Center for Education, Research & Advocacy

A DIVISION OF HOWARD BROWN HEALTH

CHRONIC DISEASE MANAGEMENT: IMPACT OF COVID-19

WHAT IS THE PATH FORWARD?

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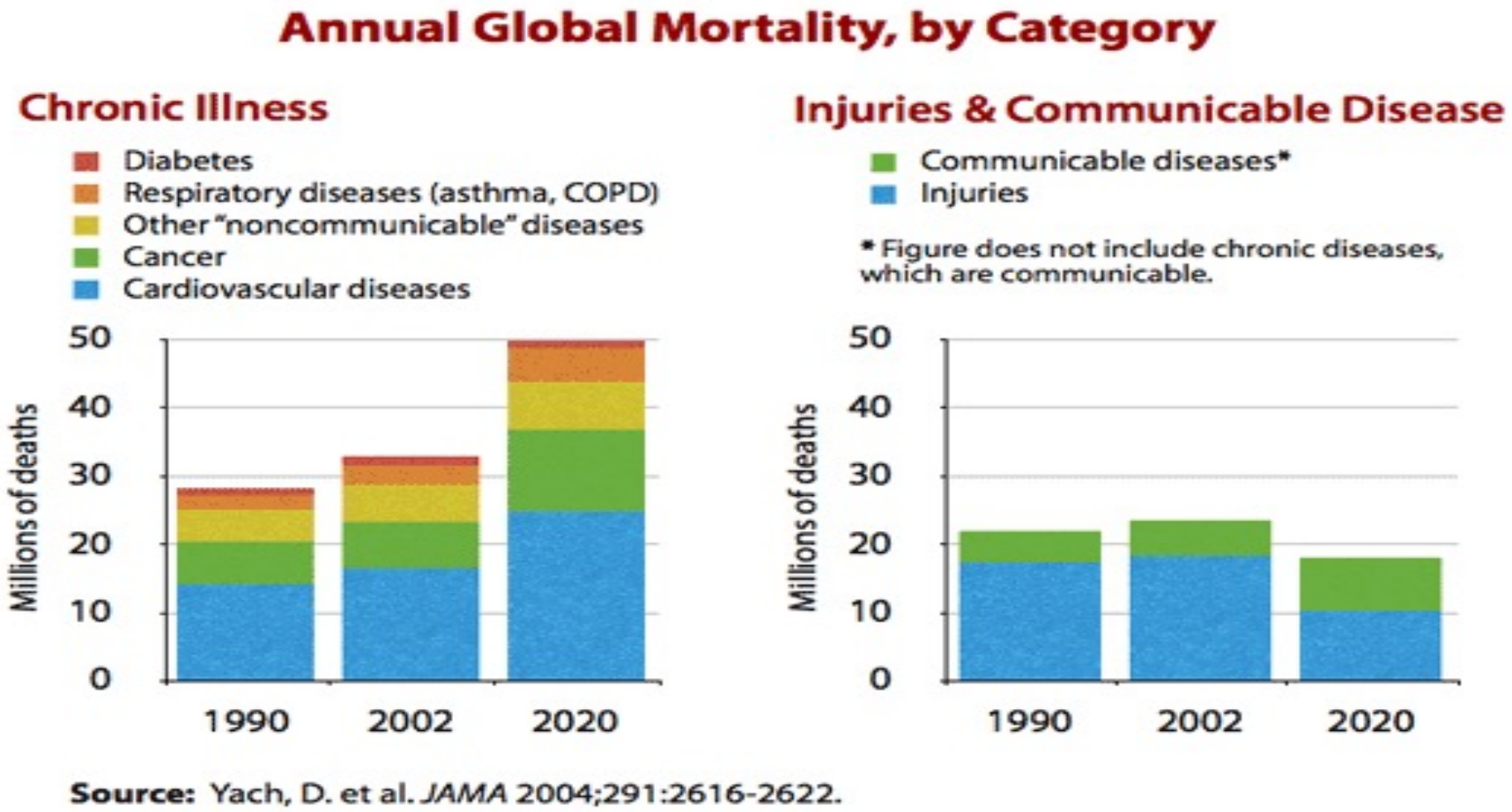
