Improving Health for Individuals w/ Multiple Chronic Conditions

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For

The Healthcare Imperative: Lowering Costs and Improving Outcomes

IOM Workshop Series

Target Population

- Aim: Reduce uncoordinated care leading to excessive health care costs
- Process: Identify those exhibiting utilization patterns of care demonstrating lack of coordination
- Potential Target Group(s):
  - Highest cost
  - Specific clusters of disease
  - Disease severity
  - ***Multiple concurrent co-morbidities***

Individuals w/ MCCs

- Why Focus on this Group?
  - Prevalence
  - Quality of Care/Health Status implications
  - Cost Implications

Policy Areas for Exploration

- Clinical Trials
- Clinical Guidelines
- Health Professional Education
- Provider Payment Schemes
- Self-care Management

Clinical Trials

- Many RCTs exclude patients with MCCs
- Comorbidities of enrolled patients are not always included
- External validity & generalizability is limited
- Areas for exploration:
  - Inclusion of individuals w/ MCCs in RCTs
  - RCT Sub-group stratification and reporting
  - Robust post-marketing surveillance system

Clinical Guidelines

- Many guidelines are silent on comorbidities
- Providers use clinical judgment based on multiple single-disease specific guidelines
- Risk for disease-disease, drug-drug & drug-disease interactions
- Areas for exploration:
  - Research to prioritize management & treatment decisions in individuals w/ MCCs
  - Development of best practices to guide providers

Health Professions Education

- Many physicians perceive training for chronic illness care as inadequate
- Competencies of geriatric syndromes, chronic pain, nutrition, patient education & coordination of services critical for individuals w/ MCCs
- Areas for exploration:
  - Undergraduate & graduate medical education focus on care coordination & management
  - Non-physician health care professional focus on care coordination & management

Provider Payment Schemes

- Many previous Disease Management efforts focused on individual, as opposed to multiple, chronic conditions
- Previous efforts did not always keep a PCP-type in the loop
- Interventions not always evidence-based and often not matched with correct target population
- Areas for exploration:
  - Applying lessons learned to future models of care coordination (e.g., Medical Home, Community Health Teams, Accountable Care Organizations, Transitional Care)

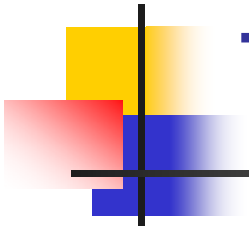
Self-care Management

- Patients are an essential partner in ensuring coordination of management of chronic care
- Providers can reinforce good health behaviors through health education
- Areas for exploration:
  - Building evidence base for self-care management
  - Patient incentives to adopt healthy lifestyle choices

Paradigm Shift

- Individual Chronic Diseases Silos
  - Reinforced by Government, Provider Specialty, Disease Management Organization, Advocacy Groups, etc...

- Multiple Chronic Conditions Approach



Thank you