



Texas Association for
Home Care & Hospice
Leading ★ Advancing ★ Advocating

53rd Annual Meeting
Thursday, September 1, 2022
11:00am-12:15pm

7b. Chronic Care Management: Benefits of an Evidenced Based Program

Presented by:

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Chronic Care Management

An Evidence Based Approach

 SimiTree

Objectives

At the end of the presentation, the participant will be able to :

1. Identify most prevalent chronic disease diagnosis for home health agencies.
2. Recognize how outcomes can be improved through implementation of disease protocols.
3. Demonstrate various components of a disease specific protocol.

What Is Chronic Disease?

Per the CDC, chronic disease is broadly defined as:

- 🔪 A condition that last 1 year or more and requires ongoing medical attention or limits activities of daily living or both.

CDC's National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP)

CHRONIC DISEASES IN AMERICA

6 IN 10
Adults in the US have a **chronic disease**



4 IN 10
Adults in the US have **two or more**

THE LEADING CAUSES OF DEATH AND DISABILITY
and Leading Drivers of the Nation's **\$3.3 Trillion** in Annual Health Care Costs

What is the Cost of Chronic Disease?

Did you know?

Approximately 10,000 baby boomers turn 65 every day, and beneficiaries with five or more chronic conditions represent the fastest-growing segment of the Medicare population.

Examples of Chronic diseases

- ▶ Alzheimer's disease and related dementia;
- ▶ Arthritis (osteoarthritis and rheumatoid);
- ▶ Asthma;
- ▶ Atrial fibrillation;
- ▶ Autism spectrum disorders;
- ▶ Cancer;
- ▶ Chronic Obstructive Pulmonary Disease;
- ▶ Depression;
- ▶ Diabetes;
- ▶ Heart failure;
- ▶ Hypertension;
- ▶ Ischemic heart disease; and
- ▶ Osteoporosis.

Consider the Impact...



Heart disease & stroke

- 810,000 deaths in the US (1/3 of all deaths!)
- Heart disease kills roughly the same number of people in the United States each year as cancer, lower respiratory diseases (including pneumonia), and accidents combined.
- \$316.6 billion in health care costs and lost productivity.



Cancer

- 1.7 million diagnosis/year
- 600,000+ deaths/year
- Cost of care \$209 billion in 2020



Diabetes

- Affects 37 million Americans-23% undiagnosed
- Potential for multiple complications such as heart dz, kidney failure, etc.
- Cost \$327 billion/year to health care system and employers



Obesity

- 1/3 adults
- 1/5 children
- Obesity related premature deaths-heart dz, CVA, DM, certain CA's
- 41.9% of population
- \$173 billion/year



Arthritis

- Affects 54.4 million adults (more than 1 in 4)
- Leading cause of work disability
- Common cause of chronic pain
- \$319 billion for arthritis and related conditions (direct and indirect cost)

THE KEY LIFESTYLE RISKS FOR CHRONIC DISEASE



TOBACCO
USE



POOR
NUTRITION



LACK OF
PHYSICAL ACTIVITY



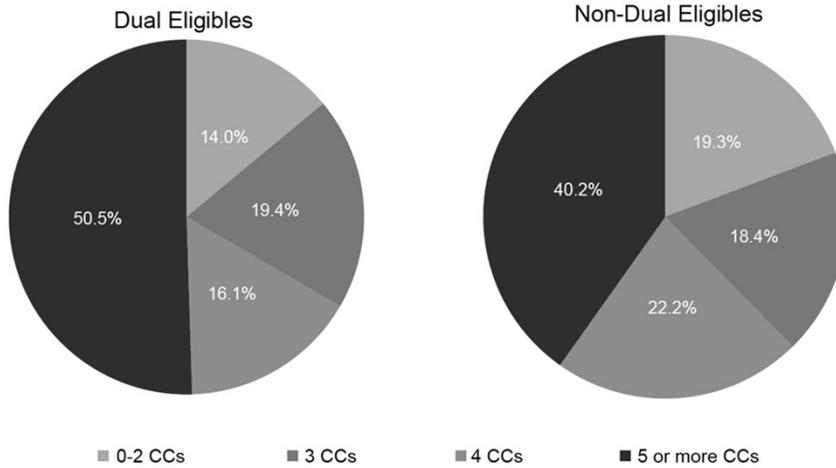
EXCESSIVE
ALCOHOL USE

Determine Risk Profile EARLY



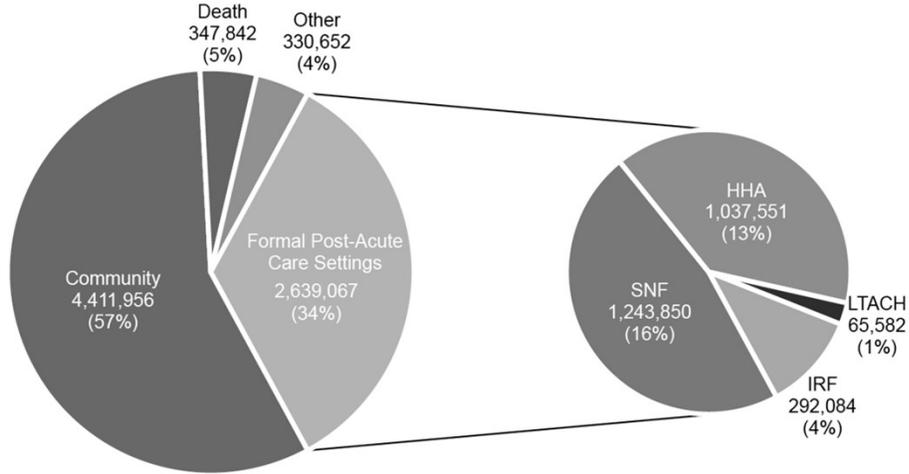
Demographics of Home Health Users by Dual Eligible Status

Chart 1.21: Percentage of Home Health Users by Dual Eligible Status and Number of Chronic Conditions (CCs), 2018



Post-Acute Care Market Overview

Chart 3.2: Initial Patient Destinations Following an Inpatient Hospital Stay for Medicare Beneficiaries, 2020



Source: Avalere Health, LLC analysis of Medicare Standard Analytic Files, 2020.

