

RISING RATES OF CHRONIC HEALTH CONDITIONS: WHAT CAN BE DONE?

By Alwyn Cassil

The growing prevalence of chronic health conditions—about 60 percent of the adult U.S. population had at least one chronic condition in 2005—has added costs to the U.S. health care system. Prevention and better management of chronic conditions are often cited as ways to improve health outcomes and slow U.S. health care spending growth—or at least generate better value for the \$2.1 trillion spent annually on health care in the United States. Yet, the health care system remains largely focused on acute, episodic care, according to experts at a Center for Studying Health System Change (HSC) conference titled, Rising Rates of Chronic Health Conditions: What Can Be Done? Panelists explored the role of obesity in rising rates of chronic conditions, the need for better information on how to treat patients with multiple chronic conditions, how to help patients improve self-management skills and how difficult changing unhealthy behaviors can be.

U.S. Health Care System Focused on Acute Care Not Chronic Conditions

In some respects, America's rising rates of chronic conditions reflect the huge advances in public health, industrial safety and medical care over the last century. A hundred years ago, most people didn't live long enough to develop a chronic condition. In 1900, an average American's life expectancy was 47 years; today it's 78 years. A hundred years ago, the top causes of death were infections—such as pneumonia, influenza and tuberculosis—accidents and child birth.

Today, the leading causes of death are heart disease, cancer and stroke. While advances in public health and medical care have been spectacular, the U.S. health care system is behind the times when it comes to providing early intervention and high-quality care for people with chronic conditions.

"We have a system that remains focused on providing acute episodes of care. We're pretty good at treating a heart attack, but

not so good at preventing and managing the underlying heart disease that leads to that heart attack," said HSC President Paul B. Ginsburg, who moderated the conference.

Tremendous attention has been focused on identifying effective clinical care for individual chronic illnesses, such as heart disease or diabetes, but more than one in four Americans has two or more chronic conditions, according to panelist Carolyn Clancy, M.D., director of the Agency for Healthcare Research and Quality.

"Where our evidence base is pretty thin is how to manage effectively people who have several chronic illnesses, particularly people for whom one of those illnesses is a mental health disorder," she said.

"When you're looking at people with multiple conditions, you've not only got interactions between illnesses and between treatments, you've got people on multiple medications, multiple providers...so many

[providers] that it's really hard to imagine that there's a common script across this array of clinicians," Clancy continued.

The Economics of Obesity

Two-thirds of Americans are overweight or obese, and the prevalence of obesity—a clear risk factor for many chronic diseases—has more than doubled in the United States in the last three decades, according to panelist Eric Finkelstein, an economist at RTI and author of *The Fattening of America: How the Economy Makes Us Fat, If It Matters, and What to Do About It*.

As cheap and fattening food abounds, Americans have steadily increased their caloric intake, Finkelstein noted, saying, "The argument that I'm selling is—the increase in food consumption is a direct result of a decrease in food prices, both the monetary price of food, as well as the opportunity or acquisition cost of getting



“The impact of information about the downside of obesity is not going to be on individuals changing their behavior as much as setting the stage for the other public policy interventions that may be more effective.”

—Paul B. Ginsburg, Center for Studying Health System Change

“We get better and better at acute intervention, to the point where it's actually hard to measure mortality rates in many institutions and the complication rates keep going down. However, our luck in collaborating with patients to get them to adhere to recommended medications after they're discharged for these procedures, as far as I can tell hasn't budged at all, and it's pretty dismal.”

—Carolyn Clancy, M.D., Agency for Healthcare Research and Quality

“By virtue of the purchasing leverage that Medicaid and Medicare combined have as purchasers of publicly financed care, and the complexity of the patient population, it's a tremendous area to make a difference and to begin to learn what's going to impact both quality and cost outcomes.”

—Melanie Bella, Center for Health Care Strategies

that food into your mouths.”

Flipping to the caloric expenditure side of things, Finkelstein pointed out that leisure-time physical activity is losing out to new technologies, such as DVDs, the Internet, cable TV and computer games. The same is true for “accidental exercise,” or the exercise people typically used to get through the work day, he said, adding, “You'd have to think pretty hard to find an occupation that hasn't been mechanized to the extent that you get almost no physical activity at all—so accidental exercise is almost nonexistent.”

