MANAGEMENT OF POPULATIONS WITH MULTIPLE CHRONIC CONDITIONS IN ONTARIO: SUGGESTED COMPONENETS OF STANDARD CARE & PERFORMANCE MEASUREMENT FOR SHARED ACCOUNTABILITY

(APPLIED HEALTH RESEARCH QUESTION)

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CONTEXT

The high prevalence of chronic conditions and the common occurrence of multiple chronic conditions (MCC) simultaneously in the same individual creates a challenge for the health care systems worldwide. The way that the health care services are currently structured to manage acute events and exacerbations of chronic diseases is not appropriate for the management of patients with MCC. There is a compelling need for re-thinking the system and for restructuring the provision of care accordingly, to deliver integrated care where the patient is at the centre of the provision of services.

OBJECTIVES

This project aims to synthesize existing research evidence that identify common elements of care that must be components of standard care for the multimorbid population and their family caregivers.

METHODS

A literature review was conducted to identify common elements required to improve outcomes of the multimorbid population and their family caregivers, across different programs, disciplines and geographic boundaries, and regardless of healthcare sub-sectors, provider types, diseases, and social context. Types of performance measures were defined, and recommended to generate shared accountability in the delivery of care.

FINDINGS

The optimal approach to manage patients with MCC is integrated healthcare system service delivery, with primary care at the centre, integrated with social community services, acute care hospitals, specialized medical care, rehabilitation services, and long-term care. There are 21 recommended essentials to be included as components of standard care for the multimorbid population in Ontario: Case management, Patient enrolment and assessment, Interdisciplinary primary care teams, Team meetings, Individualized care plan, Mental health management, Medication management, Facilitate home and community-based services, Support for self-management, Caregiver education and support, Involvement of patient and family in decision making, Integration of home care services, Single-entry point, Continuity of care and transition management, Electronic health records, Use of information technologies, Guidelines for MCCs, Performance measurement, Blended capitation remuneration system, Remuneration system adjusted to patient need, and Team based financial incentives.

Performance measures for integrated care to multimorbid patients include both process and outcome measures at individual, team and organizational level. The most critical measures for achieving high performing MCC teams are at the team level of care delivery, and there is currently a shortage of team-based performance measures in the literature.

CONCLUSIONS

This report suggests the essential elements of healthcare delivery that are required to effectively and efficiently manage patients with MCCs in the Ontario context. These elements need to be articulated with adequate performance measures and attached to incentives, in order to successfully achieve transformational care improvement and to attain system goals for this population.

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