpayers alike.

Tragically, the current debate in Washington over Medicare is about money, not health—about how much Medicare would spend on a drug benefit, not how well it is spent. Given the size and importance of Medicare, if the program were strategically focused on encouraging innovation for healthy aging, positive results would ripple throughout the health care system. To start the program on this path, the Progressive Policy Institute developed the “ABC’s” of modernizing Medicare:

- 1) **A**ccountability: Convert Medicare from a reactive regulator into a proactive manager that is accountable in every community for improving health care quality;
- 2) **B**enefits: Employ crucial new benefits for prescription drugs and chronic care management as the first opportunities to transform Medicare into a results-oriented care system;
- 3) **C**hoice: Enable beneficiaries to make choices of health plans and care management plans that are best suited for their health conditions and personal preferences.

These changes promise not only better chronic care for older Americans, but also better health care for everyone. Patients yearn for a health care system that treats them as active adults participating in their own care, not passive recipients. They want and deserve a system that serves them, not the institutions that deliver and pay for care; one that continuously seeks improvement based on the patients’ experience and ongoing scientific research.

This report explains the challenge of chronic illness, its implications for Medicare, and the kind of change that is needed. For PPI’s legislative proposal based on this new approach, see *An “ABC” Proposal to Modernize Medicare* by Jeff Lemieux, David B. Kendall, Kerry Tremain, and Dr. S. Robert Levine.

The Chronic Illness Challenge

Forty years ago, doctors poorly understood many common diseases. In half the cases, a person’s first sign of coronary artery disease was a fatal heart attack. Patients who survived were

put on simple bed rest for three or four weeks, a default treatment for any number of problems. According to Douglas Wood, vice-chair of the medical department at the Mayo Clinic, “Medical care was heavily hospital-based, even for a workup of abdominal discomfort. There were no bypasses and no cardiac catheterizations.”³

Today, patients who are hospitalized usually survive heart attacks and other “lightning strikes.” Indeed, older Americans live longer because Medicare has paid for medical advances in acute care. At the same time, Medicare’s success has helped to shift older Americans’ health care needs from life-saving care in hospitals to treatment for chronic conditions like high blood pressure, diabetes, heart disease, depression, Alzheimer’s, and arthritis.

Research indicates that chronic illness is now widespread and expensive to treat:

- ▶ Forty-five percent of the U.S. population and 78 percent of Medicare beneficiaries have at least one chronic condition.⁴
- ▶ Twenty-two percent of the total population and 63 percent of Medicare beneficiaries suffer from multiple chronic conditions.⁵
- ▶ Medicare spends two out of every three dollars on people with five or more chronic conditions.⁶ Just the care for people with diabetes takes one-fourth of Medicare’s budget.⁷
- ▶ Older Americans with five or more chronic conditions have 14 doctors, see physicians 40 times a year, and fill almost 50 prescriptions.⁸

Chronic illness also causes the majority of deaths and disabilities:

- ▶ Chronic diseases kill seven of every 10 Americans who die each year, about 1.7 million people.⁹
- ▶ Chronic conditions cause major limitations in daily life for more than one of every 10 Americans.¹⁰
- ▶ Chronic illness plagues 81 percent of Americans with a disability.¹¹

*However, people with chronic conditions are not receiving appropriate care:*¹²

- ▶ Seventy-three percent of people with high blood pressure do not receive adequate treatment.¹³
- ▶ More than half of people with diabetes are not receiving the care that prevents deadly, debilitating, and expensive complications.¹⁴ For example, some 40,000 people with diabetes have amputations that could have been prevented.¹⁵
- ▶ Seventy-five percent of people with depression receive substandard care even after seeing a physician.¹⁶
- ▶ Sixty-five percent of patients with a high risk of stroke do not receive the appropriate medication to prevent a stroke.¹⁷
- ▶ Eighty-six percent of patients with coronary heart disease have high cholesterol levels despite the benefit of managing cholesterol levels, which reduces the chance of death and disability by as much as one half.¹⁸

With a few exceptions, Medicare does not pay for the scientifically proven, state-of-the-art chronic care management techniques that could dramatically improve the health of people with chronic conditions. Instead, Medicare spends the bulk of its budget on acute care like amputations and open-heart surgery rather than on the chronic care that can prevent them.

While less than one-half of all Americans with health problems reported a chronic condition, they accounted for over three-fourths of medical costs.¹⁹ Projections indicate that by 2020, 157 million Americans (nearly half the country) will suffer from chronic conditions and require over \$1 trillion in treatments.²⁰ Public programs foot nearly half the bill, with Medicare paying the largest share.²¹ Additionally, an estimated \$234 billion is lost every year from disability and early death attributable to chronic conditions.²² These costs will continue to soar as 78 million baby boomers age and become more vulnerable to chronic illness.

How much of this money is wasted? A health care quality movement, driven by medical professionals, cites research that suggests the size of the problem.²³ Dr. Donald Berwick, a leader of this movement wrote, “Scientific evidence favors the strong conclusion that improvements in American health care are both feasible and can contribute to substantial, double-digit reductions in the total costs of care ... reductions of nearly thirty percent below current levels should be attainable while improving the overall quality of care.”²⁴

Americans pay an even higher cost in wasted lives, unnecessary pain, and premature death. The suffering afflicts not only the person with the chronic condition, but also his or her family and friends, who bear the bulk of the care giving with scant public support. It is difficult, if not impossible, to put a price tag on the daily anguish and diminished lives caused by these everyday tragedies (see sidebar on page 4).

