The Chronic Care Model: Past, Present and Future

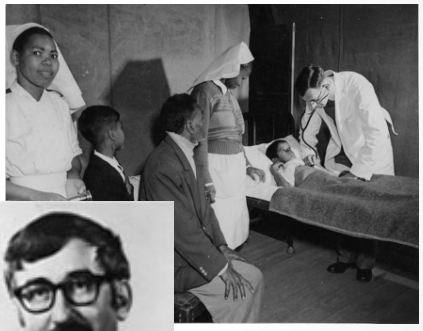
10 Jan 2012

Connie Davis, MN, ARNP
cld@conniedavis.ca

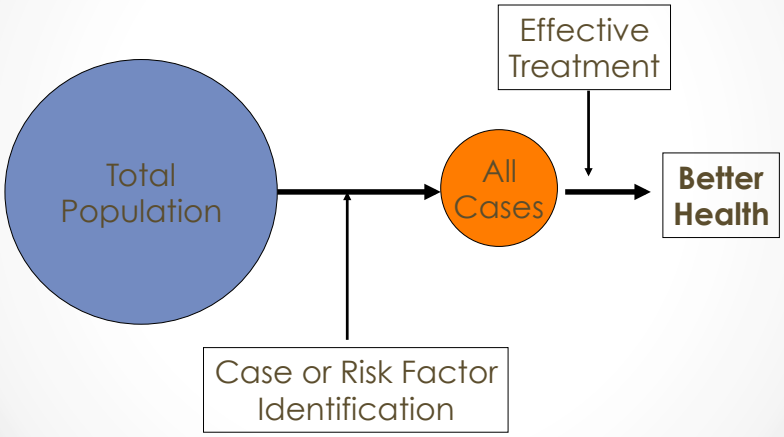
Presentation Objectives

- Describe the origins of the Chronic Chronic Care Model (CCM)
- Describe current use of the CCM
- Consider how to use the CCM at the state level

Origins of the CCM



Population-based Care

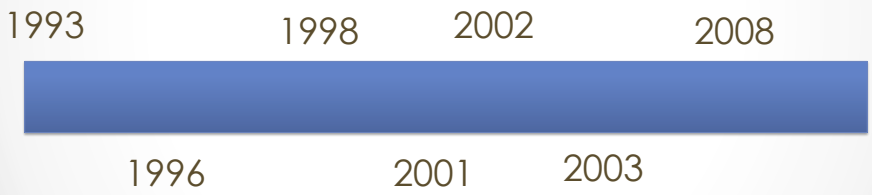


GroupHealth

Model Development 1993 --

- Initial experience at GHC
- Literature review
- RWJF Chronic Illness Meeting -- Seattle
- Review and revision by advisory committee of 40 members (32 active participants)
- Interviews with 72 nominated "best practices", site visits to selected group
- Model applied with diabetes, depression, asthma, CHF, CVD, arthritis, geriatrics, prevention
- Translated and adapted