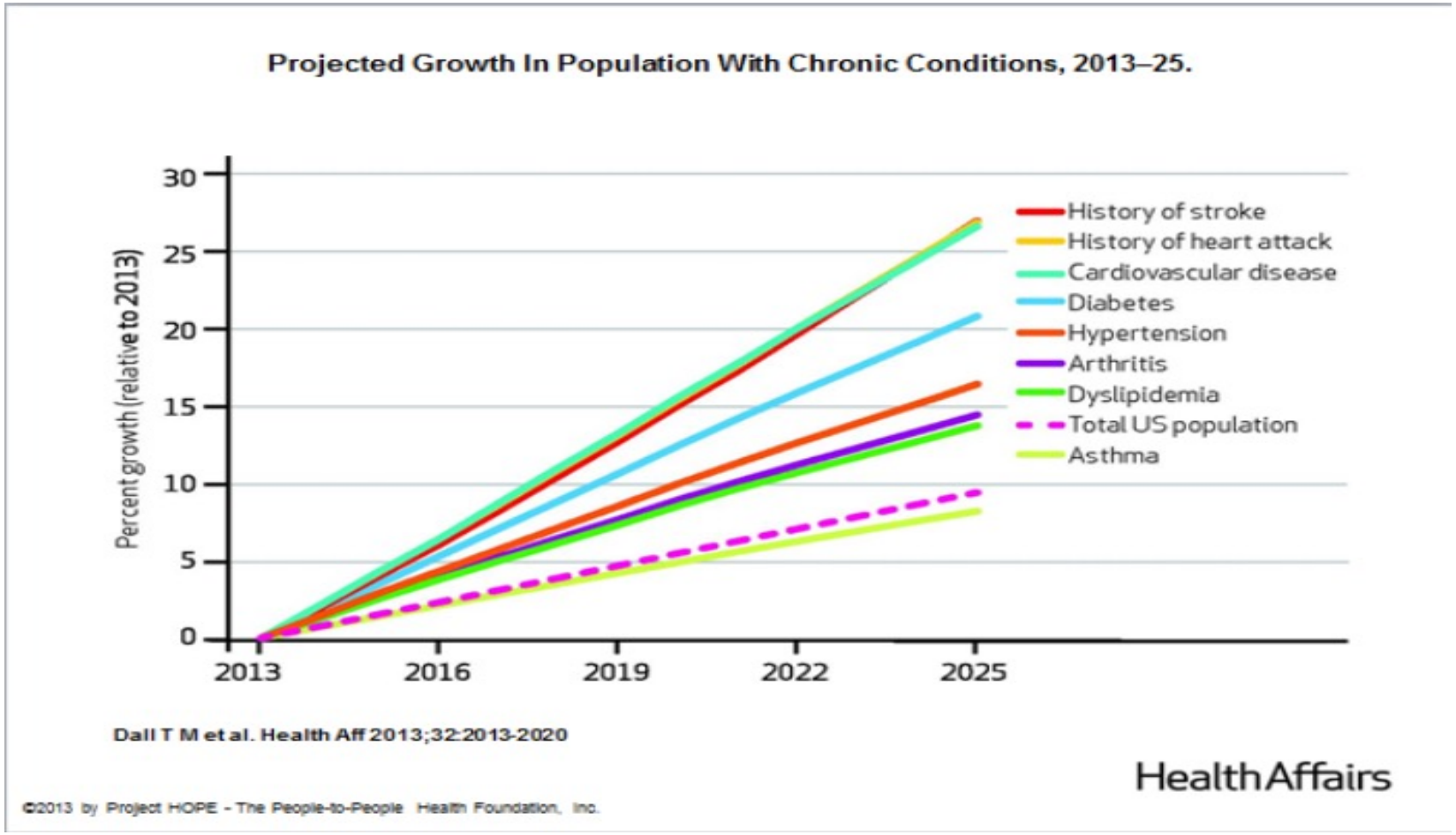
- The Cost of Chronic Diseases
- COVID -19 and the Health Debt
- HIV and COVID-19: the Intersection of Two Pandemics
- Social Determinants of Health and COVID-19
- The Path Forward

