

## **Why State Government Should Care about Problems of Chronic Care**

By Richard Bringewatt

The terrorist attacks of September 11, combined with significant changes in state and federal budgets, have fundamentally changed the nature of public policy, including healthcare policy. While it is critical that we respond to threats of terrorism and stem the tide of deficit financing, we cannot ignore another threat to our society: chronic diseases and disabilities.

Most health policy is primarily focused on stemming the tide of healthcare inflation and establishing a drug benefit. Healthcare expenditures are expected to reach \$2.8 trillion in 2011, 17 percent of the GDP. Medicaid expenditures are expected to grow 8.5 percent per year over the next five years, and Medicare expenditures are expected to grow 5.8 percent per year (source: "Health Spending Projections for 2001–2011: The Latest Outlook." *Health Affairs* 21 (March/April)).

The typical response to this projected acceleration is to cut budget allocations to mainstream healthcare providers. While this response is understandable in the face of pending deficits, it fails to recognize that the nature of healthcare has fundamentally changed from acute to chronic care. Future cost and quality concerns cannot be addressed without changing the nature of health policy.

People with chronic conditions, such as heart disease, lung disease, asthma, arthritis, and Alzheimer's disease are healthcare's largest, highest-cost, and fastest-growing service group, accounting for 75 percent of all healthcare spending (source: The Robert Wood Johnson Foundation). Some 125 million Americans have a chronic condition; by 2020 that number is expected to rise to 157 million as the Baby Boom generation ages, according to S. Wu and A. Green's *Projection of Chronic Illness Prevalence and Cost Inflation*. Of those dually eligible for Medicare and Medicaid, 80 percent have two or more chronic conditions (source: Health Care Financing Administration. 1998). Chronic illness affects more than a third of working-age Americans, according to Marie C. Reed and Ha T. Tu's *Triple Jeopardy: Low Income, Chronically Ill and Uninsured in America*, and about 7.4 million of these Americans are uninsured (source: Ha T. Tu and Marie C. Reed. 2002. *Options for Expanding Health Insurance for People with Chronic Conditions*).

While it is true that continuous growth in healthcare inflation is unsustainable, it is important to recognize that our healthcare system was not designed to address the multi-dimensional and ongoing problems of chronic illness. Instead of ongoing, prevention-oriented, multidisciplinary care, people with chronic conditions experience a plethora of confusing, costly, disconnected, and disease-oriented encounters.

An all too common case study, based on a composite of National Chronic Care Consortium member experiences, illustrates the problem: Mr. Jones is 69 and has congestive heart failure, chronic obstructive pulmonary disease, and diabetes. He takes nine medications, prescribed by three physicians. A recent hip fracture necessitates trips to the emergency room, hospital, and a rehabilitation unit, before returning home with home health care. With his problem reassessed at every stop, Mr. Jones provides much of the same information over and over again. Each care provider takes action with little regard for what occurred previously.

Given the confusion surrounding this trauma, Mr. Jones has difficulty remembering all the medications he is taking, resulting in multiple complications in care. He has a delay in discharge from rehab, and his home care skilled nursing visit is delayed due to a mix-up in the discharge notes. Mr. Jones is home for three days without home care services. On the fourth day, the home care nurse conducts another assessment. Mr. Jones' medications include some that were prescribed before his hospitalization, and the nurse suspects that he is taking too many different prescriptions for the same condition.

On the eighth day following hospitalization, Mr. Jones awakes from sleep feeling shortness of breath, very lightheaded, and dizzy with a “tingly” feeling in his limbs. He is alarmed and calls for an ambulance. He is taken to the nearest hospital, which is not the same facility where he was treated for his hip fracture. He is admitted through the ER where it is determined that his diabetes is out of control. He also has a mild case of bronchitis. The orthopedist involved in his hip fracture rehabilitation, the cardiologist he normally sees, and his primary care physician are not notified of this new admission.

Dr. Alan Lazaroff, director of geriatric medicine at Centura Health in Colorado, specializes in chronic illness care and reports how the current system actually thwarts the ability of many physicians to provide quality care. He said in testimony before the U.S. Senate Special Committee on Aging in 1998: "Much of my most important work is unrecognized and uncompensated. If I hospitalize a patient, I can bill Medicare every day I make a hospital visit—never mind whether this is the most appropriate treatment. If I meet with family members of a patient with Alzheimer's Disease, coordinate the services of several professionals, counsel patients and families about both the benefits and limitations of aggressive treatment, and help my patients cope with the emotional consequences of their illness, however, I can bill nothing. I may be able to improve quality of life at the same time that I reduce inappropriate and unproductive hospitalizations, ICU care, and emergency room visits, but the more I focus on preventing or delaying the progression of disability and the more money I save the Medicare program, the less I am paid. Something is terribly wrong with a system that rewards the unnecessary use of high-cost, high tech services for a patient population that is equally dependent upon a vast array of supportive services and which penalizes practitioners who provide the services needed most, often at a lower cost."

The transformation of healthcare is a huge task, yet National Chronic Care Consortium believes government can begin the task by adopting the following health policy principles: (1) focus on chronic illness — it is the primary cost driver; (2) empower consumers—today's well-informed Americans have more capacity for control than we give them credit for; (3) leverage technology — it is costly in the short-term, but information and medical technology hold revolutionary potential for long-term gain; (4) think *long-term* — chronic illness is a lifetime concern; (5) think systems — the actions of all purchasers, payers, providers, and consumers are interdependent; (6) focus on disease and disability prevention — chronic illness is a progressive condition; and (7) be proactive — delaying action will only cause more problems at a later point in time.

Most government officials have limited resources to work with, yet significant long-term cost and quality outcomes can occur if government officials begin to:

1. Shift the primary focus of health policy from reducing reimbursement rates for each provider segment to reducing the incidence rate of chronic disease and disability.
2. Create financial incentives to target and serve people at risk of serious and disabling chronic conditions. Virtually all payment methods contain incentives to avoid them.
3. Create financial incentives to prevent disease and disability progression. Most payment methods create incentives for providers to wait for a crisis to occur.
4. Change the existing regulatory structure. Current rules and regulations lock in place a highly fragmented and antiquated approach to chronic illness care.
5. Revisit managed care financing. Paying for care, one piece at a time, defies the ongoing and interdependent nature of chronic illness.

6. Define new quality and system measures. We cannot contain costs and ensure quality outcomes until we create measures that let us know about the *cumulative* effects of serving people with chronic conditions across time, place, and profession.

The United States is threatened by acts of terror, and most states are also threatened by severe budget limitations. Yet as we respond to these larger policy concerns, it is important to pay attention to another crisis that rests at the core of our healthcare institutions. The way we finance, administer, and deliver healthcare is fundamentally out of sync with the nature of chronic illness. The time to resolve this crisis is now. We must ensure our system of healthcare works for all Americans.

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