Timeline for Care Model Development



Early publication on care delivery for chronic conditions

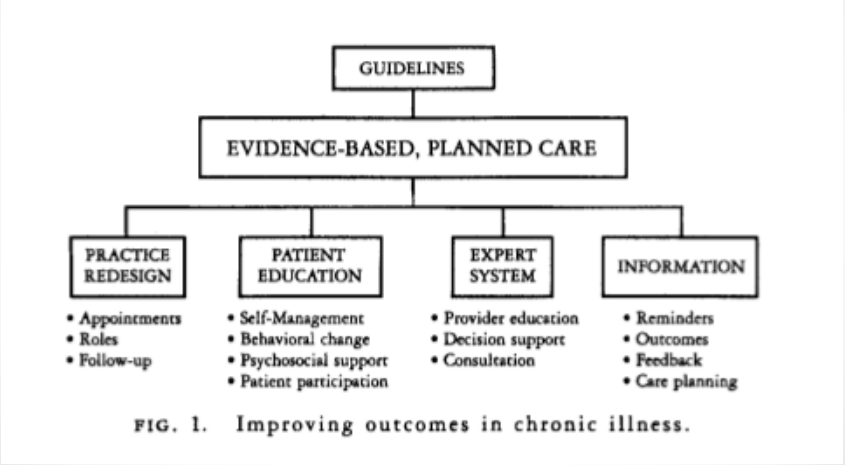
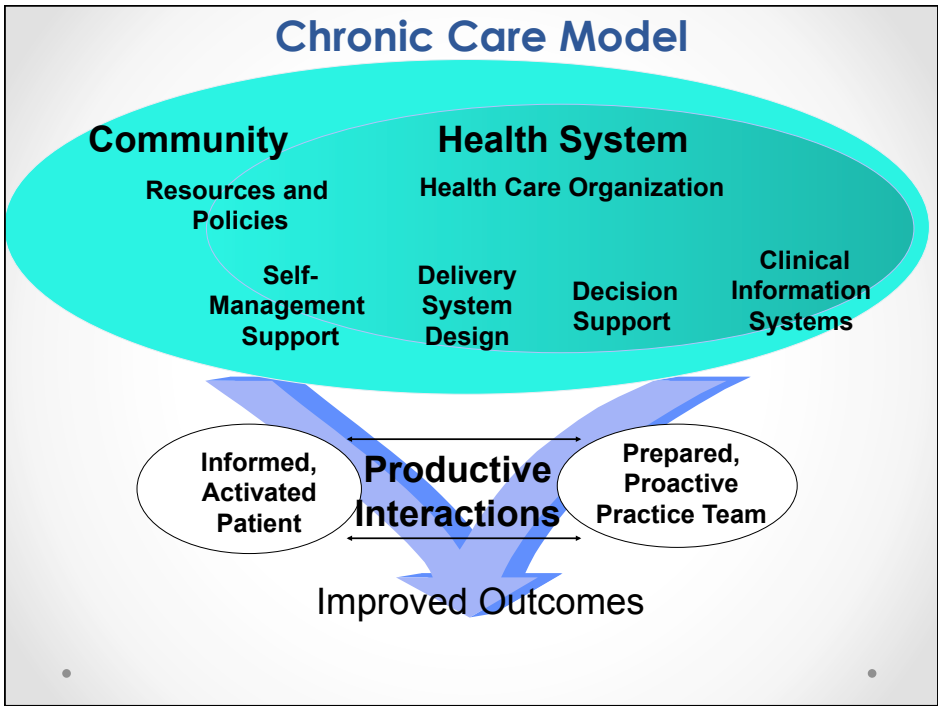


FIG. 1. Improving outcomes in chronic illness.

Wagner et al, Milbank Quarterly 1996



Self-management support

- **Help patients understand their important role in managing their health**
- **Use effective self-management support strategies that include goal setting, action planning, problem solving and follow up.**
- Organize internal and external resources to provide ongoing self-management support to patients.

Delivery System Design

- **Develop a multidisciplinary team that optimizes the role of each member in clinic & community**
- **Use planned interactions to support evidence-based care**
- Provide clinical case management services for complex patients
- **Ensure regular follow-up by the care team**
- Give care that patients understand and that fits with their cultural background
- **Improve efficiencies and access**

Decision support

- **Embed evidence-based guidelines into daily clinical practice**
- Share evidence-based guidelines and information with patients to encourage their participation
- Use proven provider education methods
- Integrate specialist expertise and primary care

Clinical Information System

- **Identify relevant subpopulations for proactive care**
- **Facilitate individual patient care planning**
- **Provide timely automated reminders for providers and patients**
- Share information with patients and providers to coordinate care
- Monitor performance of the team and care system
- Use data at the point of care

