As the health care system continues to focus on chronic care management, technology can play a crucial role in coordinating services. According to the Centers for Disease Control, 75 percent of U.S. healthcare dollars are spent on the treatment of chronic diseases. They are the leading causes of death and disability and the need for services will continue to grow as the American population ages.

As the need grows, challenges remain with billing and payment for related services. While The Affordable Care Act (ACA) provides for some payments to coordinate care, there are still some clarifications on the horizon. Additionally, multiple technological platforms still make it difficult to share information across health care professionals and facilities.

Patients, caregivers, primary care givers, specialists and facilities face hurdles in ensuring seamless care. The Triple Aim Initiative was developed by Institute for Healthcare Improvement to improve the patient experience, improve health and reduce per capita cost of healthcare. Through electronic platforms, patients and caregivers have access to necessary information and the chance to exercise some control over healthcare decisions. In some cases, PCP's and specialists can coordinate care through the same platform. Additionally, analytics allow for predictive modeling to deliver right time, right place care for high-risk individuals. Technology can also play a role in quality management in order to reduce outcome variations.

The California Quality Care Initiative is one example of improved care through the use of technology. Two years ago, a $19 million grant from the Center for Medicare and Medicaid Innovation helped launch the program for 27,000 Medicare patients living with multiple chronic conditions. Patients are conncted to a dedicated care coordinator, 24/7 access to a care team and same-day appointments. The coordinator builds a trusting, long-term relationship with the patients and facilitates pre-visit planning, manages the intake process and acts as part of a multidisciplinary team to support the patient's continuum of needs. Thus far, the program has saved more in health care costs than it costs to maintain it. Additionally, it has improved the patient experience by 2-4 percent while improving clinical outcomes and lowering hospital and emergency department visit costs by 5 percent.

While the history of chronic care programs has focused on complex, expensive solutions, there are some simple steps physicians and facilities can take. The first is to use uncomplicated care pathways, which are easy to administer and monitor. Secondly, define clear cut patient health goals which can be measured through the use of an electronic medical record by a care facilitator. Third, collect data in order to determine if refinements to care pathways are needed.

While basic these steps can help ensure patients receive a standardized, coordinated set of evidence-based interventions which improve the patients' health and quality of life, reduce the need for hospitalization and other costly treatments, and lower health care spending.