Chronic Care: A New Kind of Medicine

Reducing the impact of chronic illnesses requires a different approach to medicine. Traditional health care—going to a doctor when you are sufficiently sick and then to a hospital for a serious illness—is inadequate for most chronic illnesses. A chronic condition requires both constant attention to the problem at hand and to new problems that emerge.

For example, people with asthma often take medications to stop wheezing while also taking medications to prevent the asthma from getting worse. They adjust their medication levels themselves by measuring daily their ease and strength of breathing.

Learning how to manage a chronic illness is no easy task. One patient compared the experience to being the pilot of a small plane.²⁶ As he explained to a health care researcher, if you fly well, you arrive as planned and experience the exhilaration of mastering a complex task. If you don’t fly well, then you have a shaky landing at the wrong airport and are reluctant to fly again.

Chronic care providers play a critical role in building patients’ confidence and avoiding

The Tragedy of Poor Chronic Care

Chronic care doesn't feature dramatic rescues from poisoning or gun shot wounds like those on *ER*. Yet poor chronic care can be every bit as tragic. Indeed, it cries out for an everyday heroism where patients and health care professionals work together to prevent tragedies like Carol Hoffman's.²⁵

Hoffman, like her mother before her, suffered from Type 2 Diabetes, a chronic disease that affects as many as 15 million Americans. Without Medicare, her extensive health care bills would have depleted her modest savings and investments. Like tens of millions of older Americans, however, Medicare ill-served Hoffman in fundamental ways, making her dependent on ever more invasive and expensive care.

Hoffman worked as a teacher near St. Joseph, Missouri, until her health problems forced her to retire eight years ago, at the age of 62. On a camping trip a few years before her retirement, she sat too close to a fire and burned her foot. Over the last decade, the wound never entirely healed, despite several hospitalizations following acute infections—a problem common in people with diabetes. One infection, contracted in a hospital, penetrated a bone in her foot and she narrowly avoided amputation. Diabetes is the leading disease-related cause of amputations in the United States.

Hoffman hated to go to the hospital. She monitored her blood sugar at home and took insulin, but twice a year or so she suffered a downward spiral of reinforcing problems: She would contract infections, lose her appetite, and get depressed. She would stop eating, which would wreak havoc with her blood sugar and make the infections more likely and more virulent. Fearing hospitalization, she avoided calling her doctor until she was very sick and had to go to the hospital, where her depression worsened.

Hoffman lived on a small pension and Social Security. To fight one of her infections, she required an oral antibiotic that cost \$125 a day, which she could not afford. Medicare covered the drug, but only on an inpatient basis, so Hoffman was admitted for a six-week course of the drug therapy. She left emotionally drained and weak, which caused her to be briefly re-hospitalized only a week later. In total, the antibiotic cost came to \$5,250; the hospital bill was \$75,000.

She recovered, but soon another cycle of infections, appetite loss, and depression put her back in the hospital. This time, doctors urged her to let them amputate her badly infected leg. Fearing the loss of mobility, she resisted an amputation until it was too late for it to do any good. She died when her body lost the ability to fight the infection.

Had she survived, her amputation would have made it more difficult for her to bathe, dress, drive, clean, shop, and cook, which would have added burdens to her family members and thus worsen her anxieties about dependency and her depression. The loss would also erect another barrier to exercise, the so-called "magic elixir" of healthy aging.

Carol Hoffman's struggles are common. They are repeated in communities every day in every state. There is no drug or surgery that would have cured her condition—she had episodic acute care needs, like the infections, that can be treated, but her diabetes would never go away. Still, considerable research suggests that she could have lived a healthier, more active, and longer life if she had a support team to help her monitor and manage her condition; to ensure she received timely screenings for prevention of possible complications and related risks; to make her aware of treatment options and assist her in following her treatment choices; to review her progress periodically and make adjustments based on medical advances; and to help her make and maintain healthy behavior changes. Despite expanded diabetes benefits in Medicare, access to comprehensive diabetes management programs is limited. Primary care practitioners, who provide the great majority of diabetes care in the United States, routinely fail to perform even the most routine assessments, like foot exams, or to recommend appropriate therapies.

mishaps. They can teach, counsel, and follow patients throughout their struggle to master a chronic illness. They can become partners in their patient's care instead of distant authorities. They can share knowledge and responsibility for the care according to a patient's capacity to handle it, and they can enlarge that capacity by engaging people as participants in their own health. Finally, they can act as advocates and coordinators of all the doctors, social service agencies, and caregivers who have responsibility for a patient, which is especially important for people with multiple chronic conditions.

Chronic care often requires difficult behavioral changes:

- ▶ Obesity increases the risk of type-2 diabetes 20-fold and doubles or triples the risk of other chronic conditions including high blood pressure, heart disease, and colon cancer.²⁷
- ▶ Smoking accounts for nearly one-fifth of all deaths from cardiovascular disease. Men who smoke increase the risk of dying from lung cancer by 22 times, and women by nearly 12 times.²⁸
- ▶ People who are not physically active have twice the risk for heart disease compared to those who are active.²⁹

But the benefits of better chronic care are substantial:

- ▶ Regular eye exams and timely treatment can prevent up to 90 percent of diabetes-related blindness.³⁰
- ▶ Foot-care programs that include regular examinations and patient education can prevent up to 85 percent of diabetes-related amputations.³¹
- ▶ Every one percent improvement in controlling blood sugar levels among diabetic patients (up to a pre-set goal) saves \$800 in a patient's subsequent health care costs.³²
- ▶ Treatment for controlling blood pressure can reduce heart disease and stroke by 33 percent

to 50 percent and diabetes-related kidney failure by 33 percent.³³

One example of how chronic care works in practice comes from a mid-sized physician clinic in Seattle, which recently launched a comprehensive chronic care program.³⁴ First, patients are asked to set realistic goals for self-improvement based on advice from nurses with training in chronic care. Next, a schedule for patient visits and follow-up care is developed based on research about best practices. A computerized system keeps track of appointments, sends out reminders, and provides alerts for missed appointments. All lab work is done prior to the appointment so that doctors are prepared to review the patient's progress.

