Chronic Illnesses


While implementation of the chronic care model (CCM) has been shown to be an effective preventative strategy to improve outcomes in diabetes mellitus, depression, and congestive heart failure, data is lacking in regards to its effectiveness for chronic obstructive pulmonary disease (COPD). A literature review was conducted to explore the resources available regarding the CCM and COPD.


The purpose of this study was to determine whether the author's disease-management model was associated with long-term survival benefits. The study demonstrated that patients participating in a heart failure clinic experienced improved survival.


This article explores the rise in chronic disease in the US and prevalence based on data from the Medical Expenditure Panel Survey. It recommends orienting medical care towards ongoing care and care management and a special focus on patients with multiple conditions.


The Medicare Modernization Act of 2003 was the first step in orienting Medicare toward care of patients with chronic illnesses. This article explores other changes that will be necessary to reform Medicare to make it truly responsive to the care of patients with chronic illnesses, including change to the delivery system, the research infrastructure, clinical education, and methods of financing medical care.

This article discusses the five chronic conditions that account for 1/3 of the growth in healthcare spending, heart disease, trauma, pulmonary disease, mental disorders and cancer and factors contributing to their growth.


This article discusses the results from a qualitative interview study of African Americans with chronic illness. This article found that self-care activities were culturally based. Those who had some form of health insurance much more frequently reported the influence of physicians and health education programs on self-care regimens than did those who were uninsured.


The purpose of this study was to examine older African Americans' philosophies about their chronic illnesses and how those philosophies have affected chronic illness management. In dept interviews were conducted over the course of several years with 38 respondents. This research attests to the importance of examining racism in the analysis of how older ethnic minorities live with chronic illness.


This article describes the Chronic Care Model and Chronic Care Improvement Programs how dietetics professionals can utilize these in their profession. As Congress has recognized medical nutrition therapy as a component of Chronic Care Improvement Programs, new opportunities are available to dietetics professionals.

This article explains the benefit of planned visits on patient self-management. At multiple-agenda visits, there is not enough time to provide information and engage in decision making, and this time is often trumped by acute problems. Planned visits offer a single agenda geared to patient self-management and education.


A central concept in self-management is self-efficacy - confidence to carry out a behavior necessary to reach a desired goal. Self-efficacy is enhanced when patients succeed in solving patient-identified problems. Evidence from controlled clinical trials suggests that programs teaching self-management skills are more effective than information from solely patient education when considering improving clinical outcomes. In some circumstances, self-management education improves outcomes and can reduce costs for arthritis and probably for adult asthma patients. A self-management education program bringing together patients with a variety of chronic conditions may improve outcomes and reduce costs. Self-management education for chronic illness may soon become an integral part of high-quality primary care.


This article provides support for the pivotal role of nurses in interprofessional care.


Mr P has long-standing hypertension, obesity, and diabetes mellitus and has experienced life-threatening cardiovascular events. Mr P is receiving evidence-based clinical care but has adhered to his medical regimen poorly and remains at considerable risk of future catastrophic cardiovascular events. Practicing evidence-based medicine should be a 5-step process: research uncovers the evidence, clinicians learn the evidence, clinicians use the evidence at every visit for every patient, clinicians make sure patients understand the evidence, and clinicians help patients incorporate the evidence into their lives. Research demonstrates, however, that clinicians do not use the evidence at every visit, patients may misunderstand what took place in the visit, and clinicians are not always
effective in helping patients incorporate the evidence into their lives. These failures reflect the difficulty faced by clinicians attempting to address multiple issues while providing sufficient information and engaging in collaborative decision making during a brief clinical visit.

The chronic care model is a guide to higher-quality chronic illness management within primary care. The model predicts that improvement in its 6 interrelated components—self-management support, clinical information systems, delivery system redesign, decision support, health care organization, and community resources—can produce system reform in which informed, activated patients interact with prepared, proactive practice teams. Case studies are provided describing how components of the chronic care model have been implemented in the primary care practices of 4 health care organizations.

This article discusses a study conducted to evaluate the applicability of Clinical Practice Guidelines (CPGs) to the care of older individuals with several comorbid diseases. This review suggests that adhering to current CPGs in caring for an older person with several comorbidities may have undesirable effects.

Dr. Brehm comments on a commentary by Dr. Holman in JAMA regarding a gap in the current training and practice of physicians. He raises a related problem, the role of the payment system and its subsequent impact on the problem.