New technologies, such as statins to control high cholesterol, have helped reduce some of the adverse health consequences of obesity over time, Finkelstein said, citing a recent study that found today's obese population has a better cardiovascular disease profile than normal-weight individuals did several decades ago.

“The changing economy has lowered the cost of food consumption, price and non-price, raised the cost of physical activity in terms of the opportunity cost, as well as being physically active on the job, and that's essentially lowered the health cost of being obese,” Finkelstein said. “These three factors have really combined to create an environment where we would expect to see rising rates of obesity, which is exactly what we've seen.”

While obesity is clearly costly on many levels, Finkelstein urged caution against citing the high cost of obesity as justification for public obesity interventions because public-funded, cost-saving interventions for obesity “just don't exist.”

Instead, Finkelstein suggested that the government's role in stemming obesity should be to examine “past policies that probably helped promote obesity rates... agricultural subsidy policies, for example, even zoning policies that essentially encourage people to use automobile transportation as opposed to other forms of transportation.”

Medicaid: Train Wreck or Land of Opportunity?

Nowhere does the cost of chronic conditions hit harder than for the approximately 7 million people who are dually eligible for Medicaid and Medicare, according to

panelist Melanie Bella, senior vice president at the Center for Health Care Strategies, a nonprofit that works with state Medicaid programs to improve care for enrollees with costly and complex health needs.

The so-called dual eligibles account for about 42 percent of Medicaid costs and 25 percent of Medicare costs, Bella said. Among the most expensive 1 percent of Medicaid enrollees, 83 percent have three or more chronic conditions and 60 percent have five or more chronic conditions.

“So you might look at this and think, this is a train wreck, what in the world are we going to do about this,” Bella said. “We look at this and say Medicaid is the land of opportunity. There is no better place to tackle chronic illness than in Medicaid.”

Echoing Clancy's point about the need to identify effective interventions for patients with multiple chronic conditions, Bella said, “Medicaid and Medicare have realized you cannot do single-disease, silo disease management programs, yet trying to figure out how to go from that all the way to a program that's going to be responsive and nimble to every single beneficiary's needs regardless of the set of chronic conditions was fairly overwhelming.”

Many states are moving to identify “high-opportunity” beneficiaries and develop tailored care management interventions, she said, but states face formidable challenges, including:

- Most high-need, high-cost beneficiaries get their care in a fragmented fee-for-service environment.
- Reimbursement rates are generally insufficient to support complex care management.
- Medicaid's financing structure makes it difficult to invest in long-term solutions because of pressure to show immediate cost savings.
- Misaligned payment incentives between Medicare and Medicaid result in cost shifting and poor quality. For example, Medicare pays for hospital care, while Medicaid covers nursing home care, so if better care coordination prevents a Medicaid nursing home patient from hospitalization, the savings accrue to Medicare rather than Medicaid.

“The majority of folks in Medicare and Medicaid who are the highest cost and have the highest needs...are still in a very fragmented, uncoordinated fee-for-service system. The very folks who need it the most are stuck, arguably, in the worst place,” Bella said.

Employer Initiatives

While more and more employers are adopting health promotion and wellness programs, panelist Ron Goetzel, Ph.D., director of the Institute for Health and Productivity at Emory University, questioned whether most employer programs are effective.

“We’re seeing a sea change in terms of the number of employers that are beginning to think about and implement these kinds of programs in the workplace,” Goetzel said. “The main problem out there is that they don’t know how to do it well.”

Noting the strong link between modifiable health risk factors—such as smoking, diet and uncontrolled high blood pressure—and chronic conditions, Goetzel said the evidence is growing that workplace health promotion and disease prevention programs can be effective.

“There’s a growing body of literature that suggests that if you do things that are evidence-based, well-designed, well-implemented and well-evaluated, that these kinds of programs can improve workers’ health, lower their risk for disease, save businesses money by reducing health-related loss and limiting absence and disability, heighten work morale and work relations, and improve worker productivity,” he said.

Efforts to improve workplace wellness initiatives could include identifying and disseminating best practices, establishing public-private technical assistance services, and funding large-scale studies to evaluate the effectiveness of different interventions, he said.

“There’s a lot of ignorance out there in terms of what works and what does not, and a lot of things that don’t work are being put in place in these companies,” Goetzel said. “So there is a lot of knowledge that can be distributed, disseminated, communicated to organizations that want to put these programs in place.”