Finally, patients are treated in groups as well as individually. The group visits are especially helpful for patients who want to learn from other patients' experiences under the supervision of a doctor, who stimulates discussion with a presentation about specific chronic care issues. Doctors help patients assess their progress individually, and make adjustments accordingly.

In the first year after adopting these chronic care techniques, the clinic has improved health care quality indicators for all major chronic illnesses by 20 percent or more. Research confirms that interventions such as patient education and self-management, physician guidance, and computerized patient tracking and reminder systems are effective when used in combination with each other.³⁵

The results of researched chronic care programs bear out their effectiveness when compared to traditional treatment methods:

- ▶ Nurse-led education and follow-up visits for patients with congestive heart failure has reduced subsequent hospitalizations by one-half and overall health care costs by nearly \$500 per patient.³⁶
- ▶ For late-life depression, a collaborative care model using a personal care manager supervised by a psychiatrist, along with a primary care physician, targeted use of specialists, and outcomes-monitoring has

proven more than twice as effective in reducing major depression than today's standard care.³⁷

- ▶ Comprehensive care for diabetes using support for self-management, regular follow-ups, and self-care reminders has significantly reduced patients' blood sugar, blood pressure, and cholesterol for a six-year stretch.³⁸
- ▶ A similar effort focusing only on blood sugar control has saved at least \$685 per patient within one year.³⁹
- ▶ Patient education for adults managing their asthma has reduced visits to the emergency room and netted \$543 per patient.⁴⁰

Chronic care also offers guidance in determining what works for general disease prevention. Finding out how to engage people in their own health is just as applicable to people with unhealthy habits as to people with chronic conditions. People who get regular exercise, avoid tobacco use, and eat healthy foods have half the risk of disability as those who do not have a healthy lifestyle.⁴¹

The potential benefits from better chronic care rival the potential for better health from biomedical research. High quality chronic care requires a redesign of the way everyday medicine is practiced and financed. But the resistance to change is substantial and varied. Here are the key obstacles:

Chronic care is difficult to patent. Unlike innovations from prescription drugs and medical devices, chronic care innovations, like all medical practice innovations, are not patented. Instead, they must be wrought from a complex web of financing systems, scientific research, medical culture, and patient behavior.

Health care financing schemes undervalue the time and ways that health professionals need to communicate with chronic care patients and help coordinate their care. A vivid illustration of this problem is the frustrating fact that few physicians communicate with patients by email. Even the telephone is underused in medical practice. The reason is simple: Physicians are paid only for seeing a patient in person. They also fear being overwhelmed by

questions that they do not have the time to research and answer. Nor are primary care physicians generally paid for coordinating care and advocating for patients who must deal with a daunting number of specialists. Seniors with chronic care illnesses typically see, on average, seven different physicians each year on 15 different office visits.⁴² Quality improvement leader Dr. Don Berwick believes that 50 percent to 80 percent of these traditional office visits could be eliminated through alternatives such as email, group visits for patients with similar problems, patient support groups, and information available on the Internet.⁴³

The flow of information among patients, physicians, and hospitals is unreliable and uneven. Safe and effective chronic care requires that each specialist know what the others have prescribed, yet patient medical records are usually locked up in chart rooms instead of available electronically. Patients need to know which medical advice to follow when the advice is conflicting or unclear. They need information tailored to their needs. Indeed, information itself is therapeutic given the increased role of the patients as participants in their own care, as health care leader Donald Kemper has argued.⁴⁴

The existing health care system offers few opportunities for either individuals or health professionals to seek better chronic care. If results of chronic care were more obvious, then patients would actively seek its benefits just as they already seek the more immediate results from acute care. In acute care, the benefits are more often obvious because they address an immediate problem. Chronic care requires quality measurement and assessment to determine and display that it is effective over time. Such information can also serve to pay for the performance of health care providers who make the investments in improvements.

The current health care system is arranged for the convenience of institutions, not patients. Consider the doctor's waiting room. Few other professionals keep people waiting at length for prescheduled appointments. Occasional delays may not be significant for someone who seldom visits the doctor. For chronic care involving multiple visits to multiple physicians, however, the waste of time clearly discourages patients from seeking access to appropriate care.

Health plans that develop good chronic care are penalized by attracting more expensive enrollees. Patients can benefit from having a choice of health plans or care management systems that develop excellence in treating chronic conditions. But under a typical financing system, a health plan would receive just as much money for a healthy person as a sick person. Payments to health plans can be adjusted to reflect the differences in health status of enrollees, but care must be taken to ensure that such adjustments are accurate and predictable, so that health plans have a long-term incentive to invest in better chronic care.

Overcoming the obstacles that exist both within and outside Medicare will require a degree of change in how Medicare works that is commensurate with the changes it will demand of the health care delivery system. Medicare will have to become a force for innovation rather than an obstacle to it.

Medicare's Chronic Problem: A Lack of Innovation

Medicare began as an innovative program. When the program was enacted in 1965, a majority of older Americans had little or no health insurance. They worried that a serious illness would impoverish them. They feared, often justifiably, that doctors could do little for them and that hospitals were simply places where people died. Many stayed away from both.

