The chronic care model

How to approach chronic illnesses in your health care plan

Interviewed by Matt McClellan

Chronic illnesses are ongoing conditions that require adjustments by the affected person in addition to frequent interaction with the health care system.

Cynthia Napier Rosenberg, M.D., the senior medical director at UPMC Health Plan, says these chronic conditions are very costly to treat. Complicating matters, about half the people who have chronic illnesses also have multiple conditions.

"If a chronic illness is not treated effectively, it can cause problems in many areas," Rosenberg says. "Because of these factors, it is hardly surprising that chronic illnesses account for three-quarters of our total national health care expenditures."

Smart Business learned more from Rosenberg about ways business owners can handle the chronic care issue.

Cynthia Napier Rosenberg, M.D.
Senior medical director
UPMC Health Plan

Why is this issue important to business owners and any purchaser of health insurance?

Anyone responsible for purchasing health care in this country must understand how important it is to find a way to effectively deal with chronic care. Chronic illnesses can be expensive to treat, but if they are not treated correctly, they can become much more expensive. While the direct cost of chronic illness in this country is more than $400 billion a year, the indirect costs in terms of lost productivity has been estimated as more than half of that amount per year.

A study by the Robert Wood Johnson Foundation determined that large employers can help to bring about changes in health care that affect quality by creating incentive for programs that have been shown to be effective, such as the chronic care model.

What is the chronic care model?

Basically, the chronic care model is a framework that can redesign the health care system to better serve persons with chronic conditions. It has six core elements:

- Health care organization and leadership: The organizational environment that systematically supports and encourages chronic illness care through leadership and incentives.
- Linkage to community resources: The community can provide cost-effective access to services such as nutrition counseling, peer-support groups and patient registries.
- Support of patient self-management: Individual and group interventions that emphasize patient empowerment and self-management skills are effective in managing many chronic conditions.
- Coordinated delivery system design: This is designed to coordinate actions of multiple caregivers in the treatment of one patient.
- Clinical decision support: Incorporating evidence-based practice guidelines into registries, flow sheets and patient assessment tools can change provider behavior.
- Clinical information systems: With access to adequate database software, health care teams can use disease registries to deliver proactive care, implement reminder systems, and generate treatment plans and messages to facilitate patient self-care.

How effective is the chronic care model?

Studies have indicated that the chronic care model can achieve better disease control, higher patient satisfaction and better adherence to guidelines by redesigning delivery systems to meet the needs of chronically ill patients. For example, patients with acute depression can receive significantly better primary care treatment through a systematic program of feedback to doctors on treatment recommendations, supplemented with follow-up and care management by telephone.

Similarly, patients with diabetes have been shown to benefit with self-management support provided by the use of 'mini-clinics' of teams of providers. Instead of receiving uncoordinated care from a multitude of providers in a variety of settings, patients receive all of the care they need for their diabetes — including eye and foot care as well as diabetic education — in one place.

What is the connection to the patient-centered medical home?

At the heart of the patient-centered medical home — defined simply as physician-guided, patient-centered care — is the chronic care model. The chronic care model requires a major rethinking of primary care practice.

In the patient-centered medical home concept, there is a partnership between the physicians, the patients and their families. That partnership is what makes it work. The goal is a holistic, coordinated plan of care that uses evidence-based medicine to produce better outcomes and lower costs.

Why can't the current system deal with chronic conditions effectively?

Although the current U.S. health care system is outstanding in treating acute medical problems, it really is not designed to treat chronic, long-term conditions that require the time and expertise of many health care professionals. If you look at the current system, you see providers who are very busy and frequently lack access to other health care team members — such as diabetic educators and care managers — which are critical to the successful treatment of chronic diseases.

There is also the problem of coordination of care and finding time for adequate follow-up. If a patient needs to change doctors, important pieces of a patient's health care record are not always routinely transferred from one care setting to another. Finally, most patients and their families are inadequately trained to manage their illnesses. All of these issues are addressed in the chronic care model. <<

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