Demographic Trend of Home Health Users

Table 1.28: Selected characteristics of Medicare Home Health Users, 2012 – 2018

	2012	2013	2015	2016	2017	2018
Have 3 or more chronic conditions	85.9%	85.1%	85.9%	80.5%	82.3%	82.3%
Have 2 or more ADL limitations*	34.2%	31.9%	32.9%	27.8%	27.8%	27.9%
Have incomes under 200% of the Federal Poverty Level (FPL)**	67.9%	67.2%	62.5%	64.0%	57.1%	57.8%
Have incomes under 100% of the Federal Poverty Level (FPL)**	32.6%	31.2%	28.7%	27.5%	26.5%	22.8%
Are dual eligibles***	29.9%	31.7%	38.1%	31.3%	32.4%	30.0%
Have SMI****	27.0%	27.2%	44.0%	39.2%	38.3%	37.1%

Clinical Profile of Home Health Users

Table 2.2: Top 20 Primary International Classification of Diseases, Version 10 (ICD-10) Diagnoses for All Home Health Claims, 2020

ICD-10 Diagnosis	Number of Medicare Home Health Claims, 2020	Percent of Total Medicare Home Health Claims, 2020
Type 2 diabetes mellitus	782,916	8.31%
Encounter for other postprocedural aftercare	466,803	4.95%
Orthopedic aftercare	441,611	4.68%
Pressure ulcer	376,862	4.00%
Hypertensive heart disease	367,017	3.89%
Other chronic obstructive pulmonary disease	351,899	3.73%
Essential (primary) hypertension	338,489	3.59%
Sequelae of cerebrovascular disease	337,167	3.58%
Hypertensive heart and chronic kidney disease	280,044	2.97%
Chronic ischemic heart disease	228,570	2.42%
Fracture of femur	198,021	2.10%
Atrial fibrillation and flutter	173,750	1.84%
Parkinson's disease	165,505	1.76%
Encounter for fitting and adjustment of other devices	153,284	1.63%
Other disorders of veins	147,413	1.56%
Other disorders of urinary system	145,981	1.55%
Hypertensive chronic kidney disease	133,804	1.42%
Osteoarthritis of knee	132,658	1.41%
Alzheimer's disease	112,703	1.20%
Polyosteoarthritis	110,593	1.17%
Total for Top 20 Primary ICD-10 Diagnoses	5,445,090	57.76%

Clinical Profile of Home Health Users

Table 2.3: Percent of Medicare Home Health Users with 3 or More Chronic Conditions Compared to All Medicare Beneficiaries, by State, 2020

State	Percent of HH Users with 3+ CCs	Percent of Medicare Beneficiaries with 3+ CCs	State	Percent of HH Users with 3+ CCs	Percent of Medicare Beneficiaries with 3+ CCs
Alabama	91.98%	18.00%	Montana	91.79%	29.01%
Alaska	90.50%	23.31%	Nebraska	93.24%	28.40%
Arizona	89.05%	13.03%	Nevada	87.76%	13.58%
Arkansas	91.71%	23.78%	New Hampshire	91.14%	27.94%
California	89.27%	13.99%	New Jersey	91.05%	15.84%
Colorado	88.39%	14.46%	New Mexico	88.72%	18.24%
Connecticut	90.73%	16.50%	New York	90.50%	15.02%
Delaware	92.16%	27.11%	North Carolina	92.29%	18.82%
D.C.	88.77%	16.71%	North Dakota	95.16%	41.87%
Florida	89.23%	15.02%	Ohio	93.06%	20.09%
Georgia	91.33%	16.73%	Oklahoma	92.69%	28.54%
Hawaii	92.17%	9.52%	Oregon	91.03%	15.29%
Idaho	88.72%	22.34%	Pennsylvania	91.93%	18.43%
Illinois	93.22%	24.97%	Rhode Island	90.88%	15.85%
Indiana	93.57%	23.11%	South Carolina	91.25%	21.35%
Iowa	93.67%	30.02%	South Dakota	93.79%	37.27%
Kansas	92.81%	28.76%	Tennessee	92.26%	16.68%
Kentucky	92.65%	24.04%	Texas	91.35%	16.34%
Louisiana	91.77%	22.03%	Utah	85.98%	16.37%
Maine	93.27%	23.18%	Vermont	91.09%	32.75%
Maryland	91.20%	20.35%	Virginia	91.26%	22.49%
Massachusetts	90.93%	23.56%	Washington	91.21%	17.69%
Michigan	92.73%	20.47%	West Virginia	94.32%	30.27%
Minnesota	91.53%	18.28%	Wisconsin	93.28%	19.96%
Mississippi	91.88%	28.89%	Wyoming	89.09%	26.42%
Missouri	93.05%	23.52%			