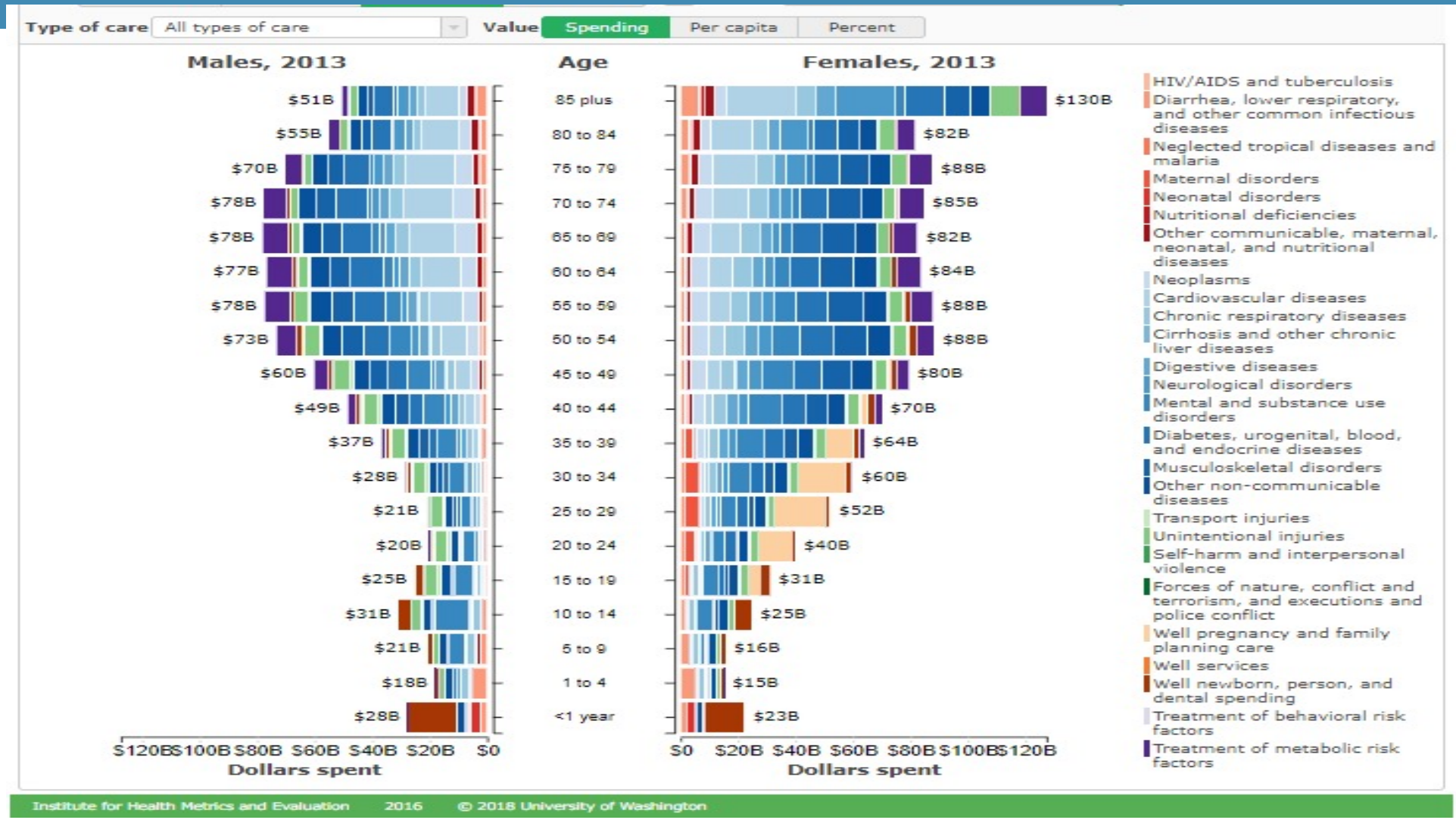
HIGH ANNUAL GLOBAL COST OF CHRONIC DISEASES