Health Care Organization

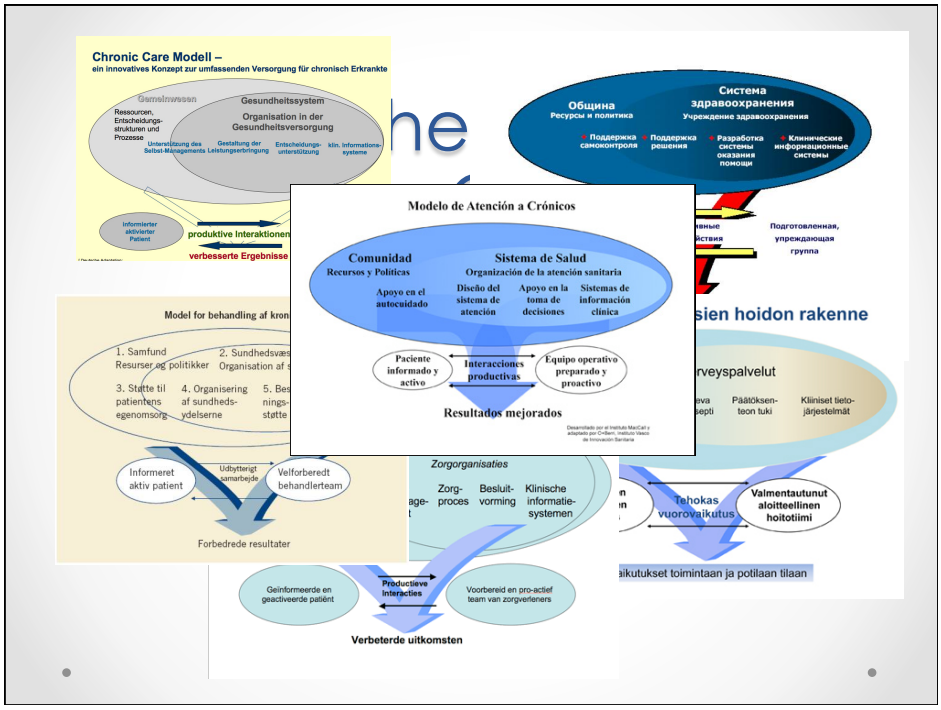
- **Visibly support improvement at all levels of the organization, beginning with the senior leader**
- Promote effective improvement strategies aimed at comprehensive system change
- Develop agreements that facilitate care coordination within and across organizations
- **Create an optimal "Medical Home" that is the center of the healthcare system**
- **Develop workforce to support transformation**

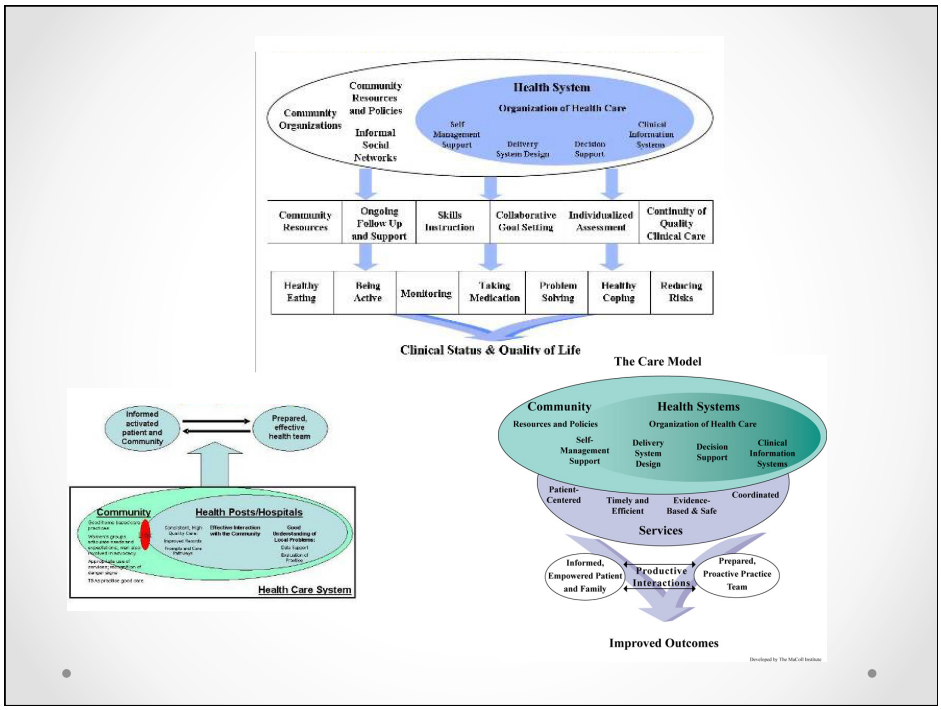
Community

- Encourage patients to participate in effective community programs
- **Form partnerships with community organizations to support and develop interventions that fill gaps in needed services**
- Advocate for policies to improve patient care and confidence
- Promote community involvement in strategic planning and improvement activities
- Understand and fix access barriers to interactions/ relationships over time