Outcomes: Readmissions Among Post-Acute Care Users

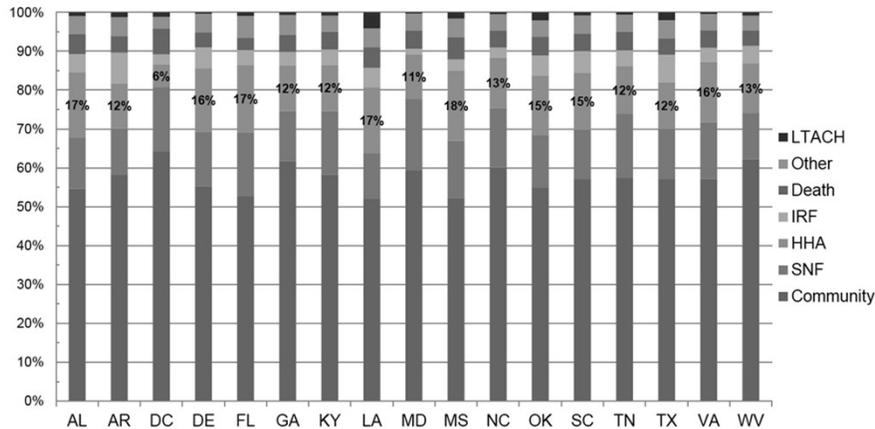
Table 6.1: 30-day Readmission Rates for Top 20 Most Common MS-DRGs Discharged from Hospital to Selected Post-Acute Care (PAC) Settings, by Setting, 2020

MS-DRG	% of Home Health Users Readmitted Within 30 Days	% of SNF Users Readmitted Within 30 Days
MISC disorders of nutrition, metabolism, fluids/electrolytes w MCC	25.79%	20.61%
Acute myocardial infarction, discharged alive w MCC	24.33%	24.63%
Other kidney & urinary tract diagnoses w MCC	23.95%	22.18%
Renal failure w MCC	23.39%	22.27%
Heart failure & shock w MCC	22.58%	23.75%
Pulmonary edema & respiratory failure	22.09%	22.40%
Renal failure w CC	21.27%	18.42%
Kidney & urinary tract infections w MCC	20.75%	16.41%
Infectious & parasitic diseases w O.R. procedure w MCC	20.46%	25.42%
Simple pneumonia & pleurisy w MCC	19.77%	19.45%
Septicemia or severe sepsis w/o MV >96 hours w MCC	19.56%	21.81%
MISC disorders of nutrition, metabolism, fluids/electrolytes w/o MCC	18.28%	14.94%
Intracranial hemorrhage or cerebral infarction w MCC	18.05%	20.05%
Kidney & urinary tract infections w/o MCC	16.33%	13.42%
Septicemia or severe sepsis w/o mv >96 hours w/o MCC	15.51%	15.60%
Respiratory infections & inflammations w MCC	15.36%	19.44%
Hip & femur procedures except major joint w MCC	14.12%	16.22%
Intracranial hemorrhage or cerebral infarction w CC or TPA in 24 hrs	10.29%	13.06%
Hip & femur procedures except major joint w CC	7.60%	10.49%
Major hip and knee joint replacement or reattachment of lower extremity w/o MCC	5.09%	8.93%
Average Rate Across All MS-DRGs**	17.30%	17.97%

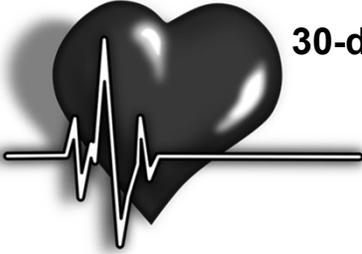
Where Did These Patients Go?

Post-Acute Care Market Overview

Chart 3.6: Initial Patient Destinations Following an Inpatient Hospital Stay for Medicare Beneficiaries in 2020, for States in Southern Region



✓ Based on data from CMS' Hospital Care Compare website, last updated July 7, 2022. Data presented reflect the national average.