CONTINUED INCREASE IN POPULATION WITH CHRONIC CONDITIONS



MODELED ESTIMATE OF US HEALTH SPENDING 1996-2013



MULTIPLE CHRONIC DISEASES

- Present in
  - 1 out of 4 Americans
  - 2 out of 3 Medicare beneficiaries
  - >90% of highest-cost decile of Medicaid recipients

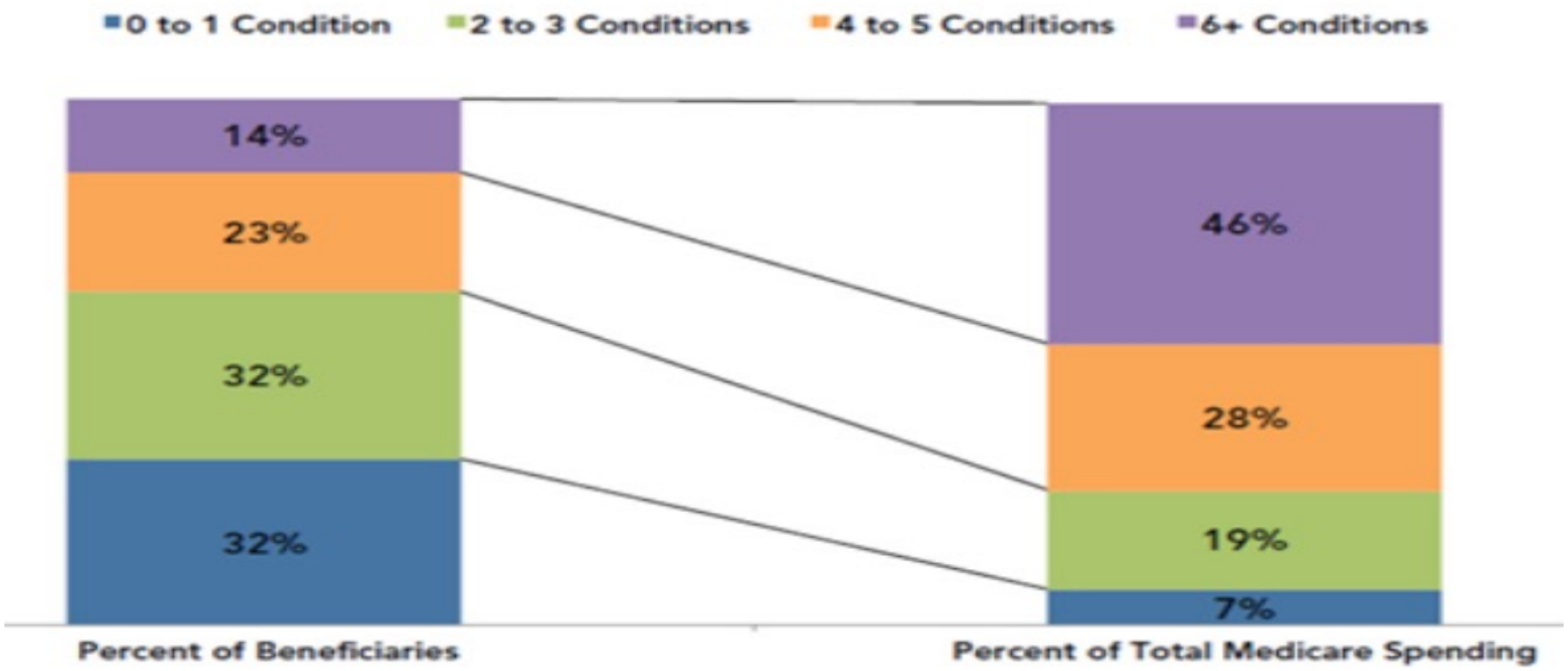
- Approximately 2/3 of total health care spending is associated with care for individuals with multiple chronic conditions.