Medicare changed all that. By providing older adults with insurance coverage for visits to doctors and hospitals, it helped spark a revolution in medical advances, helped extend peoples lives (on average, by about seven years), and helped alleviate pervasive senior poverty. Over time, Medicare boomed into the giant program we know today, and facilitated the massive expansion of the health care industry, including hospitals, clinical laboratories, medical schools, and the numbers and types of health professionals. By financing health care institu-

tions, Medicare encouraged several innovations in treatment, especially for high-tech care like new surgical methods and "intensive care" life-support techniques.

Unfortunately, the program hasn't kept pace with medical progress and changing patient needs. Its initial resilience in providing reliable

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health care financing gradually changed into bureaucratic rigidity. "At first, Medicare would just pay the whole thing. You submitted a bill. They might occasionally look at the record, but

there was no formal review," said Mayo's Dr. Wood. "As we shifted to more interventions, Medicare imposed more limitations and more rules about what would and would not be reimbursed. As more outpatient treatments were added, the regulations and review programs grew exponentially. Medicare struggled to keep up with the changes in science and practice by adding rules. The result is that thirty years ago, you got minimal treatment, but it was all paid for. Now, diagnostic and therapeutic interventions are more effective and widely available, but the outpatient rules place a greater burden (and cost) on patients, doctors, and hospitals." Indeed, over the years the program has accumulated a mind-numbing collection of laws, regulations, and administrative handbooks.

In other industries, innovation drives productivity and efficiency, which lower costs and improve value for the consumer. Under Medicare, paying for improvements in medical care requires an act of Congress or a new regulation. Doctors, hospitals, suppliers, and insurers must become lobbyists and act collectively to change a Medicare rule or benefit.

As new costly treatments produced a regulatory arms race at odds with patient care, the opportunities to game the system also increased. Hospitals added expensive new capacities that weren't always needed, but government monies allowed them to grow and gain competitive advantages. Medical specialists were paid for performing procedures, not ensuring their patient's health. Specialists and hospitals carved out their turf and lobbied legislatures to fund more lucrative procedures, while no infrastruc-

ture or incentives were created to support enhanced communication, information exchange, or coordinated care. Effective and cost-saving procedures, like chronic disease management programs, failed to be adopted when they depended on narrow political constituencies or didn't neatly fit into current reimbursement schemes.

Meanwhile, political parties aligned with one or more of the major forces, building into the system a resistance to change. Innovation is disruptive

and creates winners and losers. It is easier for potential losers to mobilize against change than it is for winners (who may not even know who they are) to mobilize for change.

The drug benefit debate in Congress highlights the resulting paralysis. Drugs like those for cholesterol control are crucial to chronic care. In recognition of their vital role in modern health care, outpatient prescriptions are widely covered by private health plans, and have been for the last two decades. But Medicare has persistently denied pharmaceutical coverage, except for an aborted attempt to cover prescription drugs in 1988 as part of the Medicare Catastrophic Coverage Act.

In a vicious cycle, Medicare's administrative procedures first stymie new treatments, then, if the treatment is approved, lock in a higher initial price. Etanercept, for example, is a new bioengineered drug that treats rheumatoid arthritis, a debilitating disease suffered by 750,000 Medicare beneficiaries. Although Etanercept is more effective than treatments Medicare does reimburse, it is self-administered and therefore ineligible. Since the drug is still manufactured in small quantities, it is expensive. The cost can only come down (not only for Medicare patients but for more than a million younger patients as well) if Medicare pays for Etanercept and the company scales up production. Yet locking it in at the current price, which is how Medicare sets prices today, will cost taxpayers hundreds of millions of dollars annually.

This example also hints at the power of Medicare, the nation's single largest insurer, to im-

pact health care for everyone, not only its beneficiaries. At first blush, Medicare simply pays the bills. But Medicare also imposes restrictions on the kind of bills paid. New services or products can't be billed until they receive a pre-defined code with pre-set payment limits set by Congress. These codes are then widely used by

private insurers to set reimbursement criteria and levels.

Even the right to submit a Medicare bill is granted only if providers keep extensive records to docu-

ment that care was given according to specific guidelines—rules mostly intended to limit fraud, not improve care. They reward compliance, not results.

Caught between cost controls and the expense and hassle of compliance, some doctors are refusing new Medicare patients. Legislators must ask themselves: Will the tens of millions of retiring boomers settle for the restricted choices and the barnacled approval processes encumbering Medicare just as life-enhancing medical innovations and effective methods to treat chronic illness are accelerating?

Solving Medicare's Chronic Problem by Improving Quality and Restraining Costs

Most Americans agree that Medicare cannot afford to cover every treatment for every person in every circumstance. Nor should it. Many treatments are frivolous, avoidable, or only slightly effective. Americans can also agree on another statement: *We should get the best possible care for the tax monies we spend. We want value for our dollar, particularly when our lives depend on it.*

The chronic care model offers new possibilities to restrain costs by focusing on quality. That may sound counter-intuitive. Indeed, an oft-repeated slogan in the health care industry is "quality costs"—to get quality care we should pay high performing hospitals and other providers more money. But Medicare's structural

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bias against innovation, the real source of better quality care, means that more money will not necessarily be used wisely or efficiently to improve health care.