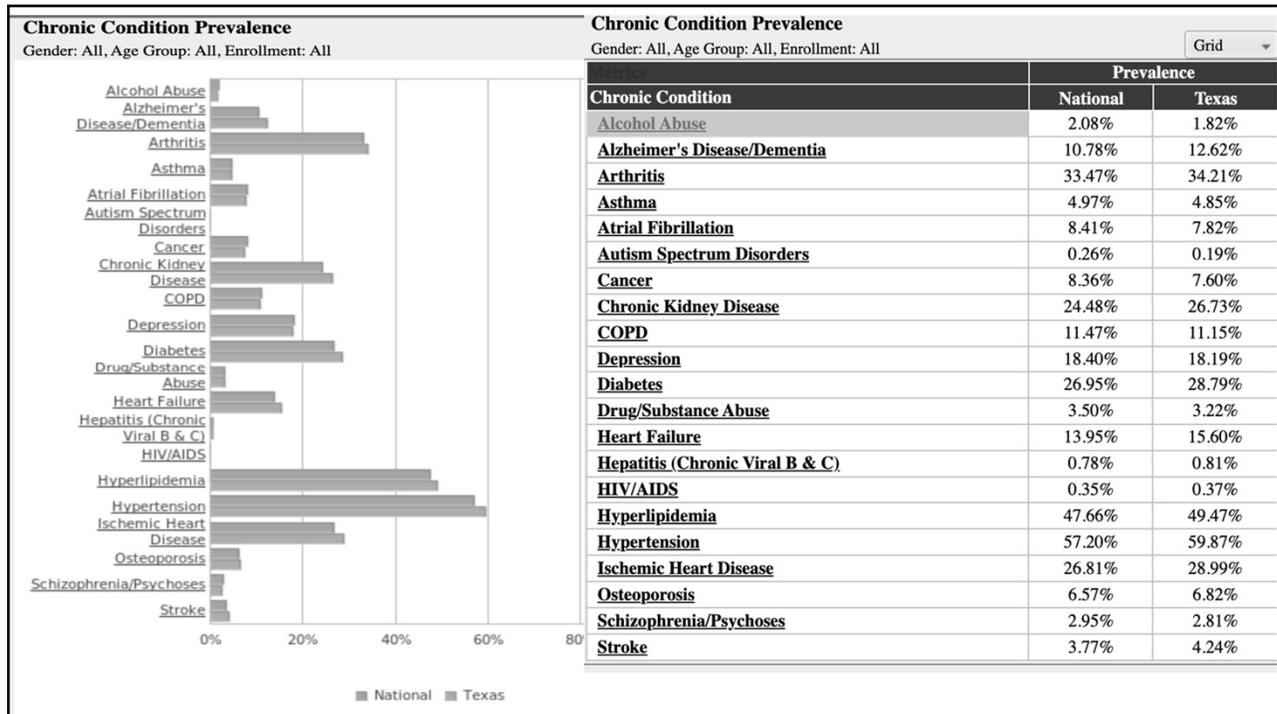


30-day average readmission rates

- Heart attack- 15%
- Heart Failure- 21.3%
- COPD- 19.8%



This image was created using the Zephyr Female Respiratory System and Heart



Chronic Condition Prevalence			Chronic Condition Prevalence		
Gender: Male, Age Group: All, Enrollment: All			Gender: Female, Age Group: All, Enrollment: All		
Chronic Condition	Prevalence		Chronic Condition	Prevalence	
	National	Texas		National	Texas
Alcohol Abuse	3.15%	2.80%	Alcohol Abuse	1.19%	1.00%
Alzheimer's Disease/Dementia	9.06%	10.55%	Alzheimer's Disease/Dementia	12.21%	14.38%
Arthritis	27.14%	27.30%	Arthritis	38.72%	40.07%
Asthma	3.26%	3.08%	Asthma	6.39%	6.36%
Atrial Fibrillation	9.47%	8.59%	Atrial Fibrillation	7.52%	7.17%
Autism Spectrum Disorders	0.42%	0.30%	Autism Spectrum Disorders	0.13%	0.10%
Cancer	9.15%	8.30%	Cancer	7.71%	7.01%
Chronic Kidney Disease	26.14%	27.90%	Chronic Kidney Disease	23.10%	25.74%
COPD	11.45%	10.85%	COPD	11.49%	11.41%
Depression	13.38%	12.56%	Depression	22.56%	22.97%
Diabetes	28.75%	30.18%	Diabetes	25.46%	27.61%
Drug/Substance Abuse	3.76%	3.16%	Drug/Substance Abuse	3.28%	3.27%
Heart Failure	14.59%	15.96%	Heart Failure	13.42%	15.28%
Hepatitis (Chronic Viral B & C)	1.03%	1.03%	Hepatitis (Chronic Viral B & C)	0.57%	0.62%
HIV/AIDS	0.58%	0.62%	HIV/AIDS	0.16%	0.16%
Hyperlipidemia	47.52%	48.70%	Hyperlipidemia	47.78%	50.12%
Hypertension	56.00%	58.01%	Hypertension	58.20%	61.44%
Ischemic Heart Disease	32.33%	34.04%	Ischemic Heart Disease	22.23%	24.70%
Osteoporosis	1.45%	1.66%	Osteoporosis	10.82%	11.21%
Schizophrenia/Psychoses	3.15%	2.81%	Schizophrenia/Psychoses	2.79%	2.81%
Stroke	3.80%	4.20%	Stroke	3.74%	4.28%

< 65-year-old, Both Male and Female

Chronic Condition Prevalence			Chronic Condition Prevalence		
Gender: Male, Age Group: <65, Enrollment: All			Gender: Female, Age Group: <65, Enrollment: All		
Chronic Condition	Prevalence		Chronic Condition	Prevalence	
	National	Texas		National	Texas
Alcohol Abuse	6.82%	5.58%	Alcohol Abuse	3.67%	2.91%
Alzheimer's Disease/Dementia	4.51%	5.56%	Alzheimer's Disease/Dementia	4.48%	6.05%
Arthritis	20.49%	19.69%	Arthritis	33.88%	35.52%
Asthma	4.49%	3.85%	Asthma	10.75%	9.96%
Atrial Fibrillation	2.83%	2.62%	Atrial Fibrillation	1.77%	1.81%
Autism Spectrum Disorders	2.23%	1.78%	Autism Spectrum Disorders	0.84%	0.71%
Cancer	2.17%	1.92%	Cancer	3.98%	3.67%
Chronic Kidney Disease	22.56%	27.89%	Chronic Kidney Disease	21.72%	27.47%
COPD	10.66%	8.63%	COPD	13.79%	12.70%
Depression	23.72%	21.31%	Depression	40.23%	38.57%
Diabetes	25.93%	29.57%	Diabetes	26.91%	31.55%
Drug/Substance Abuse	12.14%	9.65%	Drug/Substance Abuse	12.40%	11.42%
Heart Failure	10.92%	13.86%	Heart Failure	10.11%	13.92%
Hepatitis (Chronic Viral B & C)	2.63%	2.91%	Hepatitis (Chronic Viral B & C)	1.77%	2.06%
HIV/AIDS	2.24%	2.83%	HIV/AIDS	0.86%	0.98%
Hyperlipidemia	31.25%	33.23%	Hyperlipidemia	32.52%	36.28%
Hypertension	41.84%	44.99%	Hypertension	43.09%	49.03%
Ischemic Heart Disease	18.25%	19.94%	Ischemic Heart Disease	15.25%	18.63%
Osteoporosis	1.03%	1.23%	Osteoporosis	4.02%	4.76%
Schizophrenia/Psychoses	11.36%	10.19%	Schizophrenia/Psychoses	8.78%	8.79%
Stroke	2.70%	3.41%	Stroke	2.80%	3.70%

