A Systematic Approach to Caring for the Chronically Ill

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- Clinical
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- Guest blog
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Health care spending in the U.S. exceeds $3 trillion per year and 10 percent of the population – the chronically ill – accounts for approximately 60 percent of that cost. Those patients are distinguished by their complex medical conditions that often require costly interventions. As noted in a previous Vizient blog, more than two-thirds of Medicare beneficiaries have multiple chronic diseases and a staggering 93 percent of total Medicare spending goes toward beneficiaries with multiple chronic conditions.

The complexity facing these patients is overwhelming. Too many care plans, too many uncoordinated appointments, too many prescriptions to manage and no quarterback or advocate to help. Health care organizations have done well at managing diseases, but not so well at managing the complexity of the patient’s life.

Health system leaders I’ve recently spoken with will candidly admit that past disease management approaches, while well intentioned, have fallen short. But we’re seeing the emergence of a different approach, one with the potential to increase the quality of care, engage patients in their own care plan, and minimize costly, preventable emergency room visits and admissions. It’s a multidisciplinary, patient-centered approach for transforming care for the chronically ill.

In a recent collaborative effort with the Vizient Research Institute™, we looked at several organizations that are leading the way in caring for the chronically ill and concluded that six foundational elements are essential in reducing costs and improving patient outcomes. They include:

1. **Segmented patient population.** Organizations that successfully manage the health of populations understand that the strategy is not about managing one population – it is about segmenting the population and understanding that each segment requires different approaches, resources and care models. It is important to identify the drivers of needs, e.g., number of diagnoses, acuity of conditions, demographic data; differences in needs, e.g., payer affiliation, mental health and/or substance abuse issues; and utilization behaviors, e.g., frequency and intensity, primary avenue of utilization.

2. **Defined clinic infrastructure.** It’s unrealistic for many chronically ill patients to comply with their multiple care plans when it’s difficult to find transportation and keep track of multiple appointments in different locations. As a result, proximity and convenience must be considered in any complex care design. However, models for how to best support a particular provider organization will vary and each facility will have to find an approach that’s right for them.

3. **Team-based care model.** A team-based approach to care works best. High-performing teams have clearly defined responsibilities that are understood by both patients and care providers. Clarifying the boundaries between roles eliminates duplicative effort, closes gaps in care and helps patients avoid being overwhelmed.

4. **Integrated communications matrix.** Knowing when, how and with whom information is shared among the care team, patient and health system ensures that all stakeholders are able to make informed decisions. Information silos give way to a fact-based understanding of how to achieve shared goals. A communications matrix that illustrates the interactions — both giving and receiving information — that needs to take place creates a positive patient experience.

5. **Appropriate workforce structure.** Getting the right number and type of team members working together in a complex care design can feel like a juggling act. There are multiple variables, including the fact that chronically ill patients will visit more often and their visits will be more resource-intensive. The composition of the patient population is another important variable. For example, if it has higher-than-average psychosocial needs, the right number of mental health providers must be available.

6. **Clear systems and processes.** Electronic medical records, patient/provider compacts, interdisciplinary patient rounds and educational tools that engage patients all have potential to reduce complexity. Balancing the specific requirements of the care model with institutional infrastructure and cost concerns is an important consideration and a potential implementation challenge.

We are not suggesting that any institution should copy a defined model. Each of these foundational elements is essential, but it’s just as important to remember that one size does not fit all. The key is to start thinking in practical terms about providing your chronically ill patients with access to better coordinated care, fewer missed visits, higher medication adherence and ultimately, better quality of life.

To learn more, click here to read an executive summary of “A Breakthrough Approach to Managing Care for the Chronically Ill Population.”
About the author and Axiom Consulting Partners. Garrett Sheridan is the president of Axiom Consulting Partners, a management consulting firm providing strategy, organization and talent-related services to help transform academic medical centers and other health care institutions.

The groundbreaking work at the Vizient Research Institute drives exceptional member value using a systematic, integrated approach. The investigations quickly uncover practical, tested results that lead to measurable improvement in clinical and economic performance.

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