- The average chronically ill Medicare beneficiary sees 13 different physicians and fills 50 unique medications per year

Anderson G. Chronic Care: Making the Case for Ongoing Care. RWJF 2010
Chronic Conditions among Medicare Beneficiaries, Chart Book. CMMS 2011
Kronick, Bella, and Gilmer. Faces of Medicaid III. CHCS 2009

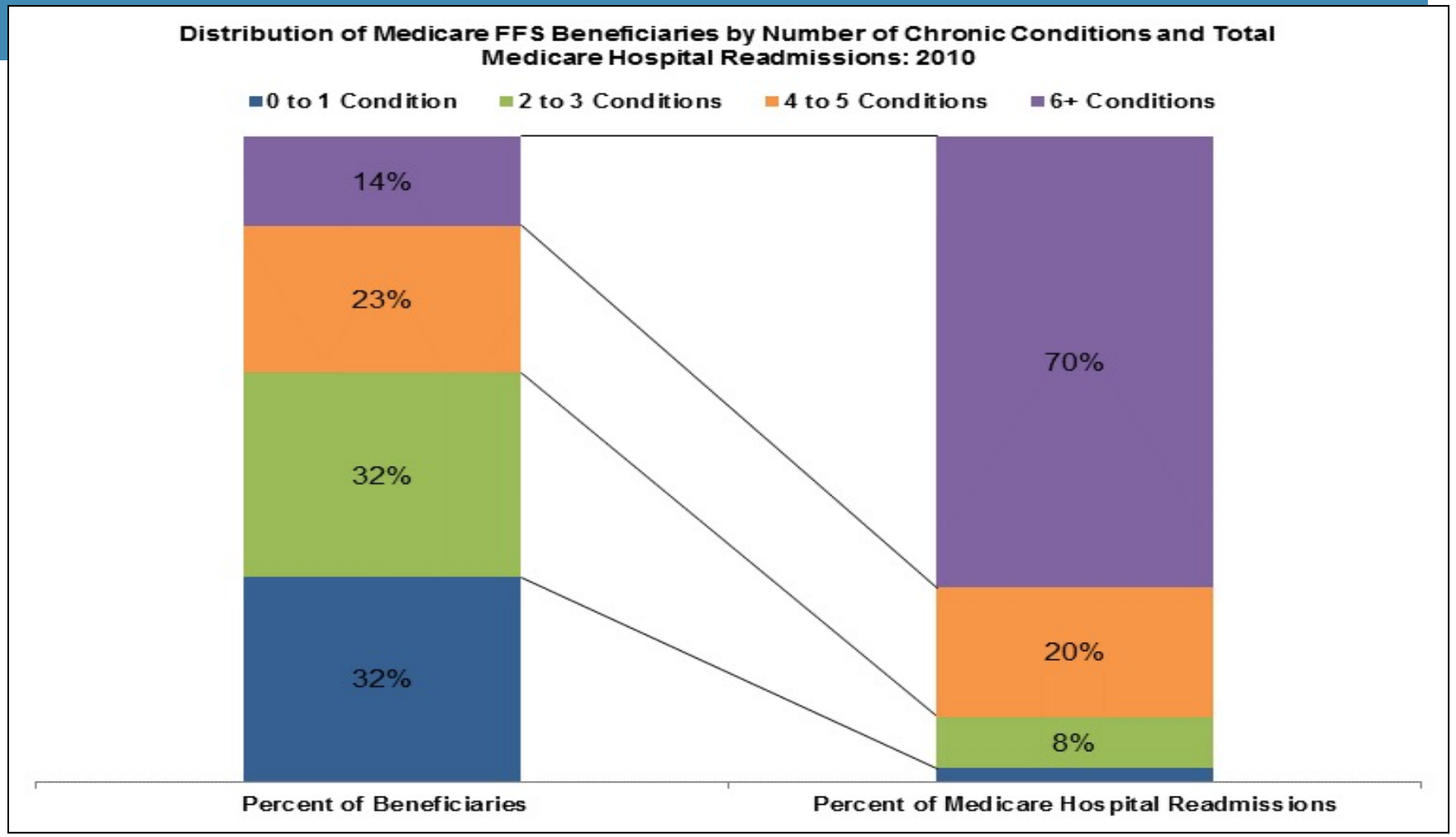
MEDICARE BENEFICIARIES WITH 4+ CC ACCOUNT FOR 37% OF POPULATION, 74% OF COSTS

Figure 3.2 Distribution of Medicare FFS Beneficiaries by Number of Chronic Conditions and Total Medicare Spending: 2010



Source: Centers for Medicare and Medicaid Services. Chronic Conditions among Medicare Beneficiaries, Chart book: 2012 Edition Baltimore, MD. 2012.

BENEFICIARIES WITH 6 OR MORE CHRONIC CONDITIONS ACCOUNT FOR 70% OF READMISSIONS



Source: Centers for Medicare and Medicaid Services. Chronic Conditions among Medicare Beneficiaries, Chart book: 2012 Edition Baltimore, MD. 2012

COST IN PHYSICIAN TIME FOR CHRONIC DISEASE MANAGEMENT

- For a typical primary care patient panel of **2,500 individuals**
  - Fully satisfying U.S. Preventive Services Task Force **preventive services** recommendations would require **7.4 hours** per working day. (Yarnall et al., AJPH, April 2003)
  - Guideline-recommended care for the **top 10 chronic diseases** would require 3.5 hours per day if well controlled; **10.6 hours** per day if uncontrolled. (Ostbye et al., Annals of Fam Med, May-Jun 2005)

THE HEALTH DEBT: WHAT IS IT?

- The accumulated impact of changes in health behaviors during the pandemic that will have long-term negative effects on health.
- Causes include:
  - Shelter in place orders with closing or limited hours of outpatient centers
  - Delay of non-urgent appointments
  - Safety protocols limiting access to health care providers
  - Fear of being exposed to SARS-CoV-2
  - Loss of employer-sponsored health and dental insurance
  - Unemployment due to pandemic

DELAYS IN CARE: THE REALITY

- By June 2020 an estimated 41% of U.S. adults had delayed or avoided medical care, including urgent care or emergency care (12%) or routine care(32%) due to COVID-19 concerns
- Avoidance of urgent or emergency care more prevalent among unpaid caregivers for adults, persons with chronic medical conditions, Black adults, Hispanic adults, young adults, and persons with disabilities
- In 2020 Cancer screenings dropped dramatically.
  - One study of 20 institutions showed a decrease of 89% in breast cancer screenings for the first half of 2020 compared to 2019, and a decrease of colorectal cancer screenings by 85%
  - Another study of 60 health care organizations covering 306 hospitals showed a drop in colorectal cancer screenings of 86% and screening for breast and cervical cancer drop by 94% While the numbers have rebounded, they remain below pre-pandemic levels

MMWR 2020;69:1250-1257
JCO Clinical Cancer Informatics 2020:4, 657-665

WORSENING HEALTH BEHAVIORS

- Approximately 43% of Americans report having worse exercise habits now compare to before the pandemic
- 31% Americans report worse diet habits
- 31% Americans report that financial hardship has prevented them from seeking health care in the last 3 months
- 11% of American adults have delayed dental care due to concerns
- A study of 2 large health centers showed that LDL, cholesterol, and HgbAIC testing dropped by 81-90%
- New medication prescriptions to manage high cholesterol and high blood sugar fell by 52-60%

NACDD COVID Resilience Dashboard

DELAYS IN HIV CARE – THE INTERSECTION OF TWO PANDEMICS

- World-wide, projections from UNAIDS show that COVID-19 related disruptions in HIV care may lead to 123,000 to 293,000 additional HIV infections and 69,000 to 148,000 additional AIDS-related deaths globally from 2020-2022
- From January 2020 to June 2020 there was only a 2.4% increase in people on ART, compared with a 4.8% treatment coverage increase from January 2019 to June 2019.
- In the U.S., COVID-19 has impacted every component of the HIV care continuum.
  - CBOs challenged by resource shortages, disruption to patient-centered service provisions, pivoting of staff to COVID-19 related activities
  - Rise of telehealth services, at home HIV testing, home deliveries