> 65-year-old, Both Male and Female

Chronic Condition Prevalence			Chronic Condition Prevalence		
Gender: Male, Age Group: 65+, Enrollment: All			Gender: Female, Age Group: 65+, Enrollment: All		
Chronic Condition	Prevalence		Chronic Condition	Prevalence	
	National	Texas		National	Texas
Alcohol Abuse	2.37%	2.28%	Alcohol Abuse	0.82%	0.74%
Alzheimer's Disease/Dementia	10.02%	11.49%	Alzheimer's Disease/Dementia	13.38%	15.50%
Arthritis	28.55%	28.72%	Arthritis	39.45%	40.68%
Asthma	3.00%	2.93%	Asthma	5.72%	5.87%
Atrial Fibrillation	10.88%	9.71%	Atrial Fibrillation	8.40%	7.88%
Autism Spectrum Disorders	0.04%	0.03%	Autism Spectrum Disorders	0.02%	0.01%
Cancer	10.63%	9.50%	Cancer	8.28%	7.45%
Chronic Kidney Disease	26.90%	27.91%	Chronic Kidney Disease	23.31%	25.51%
COPD	11.61%	11.27%	COPD	11.14%	11.24%
Depression	11.18%	10.92%	Depression	19.87%	20.89%
Diabetes	29.35%	30.29%	Diabetes	25.25%	27.08%
Drug/Substance Abuse	1.98%	1.94%	Drug/Substance Abuse	1.90%	2.19%
Heart Failure	15.37%	16.35%	Heart Failure	13.92%	15.47%
Hepatitis (Chronic Viral B & C)	0.69%	0.68%	Hepatitis (Chronic Viral B & C)	0.39%	0.43%
HIV/AIDS	0.22%	0.21%	HIV/AIDS	0.06%	0.05%
Hyperlipidemia	50.97%	51.59%	Hyperlipidemia	50.10%	51.97%
Hypertension	59.01%	60.44%	Hypertension	60.50%	63.10%
Ischemic Heart Disease	35.32%	36.68%	Ischemic Heart Disease	23.29%	25.51%
Osteoporosis	1.54%	1.74%	Osteoporosis	11.86%	12.07%
Schizophrenia/Psychoses	1.40%	1.43%	Schizophrenia/Psychoses	1.88%	2.01%
Stroke	4.03%	4.35%	Stroke	3.88%	4.35%

Current Care Compare

	Texas Average	National Average
How often home health patients had to be admitted to the hospital	13.7%	14.2%
ER Use without admission	11.6%	11.9%
Discharge to Community	-	76.3%
Potentially Preventable Rehospitalization	-	3.4%

Rehospitalization and Follow Up

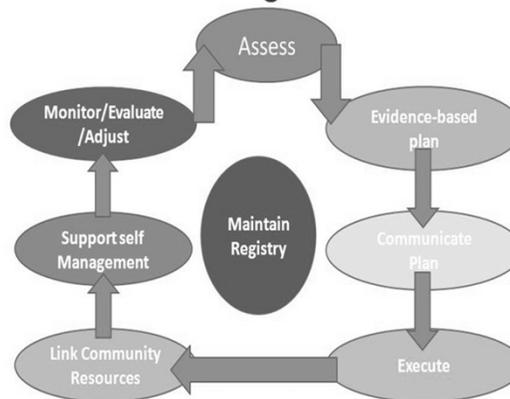
Nationally, approximately one-half of Medicare and Medicaid beneficiaries readmitted within 30 days of a hospital discharge do not receive outpatient follow-up before the readmission.

In current practice, one-size-fits-all discharge protocols may be determining a follow-up time frame more than evidence-based decision making or clinical need.

Disease Management

What Is It?

Disease Management Workflow



Disease Management

- Disease management is a system of coordinated health care interventions and communications for defined patient populations with conditions where self-care efforts can be implemented. Disease management empowers individuals, working with other health care providers to manage their disease and prevent complications.
- Disease management has emerged as a promising strategy for improving care for those individuals with chronic conditions. People with chronic conditions usually use more health care services which often are not coordinated among providers, creating opportunities for overuse or underuse of medical care.