This study sought to develop a measure of health care preferences of adolescents with chronic illnesses and to determine demographic, developmental, and health factors associated with
adolescents' preferences. A questionnaire and survey were administered. Participants rated aspects of interpersonal care as most important in their judgments of quality. In addition, technical aspects of care were also rated highly.


This editorial discusses the focus of quality improvement methods in cardiology and the current aims of quality healthcare delivery systems.


This article reviews literature which discusses the support of patient self-management of chronic illnesses. This support includes: processes that develop problem-solving skills, self-efficacy, and the application of knowledge in real life situations that matter to patients. Emerging evidence supports the implementation of practice strategies that are conducive to patient self-management and improved patient outcomes among chronically ill patients.


This article describes palliative care as a spectrum which begins at the time of diagnosis, not just when the patient begins dying. Palliation becomes a partnership between patient and physician. The length of palliative treatment can vary and can be stopped by the physician or the patient. When death becomes close palliative care becomes terminal care, a relationship of understanding will have already been formed between doctor and patient


This article is a narrative describing a mother and her son’s struggles with severe, persistent asthma.


Randomized trials have shown that disease management programs can reduce hospitalizations and
improve symptoms for patients with CHF. The authors sought to create and pilot test such a program for patients with low literacy skills. It was found that a heart failure disease management program designed specifically for patients with low literacy skills is acceptable and is associated with improvements in self-care behavior and heart failure related symptoms.


Multidisciplinary congestive heart failure clinics in the United States appear to be effective in reducing the number of hospital readmissions, however, it is unclear whether this is the case in countries such as Canada. This study sought to determine the impact of care at a multidisciplinary specialized outpatient congestive heart failure clinic compared with standard care. At the conclusion of the study, it was found that compared with standard care, care at a multidisciplinary specialized congestive heart failure outpatient clinic reduced the number of hospital readmissions and improved quality of life.


This paper presents a novel planning framework that can be used in the context of planning for the prevention of chronic disease, particularly in low-income and middle-income countries. Countries such as Indonesia, the Philippines, Tonga, and Vietnam have implemented this stepwise planning framework and their experiences helps to illustrate the applicability of the framework to solving chronic disease problems.


This study investigated residency-based experiences with changes in teaching and delivery of chronic disease care. Qualitative cross-sectional in-depth interviews were conducted with directors of grant-funded residency-based chronic care projects. The following challenges were identified: engaging faculty and residents who spend limited time in the practice center, institutional barriers related to authority, competing priorities, process, and resources. Successful innovations for chronic disease care and training are possible in residencies, but their implementation cannot be taken lightly.

This article discussed the need for investigation into multimorbidities. The author provides three categories into which research into multimorbidity should fall - defining and categorising the population; developing the tools needed to explore multimorbidity and its consequences; and using these tools to investigate promising processes of care.


Most people with chronic conditions such as diabetes, congestive heart failure, asthma, and depression are managed in primary care. NHS consultants have traditionally confined their role to patients who are referred to outpatient clinics by their general practitioners. Such patients usually have the most severe and complex problems. Effective care teams for chronic illness must be able to cross practice or organisational boundaries, but the current organisational structure of the NHS does not provide many incentives to develop such linkages. General practitioners refer patients they cannot manage and hospitals are funded on the basis of referrals. Time spent on joint work with primary care is not accounted for. To ensure that all patients get the best treatment, the role of consultants needs to change so that their specialist knowledge is more available to everyone dealing with chronic disease.


Monitoring chronic diseases for both benefit and harm is important, preferably with a single measurement. Monitoring is not always necessary or beneficial and can lead to inappropriate changes. Monitoring aims to establish the response to treatment, detect the need to adjust treatment, and detect adverse effects. Control charts help distinguish natural variability from true change and reduce unnecessary adjustment.


This author comments on methods of providing patient education about chronic diseases, emphasizing the varied needs of patients even when dealing with the same disease. He states that individualization is the task of the primary care physician and proposes that this is a three step process and believes
that this outlined method will become standard in primary care, as patients continue to seek more involvement in their treatment.

This author comments on the lack of medical student education on the topic of chronic disease.

The Yale School of Nursing has developed a framework to guide research efforts in interventions to enhance self- and family-management of chronic illness.

