

CHRONIC CARE
A SUMMARY OF THE 2001 HEALTH SECTOR ASSEMBLY

Preamble

Caring for persons with chronic conditions promises to be one of the greatest challenges for our health system and for society at large in the coming decades. Chronic illness encompasses a broad range of conditions that last for a prolonged period of at least one year, usually limits what one can do, and requires ongoing care. This statement focuses on chronic care. While it touches on many related issues, it is not intended to fully address the critical issues related to frailty and long-term care.

Chronic illness is growing in incidence, scope, and complexity. Much of this is attributable to our aging population, the environment in which we live and work, lifestyle issues, and cultural factors. Advances in medical technology and successes in managing acute illness also contribute to a rise in the prevalence of chronic conditions. Individuals with chronic conditions utilize the largest percentage of health care resources. Because they also are the fastest growing segment of the patient population, the demand for resources will increase. By promoting early intervention and ongoing care, we can significantly alter the course of the condition and delay the onset of disability.

To put this in perspective, **we predict that chronic conditions will be a major focus for our health system in the first half of the twenty-first century.** This is comparable to our health system's focus on infectious diseases in the first half of the twentieth century and on episodic care in the latter half.

The health care system must adapt to: eliminate major gaps in quality of care; promote primary and secondary prevention; and re-direct resources to their most appropriate use. Effective management of chronic conditions requires an integrated approach that spans acute clinical intervention, outpatient management and coordination, social support at the family and community levels, as well as home and long-term care. In short, a systems approach is needed that addresses not only the individual components of the system but also, perhaps most importantly, their interaction. This approach will require: new ways of thinking; new treatment patterns; new delivery and financial structures, processes, and incentives; and most importantly a person-centered approach.

The future of person-centered chronic care will focus on four things that allow a person with chronic conditions to live with optimal functionality, meaning, and dignity:

1. Educating the person with chronic conditions and those individuals directly involved in assisting them about care management;
2. Empowering individuals to manage complex regimens of multiple medications, interventions, and/or treatments; and monitoring signs, symptoms, and laboratory test results that indicate when adjustments or recommitment to the treatment plan are necessary;

3. Coordinating a multitude of medical and support services so that patients can move between levels and types of care that are needed to enhance the individual's condition and quality of life; and
4. Providing adequate financing to support integrated clinical and support services.

Addressing the needs of the growing number of individuals with chronic conditions requires a national policy and action agenda on chronic care.

Principles and Premises

1. Care of persons with chronic conditions should emphasize prevention, early detection, and minimization of disease progression across the life span, as well as take into account the high prevalence of co-morbidities and complicating disability, disease severity, and various non-medical influences.
2. A fundamental shift is needed to focus on coordinated and continuous care, not just episodic treatment aimed at a cure. Since the goal of chronic care (e.g., optimizing functionality and alleviating pain) differs from the curative goal of acute care, changes must occur in the organization, financing, and delivery of medical and support services for chronic disease.
3. The system must be person-centered, focusing on providing persons with chronic conditions the maximum level of mastery over their conditions in their daily lives.
4. Chronic care requires a much more coordinated and integrated system that includes:
 - (a) Placing substantial emphasis on an evidence-based approach that generates valid data for decision making throughout the process of providing chronic care.
 - (b) Linking technologies with human interventions.
 - (c) Providing the flexibility to easily move between and coordinate medical and support services. This will require accommodating different levels of care.
 - (d) Recognizing the family as a critical dimension of the health care team.
 - (e) Standardizing information systems that support continuity of care through the flow of information among the entire team, including persons with chronic conditions and their families.
5. Payment methods and other incentives must be modified to support integration and coordination of care as well as modifications to treatment methods.
6. A financing model must be developed and implemented that supports and encompasses the delivery of chronic care. It will likely require a mix of public and private dimensions, and may require redefinition of boundaries between Medicare and Medicaid. The financing system should:
 - (a) Be flexible;
 - (b) Allow for variability of service required over the individual's life;
 - (c) Enable patient choice; and
 - (d) Include incentives for coordination and continuity of care.
7. The regulatory system should be streamlined to support self-determination, enabling persons with chronic conditions to select treatment options that meet their personal requirements and preferences. Regulatory barriers that inhibit coordination of care must be eliminated. Regulations should not be punitive and adversarial, nor should regulations reinforce silos of funding or impede the provision of quality care.

Regulations should provide value to the system without adding excessive unnecessary burden and expense.

8. A substantial educational effort will be needed across a broad range of audiences, including persons with chronic conditions, families, health care professionals, support caregivers, policy makers, diverse communities, employers, and the public.
9. Chronic care will require a re-evaluation of health care resources and workforce needs including: numbers, skills mix, continued training needs, and how teams of healthcare professionals are taught.
10. A significant number of persons with chronic conditions will be elderly and frail. The approach to chronic care, therefore, must acknowledge and accommodate the special needs that accompany frailty.
11. Appropriately addressing chronic illness and disability does not negate the reality that all people deserve good end of life care.

Next Steps

An active and forceful dialogue is needed to raise public, private, and political awareness, leading to a national agenda on chronic care. To be successful, the agenda will have to generate a broad shift in the mindset about health and health care to encompass the above principles and premises, especially with regard to an integrated system that is person-centered and community based. We recognize that moving toward a more rational and person-centered chronic care system must be done in a way that will make better use of financial resources and not put a major financial strain on the already burdened health care system. We need to ensure that transforming the health care system expands the options available for persons with chronic conditions and is not achieved at the expense of other critical health care services. This will mean that government, payers, physicians and other health care professionals, and persons with chronic conditions and their families must be willing to share the responsibility to achieve the right balance between access to needed services and costs.