Disease Management

Disease management is a proactive, multidisciplinary, systematic approach to health care delivery that:

- Includes all members with a chronic disease
- Supports the provider-patient relationship and plan of care
- Optimizes patient care through prevention and proactive interventions based on evidence-based guidelines
- Incorporates patient self-management
- Continuously evaluates health status
- Measures outcomes
- Strives to improve overall health and quality of life and lower cost of care

Components of Disease Management Programs

- Population identification process
 - Programs designed to target individuals with specific diseases
 - Chronic and costly conditions
- Evidence based practice guidelines
- Collaborative practice involvement
 - Multidisciplinary teams-agency, MD's, pharmacies, dieticians, psychologists
- Risk identification and matching of interventions to need
- Patient Self Management Education
 - Behavior modification, support groups, primary prevention

Components of Disease Management Programs

- Process and outcomes measurement and evaluation
 - A method for the measurement of outcomes may include health care service use, expenditures and patient satisfaction
- Tracking and monitoring system
 - Routine reporting and feedback loops that include patients and providers
- Appropriate use of information technology

It all starts at INTAKE

Upfront/intake assessment to determine chronic conditions/highest risk of hospitalization

- What is the patient's primary diagnosis?
- What co-morbid conditions do they have?
- Do several of those conditions fall under a specific body system?
 - Patient with HTN, CHF, CAD and Afib
- Do they have enough medications to stock the local Walgreens?

Get the most information you can before you admit the patient!

Chronic Disorders Commonly Managed Through Disease Management

- Diabetes Mellitus
- Congestive Heart Failure (CHF)
- Chronic Obstructive Pulmonary Disease (COPD)
- Coronary Artery Disease (CAD)
- Asthma
- Hypertension



Disease Management Programs

- Care coordination is one of the primary concerns of health care payors and providers. Individuals with chronic conditions require appropriate management and interventions to ensure optimal health outcomes.
- Disease management programs should emphasize the prevention of exacerbations and complications using evidence-based practice guidelines and patient empowerment strategies, while evaluating clinical, economic and humanistic outcomes to improve overall health and quality of life for patients.

Disease Management Programs Can:

- Improve the safety and quality of care
- Improve access to care
- Improve patient self-management
- Improve financial cost containment without sacrificing quality or patient satisfaction
- Enhance efforts to provide health improvement programs on a population basis

Focus on Patient Populations

- In traditional fee-for-service settings, health care professionals typically focus on specific, isolated medical events and the health care status of individual patients.
- For example, a physician who diagnoses and treats a patient with congestive heart failure (CHF) may believe he or she has fulfilled their responsibility once the patient's symptoms are resolved.
- The physician would then prescribe appropriate medications and suggest ways to manage CHF symptoms. Generally, physicians or other health care professionals only have the opportunity to evaluate patients when the patient complains of symptoms, when the patient is seen during an office visit or when the patient is hospitalized.

Focus on Patient Populations

- Disease management programs focus on multiple facets of patient care and maximize the health status of defined patient populations.
- Successful disease management programs coordinate care for the disease among all providers, physicians, pharmacists, hospitals and laboratories.
- They also develop and implement a partnership with patients, because all of these individuals understand the value and relative contribution each brings to the program.

Example

- A disease management program for a health plan's CHF patients often involves instruction for daily weigh-ins to monitor minor weight fluctuations due to fluid retention.
- Programs may involve a daily telephone call from a nurse verifying a patient's weight. Such programs are then able to notify the patient's physician of weight changes before such changes cause hospitalizations

Patient Interactions-Asthma

- Provide educational programs about disease process
- Conduct periodic review of the patient's inhaler technique
- Performing ongoing monitoring of peak-flow function tests
- Manage chronic medication use, including compliance assistance.

Patient Interactions-Diabetes

- Provide educational programs to patients about the disease,
- Regularly monitor both self-tested and laboratory tested blood glucose levels,
- Educate patients on how to use home blood glucose monitoring equipment,
- Monitor patient compliance with prescribed therapies and scheduled clinic and laboratory appointments,
- Screen for drug/drug, drug/food, drug/lab and drug/disease interactions and adverse drug reactions,
- Provide medication management and review.

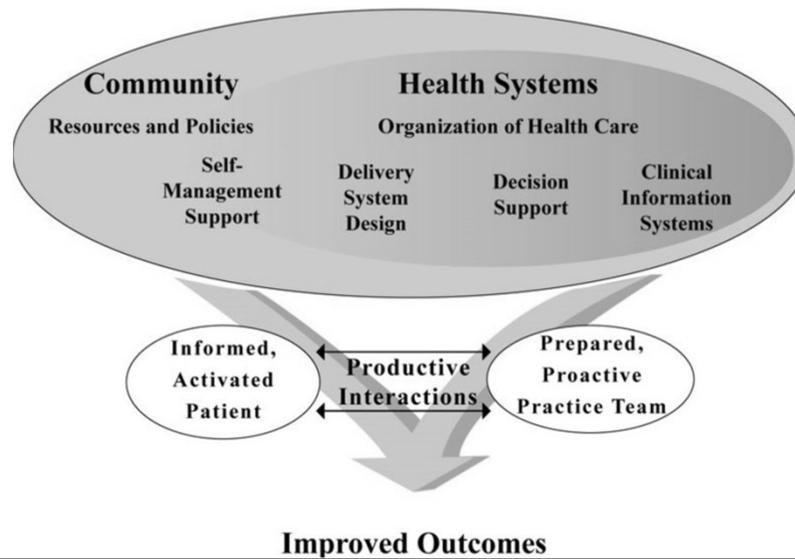
Patient Interactions-Hypertension and Cholesterol

- Educate patients about these silent diseases,
- Monitor compliance with medications, diet and exercise regimens,
- Screen for drug/drug, drug/food, drug/lab and drug/disease interactions and adverse drug reactions,
- Perform periodic blood pressure checks,
- Perform periodic cholesterol level checks.