In fact, quality can save money as well as lives. Here are three examples:

Prevention and quick action. The way to trim the cost of expensive heart surgeries is to prevent the need for them. Support to change risky behavior and wider use of aspirin, etc.—for people with high blood pressure and

diabetes in particular—are relatively inexpensive ways to do so. Improved diagnostic tools (many operated by patients themselves) act both to prevent surgical interventions and to detect problems early enough to limit the progression of disease, thereby reducing the need for invasive and expensive interventions like surgery. Of course, not all preventive measures save money; many save lives, but cost additional money. A quality focus enables us to prioritize these measures according to their impact on costs, life, and health.

Improved information systems. Achieving the best possible outcomes requires all parties to know and expand what is knowable, communicate it well, and do what is doable as a result. Utilizing new technologies, up-to-date information can improve every aspect of the relationship among providers and between providers and patients. It is essential to coordinated care and critical to cost control. For example, quality information can substantially reduce costly office visits and prescription mistakes. One study showed that in any given year, approximately 35 percent of people over 65 experienced adverse drug reactions and 17 percent are hospitalized as a result of incorrect dosages or negative drug interactions. These hospitalizations cost as much as \$20 billion per year.⁴⁵

Reducing error. The Institute of Medicine has identified three types of failure in technical care: overuse, underuse, and misuse. All three cost dollars and lives. Overuse involves paying for

an unnecessary procedure, then again for any complications that arise. Underuse turns less expensive early interventions into costly ones later. With misuse, we pay for the incorrect procedure, ensuing complications, as well as the correct procedure. In one meta-study, RAND found that 30 percent of acute care is inappropriate.⁴⁶

Adding money or benefits to the program will accomplish little if we continue paying for expensive interventions once a patient is in crisis rather than the care needed to prevent the crisis in the first place.

A quality focus has an additional virtue: It puts the debate about Medicare spending on a more rational, democratic, and moral basis than the current scheme,

where health care is rationed according to the influence of industry players. It is more rational because decisions are based on continuously updated scientific evidence; more democratic because it empowers citizens to evaluate their choices and help set community standards; and more moral because decisions of life, death, and health should not be the prerogative of government administrators or health care professionals, even enlightened ones. Patients and their families must answer these fundamental questions. Our community obligation is to provide them with the most accurate information and the best possible choices, along with access to professional guidance and care they can trust.

Despite the savings that a quality focus will garner, it will not be enough to contain Medicare spending in the face of boomer aging. We'll need additional checks and balances, including consumer choice. A patient partnership is meaningless if the beneficiaries are denied the responsibility of making choices—sometimes tough choices—about their care based on the best quality and cost information we can provide. Employees of the federal government and many large companies do that today when they choose among competing health plans. Reasonable people may disagree about how much should be spent on health care, but neither individuals nor society can afford to act as if the purse is bottomless.

In the traditional health care model, doctors make the major decisions that affect the cost of care based on the tests and treatments they order.

While restraining doctor's spending is still more art than science, at least there have been successful experiments with physicians to control costs. We have far less experience in giving patients themselves opportunities to manage their conditions and to decide how much care they need. As a result, we need a great deal more experimentation with approaches that simultaneously engage patients as participants in their care and create incentives for self-restraint.

Here again, a quality focus can help. Medicare should offer

beneficiaries choices of only those care management services that can improve quality, lower costs, or both. Because the payback for investments in better chronic care can take many years, the agency that administers the program, Centers for Medicare and Medicaid Services (CMS), should adopt a long-term budgetary outlook when analyzing the value of these programs.

With a fiscally and scientifically sound menu of choices, engaging people both as participants in their care and as consumers of health care is the fair and efficient way to restrain Medicare spending. Most important, a focus on quality ensures that we get the best value for the tax dollars we do spend, rather than rationing care based on bureaucratic inertia or political influence.

Ending the Political Impasse Over Medicare

The political debate over how to correct the problem is as outdated as Medicare itself. Rather than focus on how to improve Medicare's *performance*—how the system can continually and cost-efficiently improve the health of older Americans—legislators fight to gain competitive advantage in a turf war that everyone is gradually losing. As the demographic tidal wave approaches, Congress remains paralyzed by old habits.

For a time it appeared that budget surpluses might ease the transition to Medicare reform, but the return of budget deficits has dimmed the prospects for change, at least the sort of large-

scale benefit expansions and competitive reforms discussed in recent years. Furthermore, many politicians remain mired in deep ideological ruts. On the surface, the current Medicare debate is focused only on prescription drugs. Democrats have been rightly pushing for a new drug benefit, while Republicans have been

rightly attempting to limit the government's control over drug prices. However, the real source of gridlock is ideology. With few exceptions, Democrats have insisted on uniform national benefits

under direct government control. Republicans have countered that private markets should be left alone, with little direction or control from the government.

The debate is still about who should pay for what. It is about who should provide "the benefit" and how much it will cost, not about how to create a more flexible program that supports continually improving care.

Adding money or benefits to the program will accomplish little if we continue paying for expensive interventions once a patient is in crisis rather than the care needed to prevent the crisis in the first place. Patients must be encouraged and helped to seek care before problems arise, consult with doctors about their health care options, and deal with complex issues about caring for chronic conditions.

Finally, much of the political motivation on Medicare stems from concern about the next election, not on setting long-term processes in place that enable the program to anticipate and adapt to change. Republicans want political cover on drugs, while bolstering their anti-spending credentials. Democrats want to rub Republicans' noses in the fact that no drug benefit has been enacted.

The chronic care challenge refocuses the debate on health. The best way to drive Medicare improvements forward is with a relentless focus on healthy aging. Medicare can be revitalized without massive new government expenditures, but it will require a substantial change in attitudes. Just as medical decisions

Transforming Medicare to yield the promise of healthy aging need not be a far-off goal. Medicare has changed rapidly in the past once a consensus emerged about the direction of reform.

require ongoing adjustment, Medicare must establish a process for continuous improvement in the program itself.