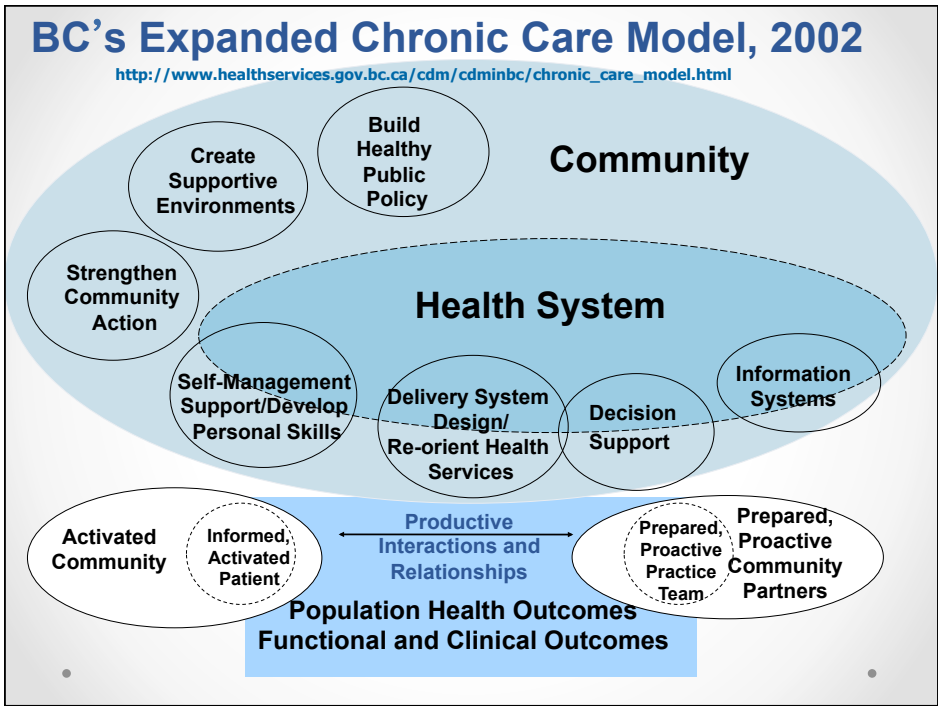
What's it look like for a person?

