Reorganizing Chronic Care Delivery

PROLOGUE: The U.S. health care delivery system, historically built around acute care, needs to reshape itself to cope with chronic conditions. The papers that follow describe approaches to chronic care management that enjoy widespread support and address the obstacles they face.

The classic model for much of U.S. health care is the one doctor, one patient encounter. Tom Bodenheimer and colleagues explain the rationale for an entirely different approach to chronic illness built around multidisciplinary teams. They point out that it takes nearly eleven hours per day for a lone clinician to provide good chronic care to the average panel of patients—a time commitment made impossible by shortages of primary care doctors. Good chronic care will require care teams, which will, in turn, require workforce development.

Multidisciplinary teams are an important feature of the well-known Chronic Care Model (CCM) developed at the Group Health Cooperative of Puget Sound. Katie Coleman and colleagues review evidence on the effectiveness of the model, aimed at providing patient-centered, evidence-based care. That review shows that the CCM extends quality-adjusted life-years, at a cost-effective price. However, the CCM is not an “immediately replicable intervention,” but a framework that will require small physician practices to undertake major operational changes.

Disease management (DM) programs offer support services to patients from outside the clinical setting—for example, nurses who regularly call diabetes patients to remind them to monitor their blood glucose levels. David Bott and colleagues from the Centers for Medicare and Medicaid Services (CMS) summarize evaluations of DM demonstration projects in Medicare, which have produced discouraging results. Sandy Foote responds with a defense of DM’s promise.

Chronic disease is even reshaping our notions of acute care, as more and more hospital stays are for acute phases of chronic conditions. John Wennberg and colleagues offer evidence that greater intensity of hospital services for chronically ill Medicare beneficiaries is associated with lower quality and lower patient satisfaction scores. Albert Siu of Mount Sinai School of Medicine takes a different tack, arguing that overall improvements in chronic care require payment reforms to encourage more sensible organization and delivery of acute care services.