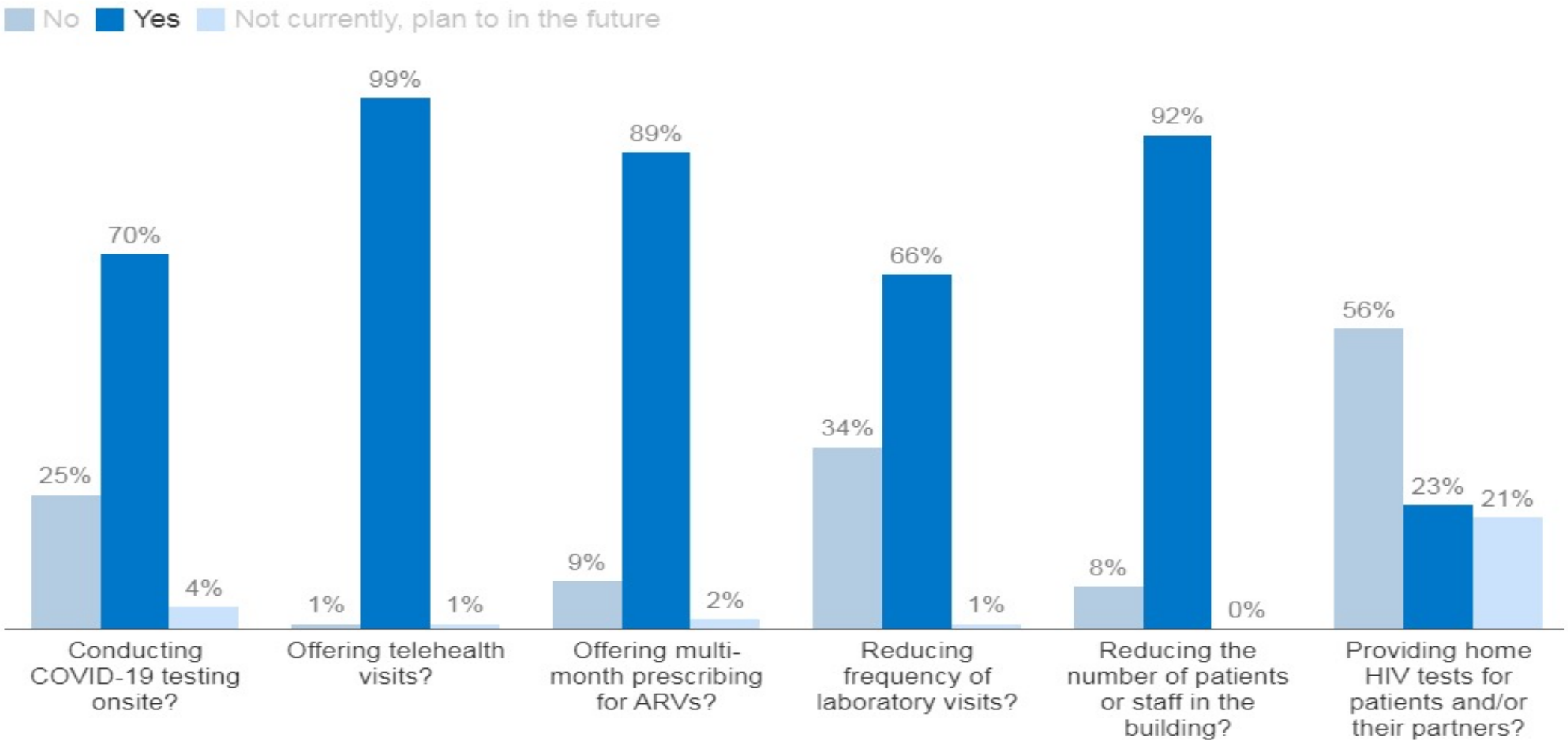
NATIONAL SURVEY OF RYAN WHITE PROVIDERS (161 RESPONDENTS OF 390 GRANTEES)

- Respondents described an immediate pivot to new ways of providing HIV care and prevention during the early months of the pandemic.
  - 99% offering telehealth, up from 22% in the past, and conducting about half of patient visits virtually. However, the "digital divide" means telehealth services are not an option for all patients.
  - 89% are offering multi-month prescriptions for antiretrovirals (ARVs
  - Seven in ten (70%) are conducting onsite COVID-19 testing.
- 30% reported an increase in new clients and nearly 40% of respondents saw a change in payer mix, primarily an increase in clients who were uninsured, followed by private coverage losses, and then increases in clients with Medicaid.

https://www.kff.org/report-section/delivering-hiv-care-prevention-in-the-covid-era-a-national-survey-of-ryan-white-providers-issue-brief/