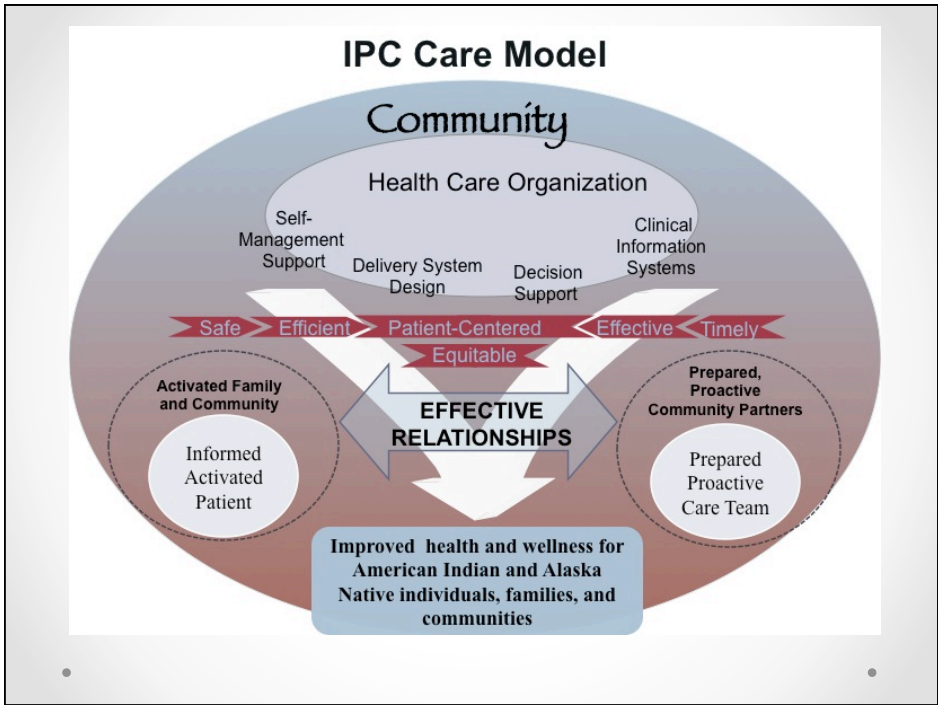

MH/SU
screening
seniors
asthma
CHF
COPD
prevention
frailty
obesity
diabetes
depression


Chronic Care Modell –
ein innovatives Konzept zur umfassenden Versorgung für chronisch Erkrankte
Gesundheitssystem
Organisation in der Gesundheitsversorgung
produktive Interaktionen
verbesserte Ergebnisse
Община
Ресурсы и политика
Система здравоохранения
Учреждение здравоохранения
Поддержка самоконтроля
Поддержка решения
Разработка системы оказания помощи
Клинические информационные системы
Подготовленная, упреждающая группа
Modelo de Atención a Crónicos
Comunidad
Recursos y Políticas
Sistema de Salud
Organización de la atención sanitaria
Apoyo en el autocuidado
Diseño del sistema de atención
Apoyo en la toma de decisiones
Sistemas de información clínica
Paciente informado y activo
Interacciones productivas
Equipo operativo preparado y proactivo
Resultados mejorados
Model for behandling af kron
1. Samfund
Resurser og politikker
3. Støtte til patientens egenomsorg
4. Organisering af sundheds-ydelserne
Informeret aktiv patient
Udbytterigt samarbejde
Velforberedt behandlerteam
Forbedrede resultater
sien hoidon rakenne
rveyspalvelut
Päätöksen-teon tuki
Kliiniset tieto-järjestelmät
Zorgorganisaties
Zorg-proces
Besluit-vorming
Klinische informatie-systemen
Tehokas vuorovaikutus
Valmentautunut aloitteellinen hoitotiimi
Geïnformeerde en geactiveerde patiënt
Productieve interacties
Voorbereid en pro-actief team van zorgverleners
Verbeterde uitkomsten