Redesigning Care

Existing research consistently finds that the U.S. health care delivery system generally does a “poor” job of helping patients with chronic conditions get their diseases under control, according to panelist Michele Heisler, M.D., an associate professor of medicine at the University of Michigan and research scientist at the Veterans Affairs Health Services Research and Development Center for Excellence.

Numerous studies show that patients with chronic conditions are not on the right medications at the right doses, Heisler said. And, and even when providers prescribe the correct medications, research also shows that only about 50 percent of patients with chronic conditions take their prescribed medications, and the numbers are even worse for diet and exercise.

“The costs of this are huge,” Heisler said. “Just counting unnecessary emergency room admissions and preventable hospitalizations, the costs of poor medication adherence alone is greater than \$100 billion a year...drugs don’t work in patients who don’t take them.”

Patient self-management is an essential component of good chronic care, Heisler said, adding that “chronic disease outcomes depend critically—once patients are on the right medications, once they get appropriate advice and support for self-management—on what they have to do between office visits.”

Citing an Institute of Medicine report on the quality of U.S. health care, Heisler said physicians and patients are working as hard as they can “but current care systems cannot do the job, we have to change systems.”

At the physician-practice level, Heisler suggested efforts to redesign care should focus on four key components of the Wagner Chronic Care Model:

- Delivery system design (who’s on the health care team and how do we interact with patients).
- Decision support (what is the best care and how do we make it happen every time).
- Clinical information systems (how do we capture and use critical information for clinical care).



“There is a role for government and policy to highlight and accentuate the [employer health and wellness] programs that actually work, that are effective, and to measure the heck out of them, and to document that these programs are effective as opposed to relying upon anecdotal evidence, which often times is wrong or misleading.”

—Ron Goetzel, Emory University and Thomson Reuters

“Incentives matter, as a number of the economists have stressed, and I think we all have to look at the fact that reimbursement does not reward prevention, reimbursement rewards high-tech procedures once complications have occurred.”

—Michele Heisler, M.D., University of Michigan and Department of Veterans Affairs

“Consumers believe that more care is better care. So when people believe that more care is better care, it’s hard to accept that evidence says it’s otherwise... The point of figuring this stuff out is not to say that consumers can’t get this, they’re not capable of understanding this—of course they are. The point is we have to understand where they are to communicate more effectively with them.”

—Kristin Carman, American Institutes for Research

This Issue Brief is based on an HSC conference—*Rising Rates of Chronic Health Conditions: What Can Be Done?*—held July 31, 2008, in Washington, D.C. A full transcript of the conference is available at www.hschange.org.

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- Self-management support (how we help patients live with their conditions and make behavioral changes to improve health).

“Ideally what we’re looking for is well-organized, efficient practices, satisfied patients on the right medication with excellent self-management and healthy behaviors, and satisfied providers able to provide outstanding patient care without feeling overwhelmed,” Heisler concluded.

Involving Patients

A key element of improving care for people with chronic conditions is improved self-management, several panelists noted. “We need self-management support—how we help patients live with their conditions and make behavioral changes to improve health,” Heisler said.

The learning curve for patients is likely to be high since many are unfamiliar with such concepts as evidence-based care and clinical guidelines, said panelist Kristin Carman, co-director of the Health Policy & Research Program at the American Institutes for Research.

“If you think about it, and this is not just true for people for chronic disease, we want people to be using and applying information about staying healthy, preventing disease and managing disease,” Carman said, adding that “consumers are not always on the same page” as employers, insurers and others who are pushing consumers to be more involved in their care.

“So when you say guidelines suggest you do this, guidelines suggest you do that, this is what many of them have in their head: ‘These are about restrictions on my choice. They’re designed to protect everyone but the patient. They represent an inflexible, one-size-fits-all approach. I’m an individual,’” Carman said.

As part of a recent project to design an employer toolkit to communicate with employees about evidence-based care, Carman and her colleagues surveyed people about how active they were in managing their health. About three-quarters of the respondents said they were attempting to make a lifestyle change to improve their health, with about half of those saying the change was moderate and about 40 percent

reporting the change was small or very small.

“The bad news is, no matter how they viewed it, they all thought it was hard or very hard...” Carman said. “If people’s self-conception is virtually everything they’re trying to do is hard, it’s not very likely they’re going to do it or be able to sustain it.” ■

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