Currently, Medicare is a finance tool, a bill payer that sets lowest-common-denominator standards for quality. Deciding who will be paid and for what *is* a powerful authority, but no more assures the best possible care than a medical degree guarantees a good physician. To fill its potential to serve the public, Medicare needs the capacity to directly catalyze ongoing improvements in the quality of care and measure the results. The financial focus emphasizes cost-control: checking the price but not the quality of service. Today's consumers rightfully expect more. They do not just look at the price of products and services they purchase, but consider the value they are receiving for the money they spend.

Recognition of the chronic care challenge can be a fresh beginning for Medicare reform because it creates sorely needed common ground. It challenges the political left to drop the view that innovation is a low priority in health care: In truth, the only way to foster security is through continuous innovation. Moreover, only a broad-based, systematic focus on quality can dramatically improve the health and health care of every older and disabled American. Democrats will have to decide: Are they fighting for better health for Medicare enrollees, or just for new government-provided entitlements?

A focus on chronic care challenges the political right to acknowledge the critical role of governmental leadership in modernizing health care delivery and financing. Rather than seeing market-based reform of Medicare as a means of slashing the budget or advancing a market ideology, expanding choices and competition in Medicare must proceed step-by-step in the context of specific goals for Medicare beneficiaries. Government leadership is essential.

Getting Started

Transforming Medicare to yield the promise of healthy aging need not be a far-off goal. Medicare has changed rapidly in the past once a consensus emerged about the direction for re-

form. In the face of double-digit cost increases in the 1980s, a Republican administration and Democratic Congress crafted major reforms to regulate prices paid for Medicare services, first for those provided by hospitals and then for those provided by doctors. Within two years of enactment, both sets of laws were fully implemented. The next round of reform, based on the chronic care challenge, is just as urgent and just as capable of producing a consensus but, unlike the 1980s reforms, it should be predicated on fostering innovation.

Each of the following three areas of reform would focus Medicare on continuous innovation. Taken together, they would initiate an era of continuous improvement for Medicare. They would produce a set of measures that can radically improve the program's quality of services while restraining costs.

- ▶ **Make Medicare's managers accountable.** The government is especially suited to catalyze collective action to raise standards broadly—not through regulation but through measurement and planning. Medicare administrators should be held accountable for achieving specific performance objectives, but given flexibility to improve the quality of care for beneficiaries. For example, patients with chronic conditions can be surveyed to determine if their health is improving on average and if they have received the appropriate care.
- ▶ **Link new benefits with quality improvement.** Meeting the chronic care challenge depends substantially on recent pharmaceutical innovations. Given the political popularity of a drug benefit, however, it would be easy for Congress to ignore the need for quality improvement were it not for its potential to consolidate consensus. Democrats and Republicans are at an impasse over how to design a drug benefit that is not bureaucratic, but neither party has highlighted the importance of ensuring the safety and effectiveness of a drug benefit. Studies have shown that patients get the wrong drug at the pharmacy anywhere from 3 percent to 24 percent of all prescriptions. A focus on

preventing such errors and improving quality would create some new political common ground and help forge a consensus.

- ▶ **Better choices—especially for chronic care.** Medicare beneficiaries will be a force for innovation if they have consumer choices and objective information to help them make their choices. A “Medicare Menu” would help make Medicare’s gap coverage, HMO plans, and care management options as stable and easy to navigate as possible. The information beneficiaries need includes both the cost and quality of care offered by providers and health plans as well as consumer satisfaction measures.

Each type of reform is illustrated below. See PPI’s legislative proposal, *An “ABC” Proposal to Modernize Medicare*, for a complete description of the proposal.

Accountable Medicare Management

Medicare is the largest single source of financing for health care in the United States. CMS wields too little influence in some ways and too much in others. It does not demand greater quality and productivity from the health care industry, yet its regulations have a big impact on what the health care community can and cannot do.

Currently, CMS favors regulations over results. The agency is renowned among social workers at hospitals and billing managers at doctors’ offices for its convoluted rules. Congress, which has limited tools to evaluate the agency’s performance, expresses its distrust by micromanaging CMS. This only exacerbates the overly hierarchical, bureaucratic, and political nature of Medicare’s rules.

Reformulating Medicare’s role in health care has two key aspects. CMS needs flexibility to reshape the regulatory structures under which it lives. And CMS must be accountable to the public in terms of the health of beneficiaries and fiscal discipline. The combination of flexibility and accountability can break the cycle of mistrust that undermines CMS’s relationships with others.

The best way for CMS to build trust and effectiveness is to restructure the agency to encourage innovation. The same principles that have worked so well for many public and private organizations will work for CMS: setting and being held accountable for public goals, coupled with the flexibility of means to reach them. Indeed, simply applying existing standards for quality reports by private health plans to CMS itself could ensure accountable Medicare management.

To break free from its reactive, regulatory culture, CMS must commit itself to reducing the burden of illness and injury in terms of lives saved, improved health, and lower costs. Congress should direct CMS to set achievable and measurable objectives, give it the flexibility to achieve those objectives, and require the agency to report on its plans and results.