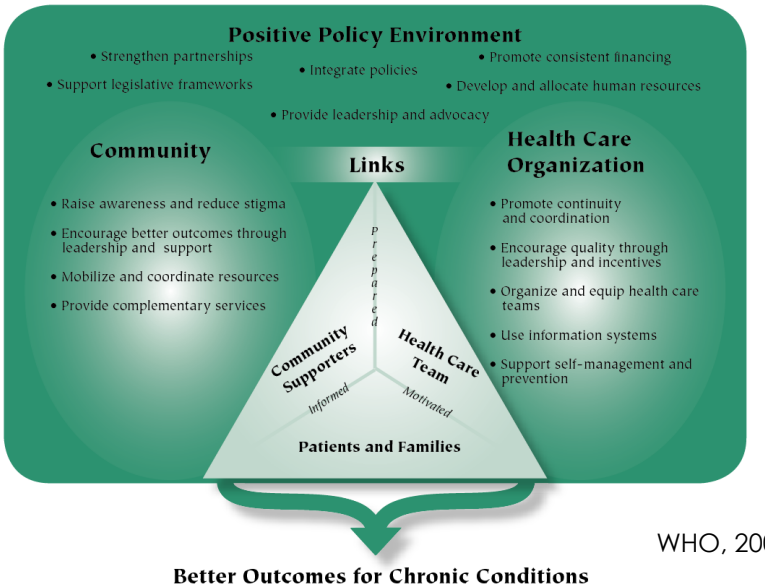
Adding Prevention and Public health


BC's Expanded Chronic Care Model, 2002
http://www.healthservices.gov.bc.ca/cdm/cdminbc/chronic_care_model.html
Build Healthy Public Policy
Create Supportive Environments
Community
Strengthen Community Action
Health System
Self-Management Support/Develop Personal Skills
Delivery System Design/ Re-orient Health Services
Decision Support
Information Systems
Activated Community
Informed, Activated Patient
Productive Interactions and Relationships
Prepared, Proactive Practice Team
Prepared, Proactive Community Partners
Population Health Outcomes
Functional and Clinical Outcomes

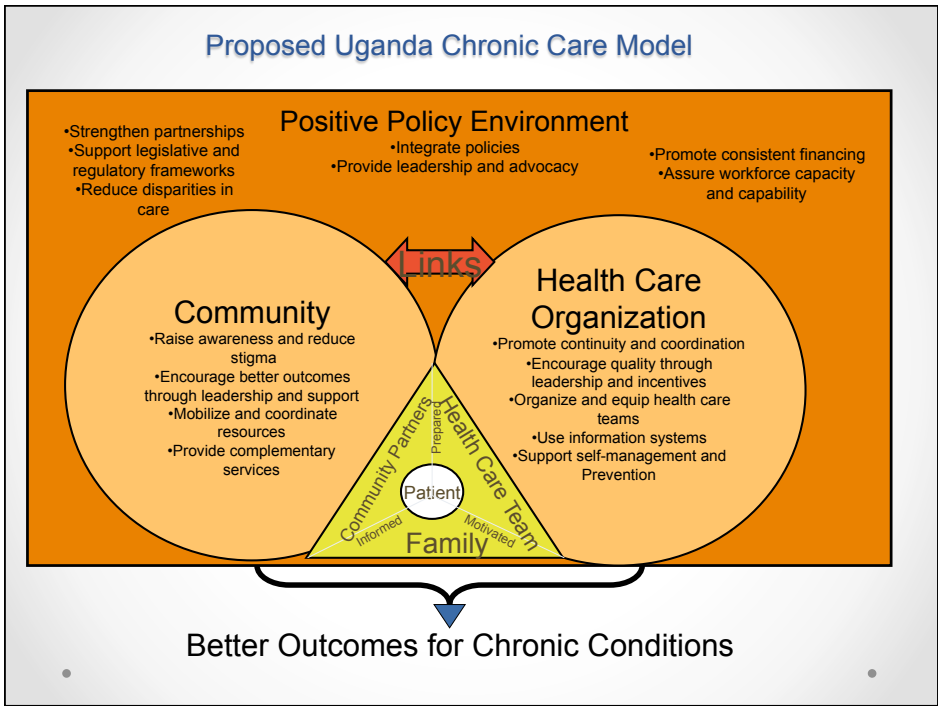

IPC Care Model
Community
Health Care Organization
Self-Management Support
Delivery System Design
Decision Support
Clinical Information Systems
Safe
Efficient
Patient-Centered
Effective
Timely
Equitable
Activated Family and Community
Informed Activated Patient
EFFECTIVE RELATIONSHIPS
Prepared, Proactive Community Partners
Prepared Proactive Care Team
Improved health and wellness for American Indian and Alaska Native individuals, families, and communities

Adding the policy level

Innovative Care for Chronic Conditions Framework



WHO, 2002



Evidence in Support of the CCM

- Cochrane diabetes review (Renders et al, 2001) supported four clinical elements
- Bodenheimer et al review (JAMA, 2002) used case studies and review of 39 studies
- Coleman et al (Health Affairs, 2009) studies referring to CCM since 2000
- Improving Chronic Illness Care Evaluation www.rand.org/health/projects/icice.html
- Assessment of Chronic Illness Care (Bonomi et al, Health Services Research, 2002)
- Patient Assessment of Chronic Illness Care (Glasgow et al, Medical Care, 2005)

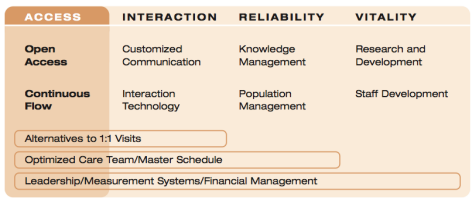
Where did the medical home come from?