Changes to Improve Chronic Care

Chronic Care Management

The Chronic Care Model



Chronic Care: Self Management support/EBP

- Identify high-quality patient education materials.
- Review materials for reading level and cultural appropriateness. Determine if different versions — languages, literacy levels — are necessary to serve patients.
- Review materials with the care team.
- Test materials with a few patients and revise as necessary.
- Make materials available to patients, families, and providers by placing them in examining rooms and waiting rooms.
- Share materials with pharmacies, faith-based organizations, and community groups.

Chronic Care: Self Management support/EBP

Tips

- Be selective and keep material brief. Include materials with larger print
- Work with lay health workers in the community to select and review materials.
- Remove outdated educational materials from the clinic.
- Coordinate patient education with the organization's care guidelines.

Delivery of Care System

Important to determine not only what care is needed, but clarifying roles and tasks to ensure that the patient gets the care that is needed.

- Centralized, up to date information about the patient's status and making follow up a part of standards
 - Use of shared technology

In a well-designed delivery system, clinicians, plan visits well in advance, based on the patient's needs and self-management goals.

Planned Visits

Coordinated, planned multidisciplinary approach

- Daily huddles
- Assessment
- Review of medical care
- Review of treatments
- Use flowsheets or guides
- Self-Management Goals
- Problem Solving
- Follow-up plan

Treatment Decisions

Treatment decisions need to be based on explicit, proven guidelines supported by at least one defining study. Health care organizations creatively integrate explicit, proven guidelines into the day-to-day practice in an accessible and easy-to-use manner.

Embed Evidence Based Guidelines

- Identify existing guidelines.
- Review guidelines and select the best one(s) for your clinical setting. Make sure they are based on the best medical evidence.
- Teach providers the basics of evidence-based medicine and guideline review.
- Have providers review and discuss guidelines to develop consensus.
- Customize guidelines for your organization, within the boundaries of the evidence.
- Use a standardized assessment to diagnose and determine disease control and risk for complications (heart, eyes, kidneys, etc.) to guide management for all patients.

Embed Evidence Based Guidelines

- Consider conducting a baseline chart audit to benchmark your current practice against agreed upon guidelines.
- Use flowsheets, pathways, or checklists to embed guidelines into daily practice. The guidelines include triggers for care.
- Link guidelines to the information system to provide prompts.
- Review and update guidelines for care regularly (at least yearly).
- Remove barriers identified with previous guidelines.

Don't reinvent the wheel! Obtain existing guidelines from the National Guideline Clearinghouse or use standards from reputable organizations.

Ensure Regular Follow Up

Designate staff to be responsible for follow-up by various methods, including outreach workers, telephone calls, and home visits.

1. Identify follow-up needs, such as eye exams, dental care, HbA1C, labs, and visits
2. Plan the follow up approach, including who will contact patients, how and when.
3. Use phone, outreach workers, and mailings for follow up

Evaluation of Disease Management Programs

- Health outcomes affect both the quality of life and the use of health care services.
- Disease management programs are objectively evaluated based on previously defined outcome points and the collection of baseline data on the natural course of the targeted disease.
- Performance indicators and outcome measures should be analyzed to determine if the program is achieving quality improvement.
- Performance indicators assess a specific performance at regular intervals and compare performance to predefined indicators.

Types of Outcome Measurements

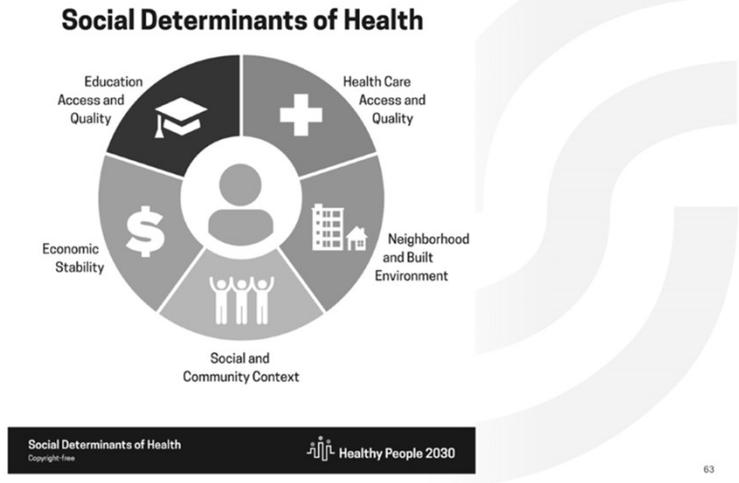
- Clinical outcomes and health care utilization, such as a change in the incidence of medical outcomes, e.g., heart attacks, increase or decrease in use of medications
- Humanistic outcomes (quality of life) measure the patient's own assessment of the impact of the program on his or her physical, social and emotional well-being
- Economic outcomes, defined as the cost of the intervention less any savings from health improvements

Community Support

Community programs and organizations that can support or expand a health system's care for chronically ill patients and prevention strategies are often overlooked. To improve the health of the population, health care organizations reach out to form powerful alliances and partnerships with state programs, local agencies, schools, faith organizations, businesses, and clubs.



Social Determinates

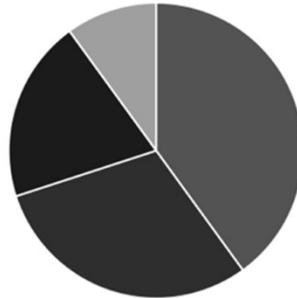


Social Disparity

Social determinants' role in health

Factors beyond medical care play significant roles in impacting patients' health

- Socio-economic factors, 40%
- Health behaviors, 30%
- Healthcare, 20%
- Physical environment, 10%



Source: University of Wisconsin, Population Health Institute, percentage estimates of impact on patient health.