Editorial - an edition of the BMJ dedicated to management of chronic disease

The authors provide comments on Boyd's article "Clinical practice guidelines and quality of care for older patients with multiple comorbid diseases: implications for pay for performance." They clarify the benefits of nutritional therapy by a registered nutritionist and that as of 2001 Medicare benefits include nutrition therapy for beneficiaries with diabetes and renal disease.

Hebert, K. A., Horswell, R. L., Dy, S., Key, I. J., Butler, M. K., Cerise, F. P., et al. (2006). Mortality benefit of a comprehensive heart failure disease management program in indigent patients. [The purpose of this study was to determine whether participation in a heart failure disease management (HFDM) program would reduce mortality in an indigent population from rural Louisiana. The study found that participation in an HFDM program was associated with decreased mortality compared with traditional follow-up care for this indigent population.] American Heart Journal, 151(2), 478-478-483.

Holland, R., Battersby, J., Harvey, I., Lenaghan, E., Smith, J., & Hay, L. (2005). Systematic review of multidisciplinary interventions in heart failure. *Heart*, 91(7), 899-899-906. The purpose of this study was to determine the impact of multidisciplinary interventions on hospital admission and mortality in heart failure. The study concluded that multidisciplinary interventions for heart failure reduce both hospital admission and all cause mortality.

Holman, H. (2004). Chronic disease -- the need for a new clinical education. *The Journal of the American Medical Association*, 292(9), 1057-1057-1059. Medical schools currently do not adequately prepare their students for care of chronically ill patients. The author of this article suggests creating a chronic care model which includes a practice team, information system, decision supports for practice, and patient self-management supports. It is suggested that students should be assigned to a supervised longitudinal case study upon enrollment in these programs. Providing these new learning experiences requires new understandings and new behaviors.


Kirkegaard, M. (2004). Medical education and chronic disease. (comment). *Journal of the American Medical Association*, 292(9), 1057-1057-1059. Dr. Kirkegaard comments on Dr. Holman's article "Chronic disease—the need for a new clinical education" and the seven areas which Holman identifies as necessary for medical students to gain proficiency to manage patients with chronic disease. To this list, he adds two more proficiencies,
inspiring students to become advocates for underserved patients and teaching students how to be culturally competent.


Approximately 20% to 50% of patients do not adhere to their medical therapies. A review of the literature was performed to summarize, categorize, and estimate the effect size of interventions to improve medication adherence in chronic medical conditions. The review concluded that several types of interventions are effective in improving medication adherence in chronic medical conditions, but few of them significantly affected clinical outcomes.


Data collection and outcome measures were completed by 24 hospitals on patients admitted to the hospital with coronary artery disease. The following outcome measures were completed at baseline and 10- to 12-month follow-up: aspirin use, beta-blockers, angiotensin-converting enzyme inhibitors, cholesterol management and treatment, smoking cessation counseling, blood pressure control, and cardiac rehabilitation referral. Prevention guideline adherence in hospitalized patients with coronary artery disease was improved with the web program utilization, interactive physician training, and initiation of collaborative quality improvement.


Background: Although enthusiasm is growing for self-management programs for chronic conditions, there are conflicting data regarding their effectiveness and no agreement on their essential components.

Purpose: To assess the effectiveness and essential components of self-management programs for hypertension, osteoarthritis, and diabetes mellitus.

Conclusions: Self-management programs for diabetes mellitus and hypertension probably produce clinically important benefits. The elements of the programs most responsible for benefits cannot be determined from existing data, and this inhibits specification of optimally effective or cost-effective
programs. Osteoarthritis self-management programs do not appear to have clinically beneficial effects on pain or function.


Researchers from the University of Pittsburgh School of Nursing have been examining whether the existence of comorbidities influences treatment adherence. Their studies have focused on patients with different chronic conditions, including rheumatoid arthritis (RA), urinary incontinence, hypertension, and HIV.


Recent organisational changes to the NHS are bound to affect the care of patients with chronic diseases. But will they help or hinder? Chronic disease represents a huge burden of ill health in the United Kingdom and a large cost to the NHS. Yet for many years government policy has focused on improving access to elective care. Recently, attempts have been made to improve the management of selected chronic conditions through the introduction of national service frameworks together with the associated activity of the NHS Modernisation Agency and the national clinical directors. But the NHS still has no agreed model for managing all chronic diseases. We aim to stimulate debate by suggesting some basic ingredients of good management of chronic diseases and examining how recent policies might influence their development and implementation in the NHS in England.


