Managing Chronic Disease in Affordable Primary Care

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ABSTRACT

National agencies are calling for quality improvement in primary care health care services and across the United States health care system. Changes would be directed toward improving quality of life for the chronically ill and decreasing their financial burden and that placed on society. Nurse practitioners, based on their expertise and preparation in patient education, are ideal health care providers to establish partnerships with motivated, informed, chronically ill patients and to promote change in health care policy, guidelines, and meeting patient educational needs. Within worksite primary care, nurse practitioners can, through the Chronic Care Model framework, provide chronic disease management and affordable health care access.

Keywords: affordable health care access, chronic care management, Chronic Care Model, self-management skills, worksite clinic

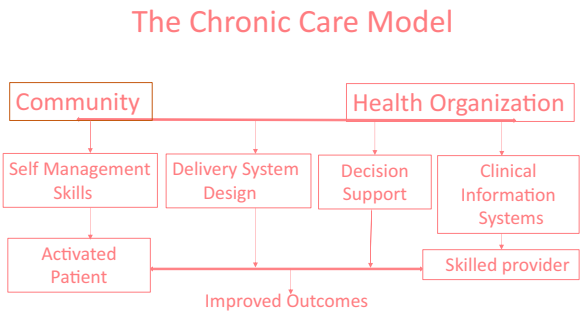
Today's focus on health care reform in the United States provides nurse practitioners (NPs) an excellent opportunity to engage in efforts that are directed toward lowering health care costs and increasing health care access to low-income, uninsured, or underinsured Americans. These efforts would enable NPs to become involved in the promotion of urgently needed health care delivery changes, particularly in the areas of organization and quality improvement. Changes would need to target chronic health conditions because of the inability of the health care system currently in place to effectively address chronic disease prevention and management. With the aging of baby boomers, the prevalence of chronic disease has increased dramatically as of late and most likely will continue to trend upward because of anticipated longer life spans. Furthermore, more than 25% of all Americans and 2 out of 3 older Americans have multiple chronic conditions. Over the next 25 years, the number of adults in the US who are 65 years of age and older will reach 72 million. They will account for 20% of the population by the year 2030. The management of chronic disease accounts for the majority of soaring health care expenditures in the US.[1-3]

When the Patient Protection and Affordable Care Act became effective in 2010, besides providing health care access for millions of uninsured Americans, it constituted a highly aggressive effort to address the problems of the nation's health care system. These problems include inadequate care coordination and chronic disease management.[4] As a result, at that time, health care providers and employers began to join forces and provided employees with not just health care access but also wellness plans designed to promote the prevention of chronic illnesses and affordable primary care services to manage those that still may occur. Employer-based health care centers (EBHCs) are subsidized by the employer and offer primary health care services to their employees. NPs have become the most prevalent health care provider within these clinics, and they have an opportunity to make a profound impact on the burden of chronic disease through the provision of support for patient self-care management skills.[5] Self-care management skill is a major component of the Chronic Care Model (CCM), an evidence-based framework aimed toward the prevention and management of chronic disease (Figure).[6-9]

BACKGROUND

The Agency for Healthcare Quality and Research believes that, in order to improve quality, efficiency, and effectiveness of patient care, systemic changes to

Figure. The CCM model.



(Adapted from: MacColl Center for Health Care Innovation. The chronic care model. Improving chronic illness program. http://www.improvingchroniccare.org/index.php?p=the_chronic_caremodel&s=2.)

primary care practices and health systems are required within today's health care reform process.[10] To date, the improvement of patient outcomes has been sought through the introduction of such frameworks as the Patient-Centered Medical Home (PCMH) and the CCM. These 2 models, both of which were developed to improve quality, efficiency, and effectiveness of health care, can be used together or independently, and they could potentially address the currently needed practice and system changes. The complexity of the care required by patients with multiple chronic health conditions requires a framework that has been designed to manage complex multiple chronic conditions. The PCMH and the CCM, which have similar components, when combined, could potentially provide the best approach directed toward chronic care management.

The PCMH was developed in 2007 through the joint efforts of several physician academies and organizations. It is defined by the Agency for Healthcare Quality and Research as a model that organizes primary care by delivering the core functions of primary health care through 5 functions and attributes: comprehensive care, patient centered, coordinated care, accessible services, and quality and safety.[11]

The CCM, is also an organizational approach to primary care but is specifically aimed at improving care for those who are chronically ill. It was designed in 1998 by the organization Improving Chronic Illness Care to promote evidence-based interaction between an informed and activated patient and a prepared, proactive provider. The CCM is composed of 6 categories. These categories are components that have been hypothesized to affect functional and clinical outcomes associated with disease management and are considered determinants or a means to measure for high-quality care of chronic health conditions. The 6 components include health care organization, delivery system design, decision support, community, clinical information systems, and implication for practice. Change concepts, principles by which care redesign processes can be guided, are found within each element.[6-9]

The EBHC is a model of care that has made a recent resurgence in today's health care delivery system. These health centers have actually been a part of health care delivery in the US since before the turn of the century. They have been garnering newfound recognition for their contribution to affordable care access and adaptability for the provision of both preventive health care and chronic disease management. P. Starrr's book, *The Social Transformation of American Medicine: The Rise of a Sovereign Profession and the Making of a Vast Industry*, published in 1982, although dated, depicts a clear image of early employer-based clinics. According to the author, they originally began appearing in the 1860s with railroad and mining companies. These employers had realized that hazardous work and injury could influence productivity and absences. Since the year 2000, their numbers began to increase in response to soaring health care costs and the establishment of a national health care policy that had been introduced through the Patient Protection and Affordable Care Act.[12] They have also become an effective strategy directed toward combating the growing primary care physician shortage in the US, which is projected to be substantial by 2025. Data from research by IHS Markit Ltd, London, UK, in 2017 conducted on behalf of the Association of American Medical Colleges projects a shortage of 25,600 physicians in 2020, an increase from 10,800, the projection for 2015.[13,14]

A white paper released in 2009 by Fuld and Company, Boston, MA, a strategy consultant, estimated that the number of worksite clinics could grow by 15% to 20% a year, from 2,200 to 7,000 clinics by 2015, as referenced in Ian Duncan's 2014 second