

Strategies for Chronic Disease Management

In 1989 when Mary Jane Osmick, MD, met patient Mary Ryan, a 77-year-old woman with severe congestive heart failure, Ms. Ryan expressed clear ideas about how she wanted to live out her life: she would not go to the hospital, she would have her hair done every week, and she would wear the colorful clothes she loved. Working with Osmick, Mary Ryan was hospitalized, briefly, only three times in several years. This experience opened Osmick's eyes to the possibilities of disease management for chronically ill persons. "I realized," she said, "that we could treat patients as they wanted to be treated."

Today Osmick is clinical director of chronic disease management at Crozer-Keystone Health System, Upland, PA. At the 1997 conference of the National Chronic Care Consortium in September in Minneapolis, Osmick and her colleagues shared what they have learned from developing Crozer-Keystone's disease management program.

MISSION: IMPROVE PATIENT FUNCTION

The system, which comprises five hospitals, several long-term care facilities and primary care clinics, an HMO, and a 150-physician network, began its chronic disease management efforts about seven years ago, explained Ian Jones, MD, the system's vice president for clinical integration. The system wanted to fulfill its mission to improve the functional status and performance of patients and respond to market pressures to reduce the cost of care. Jones pointed out that although disease management reduces the cost of care, improves physician productivity (since the sickest patients account for the most costs), and provides a competitive advantage, it also lowers hospital revenue and physician income. And many disease management interventions (e.g., putting up railings to reduce accidents) are not reimbursed, Jones noted, "so the key driver is global risk."

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agement roles, Jones predicted, because physicians control about 90 percent of care. Enrollees in health plans will drive the need for disease management, and costs will stabilize. Physician performance will be measured through outcomes, he said.

SUCCESSING IN DISEASE MANAGEMENT

"You must have proof of outcomes," agreed Susan Baseman, MSN, "or the process falls apart." Baseman develops disease management initiatives in her role as Crozer-Keystone's director of disease management programs. Key to success for disease management efforts is a shared vision by persons at all levels of the organization. The vision must be patient centered and include the goals of care and treatment, she said.

She advised persons planning a disease management program to:

- Find a champion in administration
- Obtain a formal place on the organizational chart
- Ensure the program is part of the organization's strategic plan and mission

Having an Office of Disease Management was critical to the success of Crozer-Keystone's disease management initiatives, Baseman said. The office, which is the "connecting thread between sites, programs and providers," is a central repository for data. It also coordinates resource (e.g., personnel) sharing, marketing efforts, and partnerships. Baseman recommended using both internal and external partnerships rather than creating a whole new disease management staff.

Steering Committee A steering committee guides the Office of Disease Management. The committee is made up of physicians (subspecialists and primary care); heads of disciplines such as pharmacy and nursing; and representatives from administration, information services, finance, and all care sites. Baseman strongly supports the use of a steering committee as a way to bring together people from many cultures to discuss common care goals, share ideas and lessons, communicate

plans, and create common processes. The group's main job, she said, is to create a shared vision for chronic disease management throughout the organization. The steering committee also conveys patient-related and other issues to governing bodies, and acts as a "creative brain trust" that comes up with ways to provide better care.

SASI The health system used NCCC's Self-Assessment for Systems Integration tool to clarify where it should put its resources. A SASI governance group of 12 top executives also ensures systemwide buy-in for disease management.

Benchmarks Baseman advised those creating disease management programs to set time lines for creating programs and to consistently evaluate the programs' cost, outcomes, and delivery.

BUY OR MAKE A PROGRAM?

In planning a disease management program, Osmick said, organizations must decide whether to buy a program or create their own. Making a program has several advantages: The organiza-

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tion controls and owns the program, staff are more likely to accept it, and the program can be changed to correct mistakes. On the downside, she said, although buying a program can be costly, making one requires extensive time and resources. "There's a huge learning curve," Osmick said, and sustaining momentum can be difficult because group process is arduous.

PITFALLS TO AVOID

She warned of potential barriers to success:

- Lack of systemwide integration
 - Rivalry between primary care physicians and specialists
 - Noncompliance by indigent patients because they lack transportation or child care, for example
- Osmick recommended that the emergency department be involved in the disease management program. She also advised tackling an especially costly disease process (e.g., HIV infection) only after gaining experience with less complicated chronic illnesses.

—Judy Cassidy

BARRIERS TO AN INTEGRATED HEALTHCARE SYSTEM

Chronic care is the highest-cost, fastest-growing area of healthcare, and it will be for the next 30 years, predicted Richard Bringewatt, president of the National Chronic Care Consortium, Bloomington, MN. Setting the stage for a panel discussion at the organization's conference, Bringewatt noted that the current delivery system fails to address the needs of chronically ill people. Like participants at a New England town hall meeting, a group of healthcare leaders expressed a variety of viewpoints about the source of the problem and its solution.

Bringewatt said chronic illness is ongoing, involves an array of professional and paraprofessional caregivers, and includes disability. The solution requires a "trioocular view"—acute care for episodic, high-tech care; long-term care for "care over cure"; and managed care for wellness and prevention. Collaboration among these sectors is needed to overcome care fragmentation, Bringewatt said.

"Structural reform in how we finance healthcare" is also needed, said Sheldon Goldberg, president, American Association of Homes and Services for



Panelists Thomas Adams, CEO, Medical Group Management Association; William Cox; and Sheldon Goldberg (left to right) discuss systemic solutions for serving the chronically ill.

the Aging, Washington, DC. He called for defining healthcare broadly and changing economic incentives that reward only the institutional model of care. Models of practice in settings other than the hospital and physicians' offices are needed, he said.

"Historically, individual healthcare sectors have had limited trust for each other," noted Charles Hawley, vice president, continuum development and long-term care, Sisters of Providence Health System, Seattle, who moderated

the session. Fragmentation in funding sources causes fragmentation in service delivery, added William Cox, executive vice president, Catholic Health Association. This lack of integration in delivery reinforces "traditional cultural barriers that have always existed," he said. "It's going to require us, in forums like this, to constantly come back to why we're doing [healthcare]. We're doing it because our clients—the chronically ill person and his or her caregivers—need us to do it."

—JC