Objective: Both the Arthritis Self-Management Program (ASMP) and the generic Chronic Disease Self-Management Program (CDSMP) have been shown to be successful in improving conditions in patients with arthritis. This study compared the relative effectiveness of the 2 programs for individuals with arthritis.

Results: Both programs showed positive results. The disease-specific ASMP appeared to have advantages over the more generic CDSMP for patients with arthritis at 4 months. These advantages had lessened slightly by 1 year.

Conclusion: The disease-specific ASMP should be considered first where there are sufficient
resources and participants. However, both programs had positive effects, and the CDSMP should be considered a viable alternative.


Little is known about the effectiveness of disease management programs nationwide. This study was conducted to determine whether disease management by physician groups is associated with diabetes care processes, control of intermediate outcomes, of the amount of medication used when intermediate outcomes are above target levels. At the conclusion of the study, disease management strategies were associated with better processes of diabetes care but not with improved intermediate outcomes or level of medication management.


This article reports on two papers presented at the National Congress on the State of the Science in Nursing Research. The first paper focuses on the adherence to treatment regimens for chronically ill patients and the nurses who treat them. The effect of co-morbidities on the treatment adherence was also examined. The second paper spoke about a team of advance practice nurses who coordinated patient care of chronically critically ill patients for two months after discharge to try to reduce the readmission rate.


The UK government announced a new healthcare strategy using a community matron - a specially trained nurse - who will act as a case manager in providing care. The role of the community matron will involve designing a personalized care plan, regular monitoring of patients, and initiating care (including writing prescriptions).


This article discusses the need for increased public health activity in addressing chronic disease prevention and control.

There are specific issues that arise when treating chronic conditions among adolescents. This paper discusses disclosure of the diagnosis, management of adherence to therapy, the need for an interdisciplinary network approach, lifestyles' anticipatory guidance and prevention, and the transition into an adult health care setting.


The authors provides comments on Rothman et al's "A randomized trial of a primary care-based disease management program to improve cardiovascular risk factors and glycated hemoglobin levels in patients with diabetes."


Though recommendations have been made supporting efforts to reduce the impact of chronic conditions on children's health and on their families, adoption by the Canadian health system has been minimal. The author discusses opportunities for the health system to take action to address the health needs of children with chronic conditions.


While conventional wisdom states that care for older patients with chronic diseases is best performed by specialty physicians in acute care settings such as academic medical centers, a new report suggests otherwise.

Researchers with the Center for the Evaluative Clinical Sciences at Dartmouth Medical School in Hanover, NH, reported that medical costs varied across the nation but that quality of care is not necessarily linked to higher-cost care. For more than a decade, these researchers have been studying and issuing reports showing such variation, but this study shows for the first time differences among specific hospitals and their physician networks. These differences in cost, visits to specialists, days in the hospital, and use of intensive care beds exist after controlling for illness severity.

Dr. Morioka-Douglas comments that part of the lack of medical education in addressing chronic illness involves the lack of reimbursement for activities essential to management of chronic disease, such as telephone and email consultation.


This author discusses the implications of chronic disease, not just in wealthy countries, but in middle- and low-income countries as well. She discusses the shift in nutrition and lifestyle as contributing to rising rates of obesity and contributing to illness. Also, she discusses the government's and individual's roles in healthy lifestyle choices.


These authors discuss the need for and importance of proactive approaches to palliative care in those with chronic illnesses.


The purpose of this study was to assess self-reported symptom burden of chronic critical illness among individuals on a respiratory care unit. Physical and psychological symptom distress is common and severe among patients receiving treatment for chronic critical illness. Due to the high mortality rate observed in the study, greater attention should be given to relief of pain and other distressing symptoms for the chronically critically ill.


The author discusses the impact of chronic illness in Eastern Mediterranean Region. She suggests ways in which policymakers can promote lifestyle changes, such as amending essential drug lists to include those to treat chronic diseases, changing the nutrition education from a focus on undernutrition to focus on obesity, and government programs which have been successful throughout the region.

This author comments that new NHS funding policies for follow-up care in primary and secondary care settings will be necessary for patients to recieve adequate chronic illness care.


This article discusses the chronic care model as a means to provide a framework for change in the practice and organization of care for chronic illnesses, specifically diabetes.


This study sought to examine the contribution that specific diseases, as causes to both death and disability, make to educational disparities in disability-free life expectancy (DFLE). The study concluded that disabling diseases such as arthritis, back complaints, and asthma/COPD contribute substantially to differences in DFLE by education. Public health policy should focus on these nonfatal diseases in addition to fatal diseases.