PPI proposes that CMS start with chronic conditions that are most costly in terms of dollars and lives and that hold the greatest chance for cost savings. CMS would survey the Medicare population to assess the quality of care and health status of beneficiaries with these chronic conditions and ask them to rate their satisfaction with their care. Next, it would review best practices to determine where current practices fall short. Then it would examine all the current regulations that impede quality care and develop a plan to encourage best practices. CMS would present this plan to Congress for public comment. After implementation, it would re-assess the quality of care, the health status, and satisfaction of beneficiaries; account for the costs and cost-savings; and report the results back to Congress and the public.

To some observers, transforming a large, public bureaucracy like CMS is an impossible dream. Yet it happened to the New York City police department in Mayor Rudolph Giuliani’s first term and helped produce a dramatic decline in crime rates. The department began by compiling and making available real-time, detailed information about crime and criminal activity, using a system known as CompStat. Up-to-date trend data allowed local police captains to monitor their crime-fighting progress, deploy resources based on trends, and plan strategies for future efforts. Most important, with real data, the captains

could be evaluated on their performance. Their peers and superiors ruthlessly grilled those failing to make improvements and those without a strategy for progress. Many were sacked. The pressure led to new tactics that significantly reduced crime rates in every precinct. These evidence-based, locally-customized approaches were critical to New York's dramatic public safety success. Since the CompStat data was also made available to the public, citizens and the news media could also evaluate the trends.

The analogy to Medicare is fairly direct. CMS must begin by collecting and disclosing detailed information on the health care, quality, and payment performance of Medicare, nationwide as well as by region and locality. CMS would use standards for assessing quality set by a new independent quality commission, much like the Securities and Exchange Commission. New data would have to be gathered and existing data sorted into valid internal performance measures. Starting with simple payment information, CMS could eventually attain full and up-to-date knowledge of how well the program is working, right down to whether or not individual beneficiaries are receiving optimal care.

With such information in hand, the transformation at CMS can become a reality. Just as New York City's police precinct captains were held accountable, CMS can hold local administrators responsible while unleashing their creativity. Local administrators can begin asking: Is good disease management available? Are there local HMOs and care management plans available, and do they do a good job? How can the number of patient crises be reduced? Are the local physicians and hospitals reaching out to their communities, and helping foster continuous care? To be sure, measuring performance in health care is more complex than in crime prevention, but the basic approach is the same.

With the same information aggregated nationally, Congress and the public can hold CMS accountable for results without paralyzing them by micromanaging the process.

Quality Improvement Through New Benefits

Modernizing Medicare's benefits is the most crucial and obvious task facing Congress. Medicare's benefits reflect the dominant form of private health benefits available at its inception in 1965: hospitalization (Medicare Part A), doctor coverage (Part B), and no outpatient prescription drug coverage. Also missing is recognition that the best care for chronic conditions is a team approach that engages patients as partners in their care. Medicare needs new benefits for both prescription drugs and care management.

Simply adding benefits without a plan to continuously improve quality, however, will trap Medicare in the past. As the history of medicine proves, today's state-of-the-art is tomorrow's wasted opportunity.

A new prescription drug benefit should be delivered through a variety of new and existing organizations that give beneficiaries a wide range of choices and connect prescription drugs with care management techniques. These organizations would be assessed through standard quality measures, particularly on their impact on the health of beneficiaries.

All Medicare drug plans would be required to report on the quality, effectiveness, and safety of drug prescribing, dispensing, and usage. The secretary of Health and Human Services (HHS), the agency that runs Medicare, would devise an initial set of reporting requirements based on consultation with appropriate private and public sector experts and organizations (ultimately the CompStat-like commission described above would set reporting requirements). These specifications would consider: the availability of information to the public; the relevance and ease of understanding to beneficiaries; the experiences and concerns of beneficiaries; the effective operation of the prescription drug benefit (prescribing, dispensing, and payment) and the achievement of intended health benefits; and the degree of administrative burden on prescription drug plans and providers for reporting requirements.

To break free from its reactive, regulatory culture, CMS must commit itself to reducing the burden of illness and injury in terms of lives saved, improved health, and less cost.

Another important tool for improving the quality and safety of a drug benefit is for doctors to have electronic access to a current list of a patient's medication. It would help prevent errors and adverse side effects that occur when the medication list is not complete or is not thoroughly checked. This information infrastructure does not exist now in part due to provider's fears of violating patients' privacy when exchanging medical information. If patients themselves could efficiently grant permission to exchange their medical information, however, then privacy concerns would no longer be an obstacle to safer and better care. A new, nonprofit organization called the Patient Safety Institute is building exactly this kind of electronic information exchange.⁴⁷ As part of funding for a new drug benefit, Congress should provide funding for the creation of this type of exchange.

Better Choices—Especially for Chronic Care

The best hope in the long run for developing a dynamic and accountable Medicare is through the informed choices of Medicare beneficiaries. Indeed, both democratic politics and competitive private markets owe their success to the principle of trusting citizen-consumers with real choices. Meaningful choices require meaningful information from multiple sources. The Information Age has achieved a significant extension of this principle and demonstrated once again the power of informed choice to continuously improve individual lives.

PPI proposes a Medicare Menu to secure and widen beneficiaries' options and enable them to help drive innovations in care with their choices. This new menu would give private health plans substantial financial incentives to provide high quality care to patients with the greatest needs. Currently, Medicare overpays health plans for enrolling healthy people and underpays them for enrolling sick people. The administrative challenge is to identify the mix of healthy and sick enrollees in a plan. As it happens, certain patterns of prescription drug spending are highly correlated with predictable

costs. The information on drug usage generated by a new drug benefit can potentially solve this problem.

Finally, as care management programs for patients with chronic conditions proliferate, they too should be included on the Medicare Menu along with information about their performance.