Dates	redesign activity	other events in health care
1960-1969	medical home for ill children, POMR, EHR	PC named, NPs & PAs, Medicare & Medicaid
1970-1979	Primary Care Research Groups, SGIM	NCI, NIA, Managed Care, VA amb. care
1980-1989	AHCPR PC PBR	USPSTF
1990-1999	IHI's IDCOP, CCM, Microsystems, IPFCC	RVUs, hospitalists, determinants of hlth
2000-2009	AAFP promotes MH, joint principles, demos	Medicare part D

Kilo & Wasson, Health Affairs, 2010, Practice Redesign and the Patient-Centered Medical Home: History, Promises and Challenges

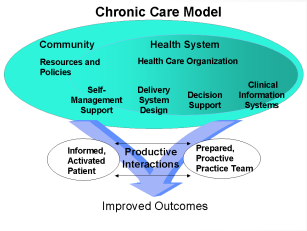
Model Amalgamation

IDCOP



\+

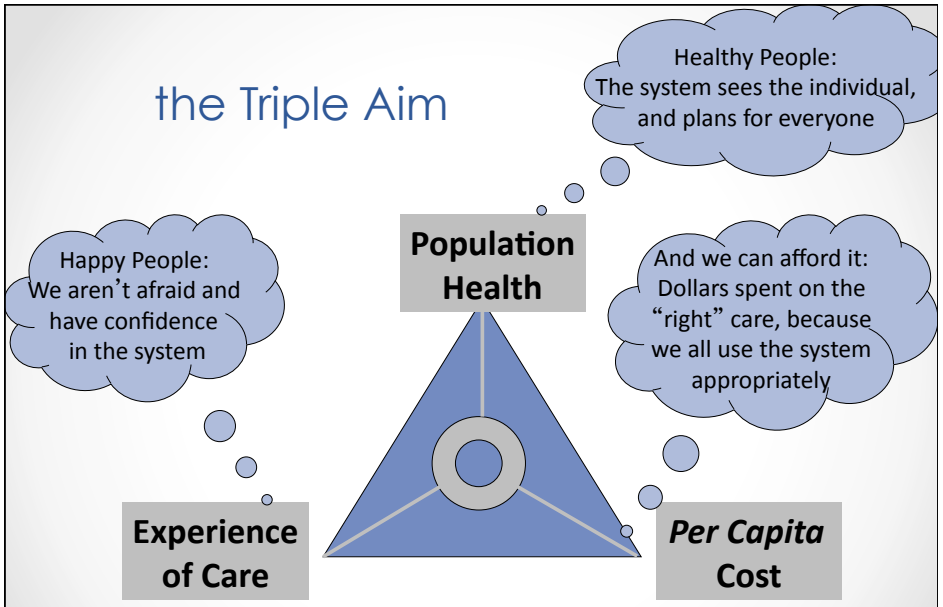
CCM



=

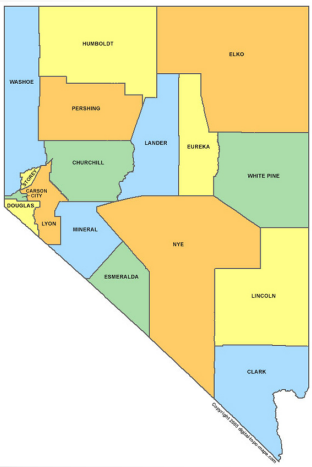
PCMH

the Triple Aim



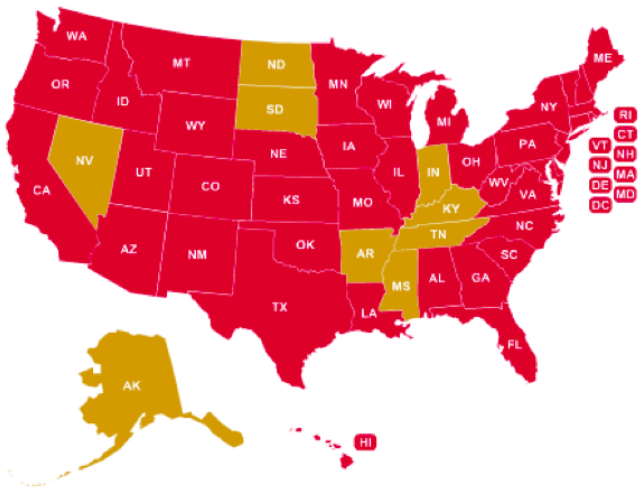
The Triple Aim, www.ihi.org

What can a state do?



- Collaborative improvement efforts in partnership
  - condition-specific collaboratives
  - PCMH (recent Commonwealth report by Kaye et al)
  - prevention
- Support for EB programs
  - Chronic Disease Self-management Program
- Policy changes
- Support the Triple Aim

Exhibit 1. The states shown in red have dedicated resources to advancing medical homes for Medicaid and/or CHIP enrollees between January 2006 and September 2011.



Kaye et al, 2011 The Commonwealth Fund

Is geographic improvement possible?

Indiana

- Health Commissioner and Medicaid Director to improve care for 80,000 chronically ill Medicaid recipients
- State leadership and money creating a Medicaid care system
- Statewide Collaborative Program PLUS
  -call center
  -community-based nurse care managers linked to practices
  -statewide Web-based patient registry
  -registry updated with claims data
  -collaboratives
  -embedded RCT
- Reported cost-savings to the Governor

courtesy of Mike Hindmarsh hindsighthealthcare@rogers.com

Is geographic improvement possible?

North Carolina

- State leadership and money has created a visionary Medicaid care system
- Measurement system, Guidelines, Physician networks, Care Managers, Collaboratives