The purpose of this review was to assess the clinical and economic effects of disease management in patients with chronic diseases. Disease management programs were found to be associated with marked improvements in many different processes and outcomes of care.


This study was conducted to determine if participants in chronic disease self-management courses have a change of perspective of their health status, and if this is measurable with a paper-based questionnaire. This study suggests that pre-intervention/post-intervention assessments of interventions...
such as self-management courses are confounded by a change in perspective of a large proportion of respondents.


This article discusses a study which sought to explore how physicians determine medical regimen adherence among patients with chronic illnesses. An internet-based survey was completed by two-hundred seventeen physicians which sought to determine if prior physician training on the matter had an impact on patient adherence. Formal educational interventions may improve adherence-related knowledge and skills.


A long-term follow-up of a previously published randomized trial was conducted which compared all-cause mortality and recurrent hospitalization during the median follow-up of 7.5 years in a heterogeneous cohort of patients with chronic illness initially exposed to a multidisciplinary, home-based intervention. This study suggests that a nonspecific home-based intervention provides long-term cost benefits in a range of chronic illnesses, except for chronic obstructive pulmonary disease.


The prevalence of chronic illnesses is increasing and therefore it will be increasingly important for physicians and medical students to understand chronic illnesses and appropriate care during their training. A survey of medical school course directors revealed that overall the directors agreed on the need to address the improvement of training students in the care of the chronically ill, however, the directors reported a wide variety of methods for how they would like to address or are currently addressing this in their courses.


This study sought to understand which medications are underused, by whom, and how often among
chronically ill adults. These adults were asked to identify how often they underused prescriptions because of cost. Many chronically ill adults frequently cut back on medications as a result of cost.


This author comments on by DiPiero and Sanders', "Condition based payment: improving care of chronic illness." He describes the impact of chronic care practice enhancement payments instituted in British Columbia.


This website reviews a RAND corporation study which is the first large scale assessment of quality of care in patients with multiple chronic conditions. It reviews the article "Relationship between number of medical conditions and quality of care", by Takashiro et al (2007), which can be found in this database.


The authors comment on efforts to grasp opportunities to decrease deaths from chronic disease. The challenge, they say, is to get the international funders of action against infectious disease to fund action against chronic disease.


According to a study completed by the Rand Corporation, patients with multiple chronic illnesses do not receive worse quality of medical care than those without multiple chronic illnesses. Three groups of patients were examined to determine whether they received recommended medical care for a variety of common chronic illnesses. The study found that the likelihood that patients received recommended care increased by about two percent with each additional chronic illness.

In response to Boyd's "Clinical practice guidelines and quality of care for older patients with multiple comorbid diseases: implications for pay for performance," the author expresses concern over pay-for-performance schemes and the effects that they may have on appropriate clinical practice.


The author comments on Landon's "Improving the management of chronic disease at community health centers." The author points out that the study covered too short a period of time to capture health outcomes, and that they failed to provide for the policy implications of their work.


This article questions what is already known about interprofessional interventions and the care of people with long-term conditions. In addition, the article examines available evidence and the potential for interprofessional education in changing practices.


The purpose of this study was to examine the role of literacy on the effectiveness of a comprehensive disease management program for patients with diabetes. The study concluded that literacy may be an important factor for predicting who will benefit from an intervention for diabetes management.


The author comment's on Landon's article "Improving the management of chronic disease at community health centers", in establishing appropriate outcomes for evaluating treatment. This includes allowing enough time before assessing an intervention and partnering with the right people/organizations to establish appropriate outcomes.

This review focuses on the interaction between adolescents and chronic conditions and the health systems that support them. Evidence is showing that adolescents with chronic conditions are doubly disadvantaged due to engaging in riskier behavior to that of their peers and having greater potential for adverse health outcomes as a result of these behaviors.


It is well documented that racial disparities in health care are prevalent and solutions to this problem are not well documented. This study sought to determine whether generic quality improvement efforts were associated with changes in racial disparities in diabetes care. At the conclusion of the study, racial disparities were diminished in some aspects of diabetes care, however, reducing disparities may require a focus on minority health.


This study explored whether patients enrolled in 3-tier pharmacy benefit plans who receive generic or preferred brand-name agents when initiating chronic therapy were more adherent to treatment than those who received non preferred brand-name medications. This study concluded that in a 3-tier pharmacy benefit plan, prescribing generic or preferred medications within a therapeutic class is associated with improvements in adherence to therapy.