People with a chronic illness should have a doctor who is paid to coordinate their care and ensure good results.

Care management for patients with chronic conditions is a broad and rapidly evolving field. While it holds great promise for better health outcomes and

lower costs, best practices have not been firmly established and will change. If Congress were to enact a specific program, it could easily fail, squandering the opportunity for innovation. Instead, CMS needs to encourage a wide range of experiments and demonstrations, then implement what works.

CMS has already started 15 care demonstration locations throughout the country as a result of legislation passed in 1997. CMS has the authority to implement successful demonstrations, but its budget is limited to the savings that it can generate in one year. Under PPI's "ABC" proposal, the budget for innovative approaches would consist of up to 10 years of projected savings. A new Congressional Health Benefits Agency would oversee the projections of savings. CMS also needs to move quickly to implement a greater number and wider variety of possible care systems including the following:

Recognized chronic care physician leader.

People with a chronic illness should have a doctor who is paid to coordinate their care and ensure positive results. That is why the American Diabetes Association and the National Committee for Quality Assurance recognize doctors who achieve good outcomes in diabetes care.⁴⁸ A growing group of employers pay these doctors more because they believe that it will lead to better health and lower costs. CMS should contract with patient-oriented organizations that would develop recognition programs according to general guidelines that CMS would set. CMS would use these recognition programs to reward physicians who provide high-quality chronic care services including enhanced educa-

tion, communication, coordination, and outcomes tracking. Sen. Blanche Lincoln (D-Ark.) has introduced legislation based on a similar approach.⁴⁹

Comprehensive care management. People with certain chronic conditions like diabetes should have the option to receive all their care from a coordinated care network of doctors. In the case of people with diabetes, treatment for any health problem must take into account their diabe-

tes. CMS can encourage groups of doctors, hospitals, and other providers to step forward and offer comprehensive services to the chronically ill. These provider groups, however, would not have to bear the full risk of providing all needed health care, like an HMO would. Instead, the risk could be shared between CMS and the providers so they have an incentive to become efficient rather than profit from withholding care.

Complex care management. One-fifth of Medicare beneficiaries have five or more chronic conditions.⁵⁰ These patients are substantially more costly to care for and require much more intensive work up-front to achieve success. CMS should provide care managers to these individuals and adjust payments to care management programs to reflect the higher costs.

Payments for new care management services and technology. Care management often involves using new devices and nurses to monitor and support patients. One example of a program that has the potential to reduce costs is called Health Buddy.⁵¹ Chronic care patients plug a small, countertop device into a telephone line that lets them record their health condition daily. This information is automatically sent over a secure phone line to a nurse or care manager who can recommend fast action based on early warning signs. Patients access Health Buddy regularly because it is easy to use, and they get comfort from having someone else monitor their health. In one study of patients with congestive heart failure, Health Buddy's simple, team-based system reduced hospital stays and trips to the emergency room by 69 percent and

reduced costs by more than \$8,000 per patient per year.

Chronic care payment enhancements. Doctors should be paid more when they see patients with chronic conditions so they can take the time to help patients understand and master all the self-care techniques. Under current law, a doctor gets paid the same whether he or she provides a consultation to a healthy 65-year-old or a frail 85-year-old with multiple chronic conditions. CMS

should experiment with payment enhancements to determine if they can improve health outcomes.

In every new experiment or effort to implement care management, CMS should require reporting on the outcomes, costs, and patient satisfaction. Such information is critical for CMS and others to evaluate the success of such efforts and for beneficiaries to select a care system that works best for them.

Conclusion: From Chronic Problems to Political Stability

Conclusion: From Chronic Problems to Political Stability

Medicare is not the only place to tackle the chronic care challenge, but it is the most critical.

For years, pundits have warned that the Medicare program is in crisis. Looming deficits and generational conflicts are predicted as the baby boomers become eligible for coverage, and the predictions are employed to lobby for higher taxes, lowered coverage, or both. In these scenarios, Medicare is still standing at the gate and deciding who and what is let through, as the pressures of an aging population mount. For some, the obvious answer is to widen the gate, while others believe we should just build a higher fence.

It is the gatekeeper metaphor that needs changing. Medicare cannot get better by simply doing more of the same in the face of the radically new challenge posed by chronic illness. By shifting the debate from how much we are spending to what we are achieving,

By shifting the debate from how much we are spending to what we are achieving, Medicare can become less of an ideological battleground and more of a test what works.

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Certainly the pressures are real. Costs are rising again. The boomers (and their political clout) will not quietly go away. Medical research is rapidly progressing, making inroads into diseases once thought untreatable and generating new options for both acute and chronic care. Shouldn't we celebrate this fact?

To the doomsday scenarios, a public campaign to face the chronic care challenge offers a far more hopeful response. It calls on America's strengths: its individualism as well as its community feeling, the energy of its entrepreneurs and private markets, as well as its native belief in equal opportunity. Rather than resisting innovation, it calls on both the private and public sectors to embrace it.

The enormous waste and archaic

management in the current system is our opportunity. By turning Medicare into a performance-based and purpose-driven program accountable for better health outcomes, but with the flexibility to reach them, the chronic care framework offers a proven method for reform. By treating America's elderly as partners in their own health, rather than as children who must be told what to do, we can unleash their creativity, initiative, and sense of responsibility. And by unburdening health providers of the wrong kind of regulation, we can enable the best-trained medical professionals in the world to do what they do best.

The financial pressures will still exist, but we will have the information to better judge how to get maximum leverage for the dollars we spend. Most important, countless lives, including our own, may be improved or saved.

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