Figure 3

Respondents report taking a range of steps to address the pandemic



NATIONAL SURVEY RESULTS, CONTINUED

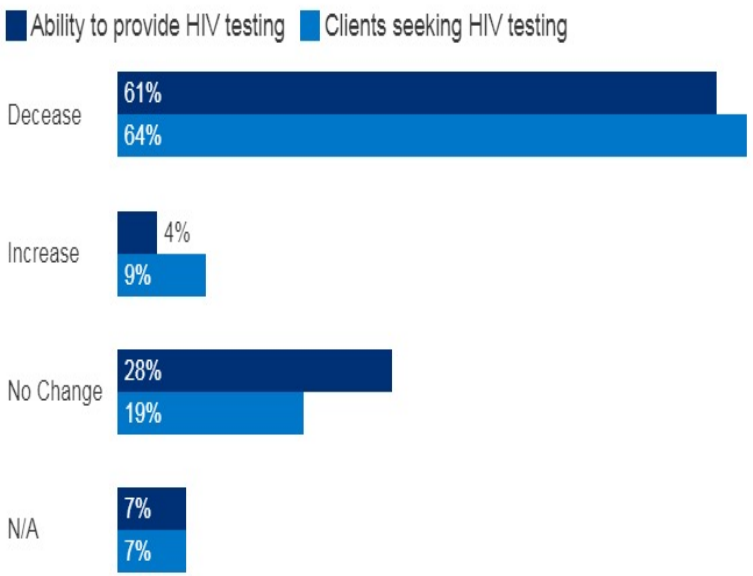
- Respondents report that clients face significant stress, noting job loss, declines in mental health, and decreased access to support services
- Respondents also experienced significant challenges related to staffing including staff layoffs, furloughs or reduced staff hours. Low staff morale reported by 74%
- 28% shut down all or most of their HIV prevention services in response to the pandemic. Other challenges included difficulty connecting with service partners and increased costs.
- However, despite these historic challenges, respondents largely report adjusting to a "new normal" and significant resiliency in adapting to new ways of providing care.

IMPACT ON HIV PREVENTION SERVICES

Figure 14

Client demand for and ability to provide HIV testing have decreased in the COVID-19 era

Since the beginning of the COVID-19 pandemic, has your program seen an increase, decrease, or no change in each of the following?



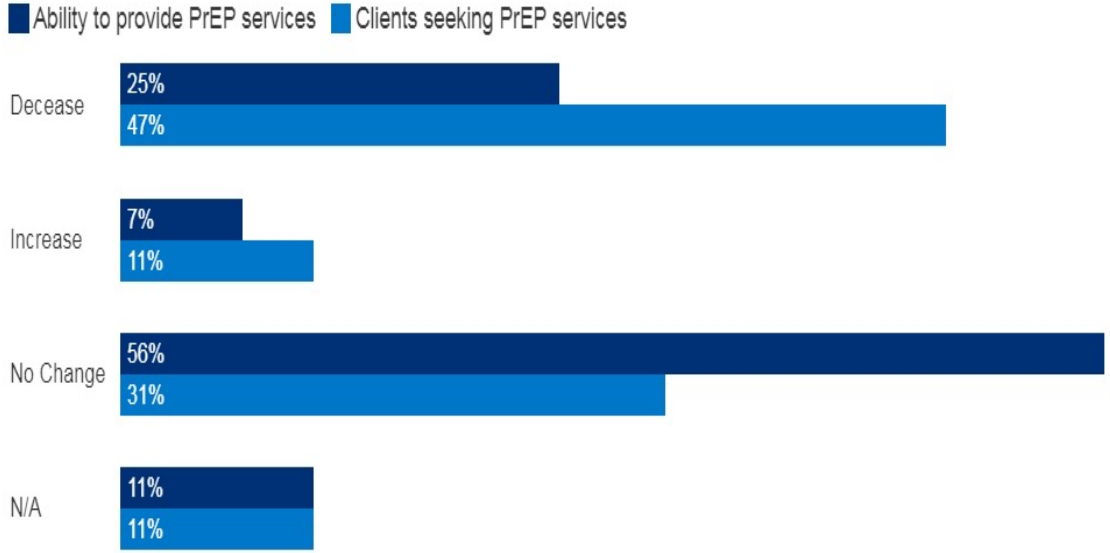
SOURCE: KFF Survey of Part C and Part D Ryan White Provider, 2020.

KFF

Figure 15

Demand for PrEP declined during the pandemic but most maintained or improved their ability to provide it

Since the beginning of the COVID-19 pandemic, has your program seen an increase, decrease, or no change in each of the following?



SOURCE: KFF Survey of Part C and Part D Ryan White Provider, 2020.

KFF

HALF OF AMERICANS CANNOT AFFORD AN UNEXPECTED $400 BILL

26% of U.S. adults 18-64 report problems paying household medical bills in past year.

Of these,

- 2/3 have health insurance
- 60% have postponed needed healthcare because of cost
- 35% have been unable to pay for basic necessities like food, heat or housing

The Burden of Medical Debt. KFF.org. Jan 2016

INCREASING RATES OF UNINSURED AND MEDICAID AT RYAN WHITE CLINICS

Table 2: Share of Respondents Reporting Coverage Changes in The COVID Era, by Medicaid Expansion Status

	Uninsured		Private		Medicaid		Medicare		Other	
	Exp.	Non-Exp.	Exp.	Non-Exp.	Exp.	Non-Exp.	Exp.	Non-Exp.	Exp.	Non-Exp.
Increase	45%	55%	2%	5%	28%	9%	4%	3%	7%	5%
Decrease	3%	3%	29%	43%	2%	7%	3%	7%	0%	3%
No Change	52%	41%	69%	52%	70%	84%	92%	90%	93%	92%

https://www.kff.org/report-section/delivering-hiv-care-prevention-in-the-covid-era-a-national-survey-of-ryan-white-providers-issue-brief/