This study was a controlled pre- and post-intervention study of community health centers participating in the Health Disparities Collaboratives (sponsored by the Health Resources and Services Administration) of the care of patients with diabetes, asthma, or hypertension. The results showed that the intervention centers had greater improvement in the measures of quality of care for patients with asthma and diabetes, but not hypertension.

This article describes how the Chronic Care Model was implemented in 22 teaching hospitals. The results of their efforts were tracked by each of the team members, with respect to clinical and educational outcomes. The two most effective drivers of change were organization-wide leadership and the academic culture (competitiveness, the aspiration for excellence, focus on the research mission, comfort with data, and commitment to the education mission).


This article discusses the impact chronic diseases have on the mortality of individuals in low-income and middle-income countries. The article proposes a new goal for reducing deaths from chronic disease.


According to surveys, approximately 10% of adolescents suffer from a chronic illness. This paper seeks to analyze the reciprocal effects of chronic conditions and adolescent development by reviewing the effects of chronic disease on growth and puberty and on psychosocial development.


This article discusses the chronic disease, its prevalence, direct and indirect costs, and the importance of radiology in chronic disease. It also discusses the effects of the structure of the health care system on chronic disease.


The author's discuss the wide variation in the reported prevalence of chronic diseases in children as discussed in van der Lee et al's article "Definitions and measurement of chronic health conditions in childhood: a systematic review." The problem that he addresses is the lack of consistent definition of "chronic disease" as a reason for this variation.

This article discusses the issues related to disease-specific guidelines in patients with co-morbid conditions.


The long-term effects of a period of 11 days of in-patient multidisciplinary team care were compared with routine out-patient care in 80 patients with active rheumatoid arthritis (RA). Endpoint measures included swollen and tender joint counts, the patient's assessment of pain, the patient's and the physician's assessments of disease activity, the ESR and the Health Assessment Questionnaire (HAQ). Two years after hospitalization, all 39 patients randomized to the in-patient group and 39 out of 41 patients randomized to the out-patient group were evaluable. At 2 yr, in the in-patient group the improvement according to mean changes from baseline was greater than that in the out-patient group for all endpoint measures except for the HAQ score, the differences not reaching statistical significance. Averaged over the time points 2, 52 and 104 weeks, the improvement was significantly greater in the in-patient group than in the out-patient group, except for the ESR and HAQ score. In conclusion, a short period of in-patient multidisciplinary team care has a beneficial effect on disease activity over a period of 2 yr and should be considered as a useful treatment modality in patients with active RA.


This study was designed to assess the efficacy of multidisciplinary team care in rheumatoid arthritis. Data were obtained through a Medline and manual literature search. The study concludes that short-term inpatient team care, when compared to standard outpatient care, showed favorable outcomes.


The author provides commentary on the Dixon et al article "Can the NHS learn from US managed care organisations?"


Wagner proposes comprehensive system change to improve chronic illness care.

The objective of this study was to examine the effectiveness of an interdisciplinary intervention for pediatric asthma through an asthma management intervention. The primary outcome measure was change in asthma symptoms, and secondary outcomes included health-care utilization and asthma-related quality of life. Both groups demonstrated significant reductions in asthma symptoms and improvements in quality of life without any between-group differences identified over the course of follow-up. In contrast, the intervention group demonstrated less frequent health-care utilization over the 12-month follow-up period. While the intervention did not result in improvements in asthma symptoms, it accomplished modest reductions in the utilization of acute medical care.


This article evaluated the efficacy of patient self-management educational programs for chronic diseases and critically reviewed their methodology. Self-management education programs resulted in small to moderate effects for selected chronic diseases.


Currently approximately 80% of all health care dollars are spent treating chronic conditions and more than 100 million Americans suffer from one or more chronic conditions. However, health care continues to be geared towards acute care.


The author comments on Murray et al's "Palliative Care in Chronic Illness"


Medicare's benefit structure and reimbursement mechanisms are poorly aligned for high-quality chronic care in spite of chronic disease being highly prevalent. There is little evidence to suggest that
successful quality improvement initiatives would reduce the costs of the Medicare program. This paper describes chronic care innovations to date and discusses ongoing and planned efforts by the Centers for Medicare and Medicaid Services to test related changes to Medicare’s benefit structure and provider reimbursement.