- Financial rewards for participating
- Early results promising
- Plans to extend to include all patients regardless of insurance coverage

courtesy of Mike Hindmarsh hindsighthealthcare@rogers.com

Is geographic improvement possible? Washington State

- Diabetes Surveillance
- Regional Collaboratives
- Standard guidelines & payment reform
- Laid groundwork for PSHA

courtesy of Mike Hindmarsh hindsighthealthcare@rogers.com

Is geographic improvement possible?

Pennsylvania

NEWS ◆ NEWS ◆ NEWS ◆ NEWS ◆ NEWS

OFFICE OF THE GOVERNOR
COMMONWEALTH OF PENNSYLVANIA

Governor's Press Office ◆ Room 308, Main Capitol Building ◆ Harrisburg, PA 17120
www.governor.state.pa.us ◆ 717-783-1116 (Phone) ◆ 717-772-8462 (Fax)

EDWARD G. RENDELL, Governor

FOR IMMEDIATE RELEASE:
Sept. 17, 2007

CONTACT:
Chuck Ardo
717-783-1116

Beth Myers (GOHCR)
717-346-XXXX

GOVERNOR RENDELL APPOINTS MEMBERS TO CHRONIC CARE COMMISSION AS PART OF HIS PRESCRIPTION FOR PENNSYLVANIA

HARRISBURG – Governor Edward G. Rendell has appointed 37 Pennsylvanians to a commission that will work to improve how Pennsylvanians with chronic disease receive health care in the future. The initiative is part of the Governor's Prescription for Pennsylvania health care reform plan.

"About 78 percent of all health care costs in Pennsylvania are attributable to 20 percent of all patients – those with chronic diseases," Governor Rendell said. "The members of this Chronic Care Management Commission will be responsible for developing the process to effectively manage chronic disease across the state. We can't reduce the occurrence and cost of chronic diseases without aggressively addressing prevention, detection and treatment in a comprehensive, pro-active way."

- Started at the National Governors Association
- All the major players at the table
- Timeline & budget to make it happen

courtesy of Mike Hindmarsh hindsighthealthcare@rogers.com

Questions?

Resources

- www.improvingchroniccare.org
- www.commonwealthfund.org

Thank you!