SOCIAL DETERMINANTS OF HEALTH

- A person's health and chances of becoming sick and dying early are greatly influenced by education, income, nutrition, housing and neighborhoods.
- 40-90% of health outcomes are attributable to social, behavioral, and economic factors. (Fraze et al. Health Affairs 35:11 Nov 2016)
- States with a higher ratio of social to health spending [(social service + public health spending) ÷ (Medicare + Medicaid spending)] have significantly better subsequent outcomes for adult obesity; asthma; mentally unhealthy days; days with activity limitations; and mortality rates for lung cancer, acute myocardial infarction, and diabetes. (Bradley et al. Health Affairs. May 2016)
- Growing Evidence demonstrates that meeting the housing, nutritional, and personal care needs of High-Cost Patients can *improve health* and *lower healthcare expenses*. (Blumenthal and Abrams, JAMA 316;16)

TELEHEALTH NOT ACCESSIBLE FOR ALL

Table 1: Respondents Generally Agreed on Which Groups Most Benefited from/Struggled with Telehealth	
Most Benefited	**Most Struggled**
Younger populations/tech savvy individuals	Older populations/less tech savvy individuals
Those in rural areas with limited transportation (with tech access)	Those without internet/computer/smartphone access, those with limited phone data, including those in rural areas without broadband & cell infrastructure
Those with childcare responsibilities	Unstably housed individuals
Medically uncomplicated and stable individuals	Medically complex and vulnerable individuals
Some historically harder to reach patients	Those who lack privacy to make calls
Those penalized for taking time off at work	Those in need of translation services
Established patients	New patients

THE PATH FORWARD: CHARACTERISTICS OF SUCCESSFUL CDM PROGRAMS

- Care Management Programs that have convincingly demonstrated better cost and quality outcomes have these attributes in common:

  - ✓ Use of multidisciplinary care teams
  - ✓ Direct, face-to-face contact with patients
  - ✓ Significant patient engagement
  - ✓ Strong health information technology systems
  - ✓ Use of risk segmentation to identify individuals for targeted interventions

Blumenthal and Abrams. Tailoring Complex Care Management for High-Need, High-Cost Patients. JAMA 316;16. Oct 2016

OPPORTUNITIES TO MEET THE HEALTH DEBT CRISIS

- Address lack of physical activity, poor nutrition, tobacco use and excessive alcohol use - this can prevent 80% of all heart disease, stroke, and type 2 diabetes, and 40% of cancers
- Increase funding to communities most in need and vulnerable populations
- Integrate chronic disease messaging and resources to address nutrition, physical activity, food insecurity and other underlying causes of chronic disease

LARGE-SCALE APPROACHES TO ADDRESS THE HEALTH DEBT

- Modernizing Public Health Data mechanisms and improving Chronic Disease Surveillance will allow the tracking of testing, cases, and outcomes in real time, improving the public health infrastructure and providing support for funds allocation
- Creating linkages across systems between health care providers, insurers, educators, and community based organizations, local health departments, primary care physician groups, and federally qualified health centers will lead to better information sharing, care coordination, program development and implementation, and common health platforms.
- Engaging Health Care Foundations and other charities to address gaps in health care funding and augment and maximize public funding.

INNOVATIVE PROJECTS IN CHICAGOLAND TO ADDRESS CHRONIC DISEASE MANAGEMENT ARE IN MOTION AND EXPANDING

- Funding for these types of initiatives often not available via typical health care coverage – funding may come from Public grants or from Health Care Foundations
- Examples of ongoing projects large and small in the Chicago area*
  - **St Leonard's House: Integrated Behavioral and Physical Health Services for Reentering Citizens** – provides enhanced health education programs and expanded behavioral and physical health care services to people returning to the community after incarceration.
  - **Erie Family Health Center: Reshaping Diabetes Prevention and Management in the Context of Covid-19** – aims to transition diabetes prevention programing to include virtual programing and remote one on one diabetes education and support
  - **Housing Opportunities for Women, Inc: Healthy at Home: Improving Health and Wellness Outcomes for Individuals and Families Previously Experiencing Homelessness** – provides health care case management to high need clients including people with HIV, people with other chronic illnesses, and aging adults.
  - **Gilda's Club Chicago: Remote Service Delivery for COVID-19 and Beyond** – remote social and emotional support services for people living with cancer, specifically targeting high need, medically underserved communities

*All funded in part by Washington Square Health Foundation, information provided by WSHF

TEAMWORK ESSENTIAL AND SCOPE MUST BE WIDER THAN HEALTH

- We need a Team
  - Health departments
  - Providers
  - Educators
  - Insurers
  - Consumers
  - Funders

More than Health

- Housing
- Food
- Legal Aid
- Education
- Safety
- Technology