Disease Specific Protocols



55

Why Use Disease Specific Protocols?

Staff education

- Guide new staff on establishing frequency

Improve care coordination

- Benefits of other disciplines

Better episode management

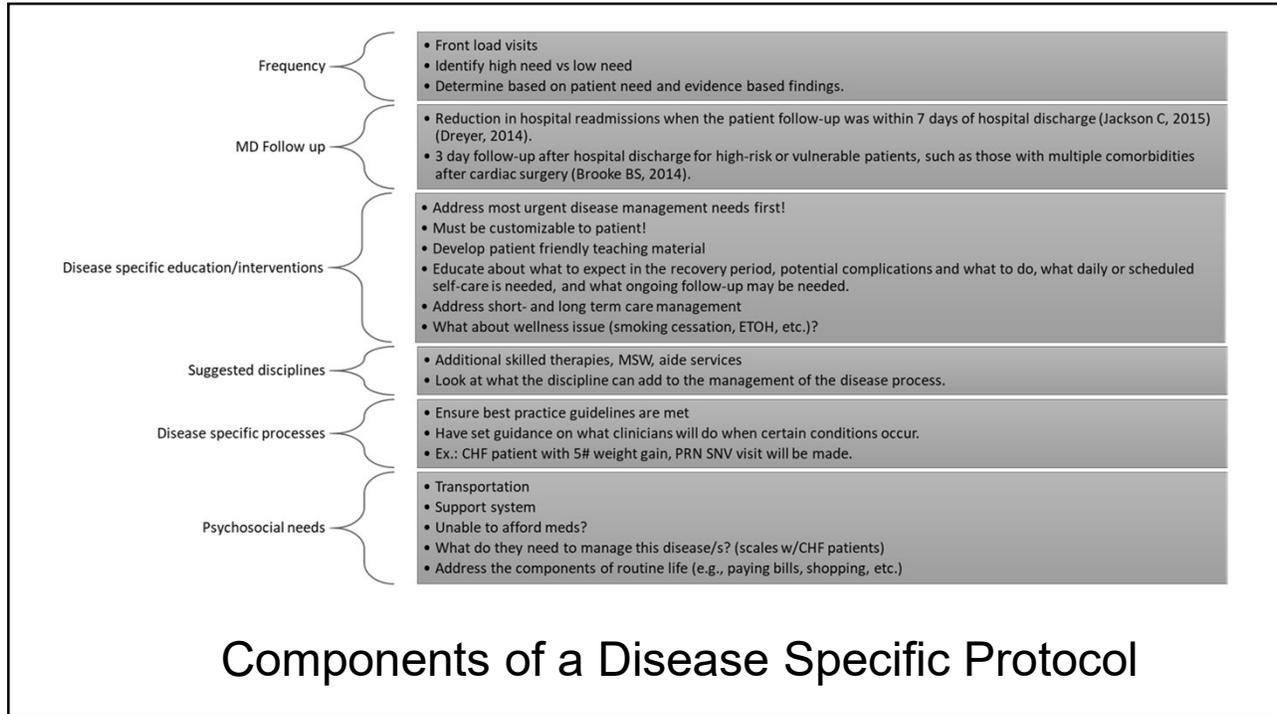
Ease of tracking disease specific outcomes

- Consider specialty programs for areas of high risk for your area

Reduced rehospitalizations

- Improved disease management for patients
- Effects payment and outcome measures

**REMEMBER PROTOCOLS ARE GUIDELINES!
ALL CARE PROVIDED MUST BE PATIENT SPECIFIC!**



Comprehensive Care Plan

A comprehensive care plan for all health issues typically includes, but isn't limited to:

- Problem list
- Expected outcome and prognosis
- Measurable treatment goals
- Cognitive and functional assessment
- Symptom management
- Planned interventions
- Medication management
- Environmental evaluation
- Caregiver assessment
- Interaction and coordination with outside resources, practitioners, and providers
- Requirements for periodic review
- When applicable, revision of the care plan

Disease specific education/interventions

Address most urgent disease management needs first!

- What do they need to know TODAY to make sure they can remain safely in the home?
 - CHF: dyspnea, swelling, pink tinged sputum
 - DM: FSBS upper and lower limit, S/S of hypoglycemia along with treatment
 - High risk medication complications requiring IMMEDIATE attention

Interventions & Goals must be customizable to patient!

Per the CoPs: §484.60(a)(1) Each patient must receive the home health services that are written in an individualized plan of care that identifies patient-specific measurable outcomes and goals, and which is established, periodically reviewed, and signed by a doctor of medicine, osteopathy, or podiatry acting within the scope of his or her state license, certification, or registration. If a physician refers a patient under a plan of care that cannot be completed until after an evaluation visit, the physician is consulted to approve additions or modifications to the original plan.

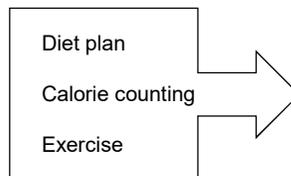
The lost art of writing interventions & goals

So what is an outcome?

Per Merriam Webster an outcome is “something that follows as a result or consequence”



Current situation



Projected outcome

What IS a Patient Specific Outcome and Goal?

Patient with long term type 2 DM with frequent episodes of hypoglycemia. Patient currently on metformin 500 mg BID with MD order to check FSBS BID. Patient has not demonstrated compliance with metformin as prescribed and unsure of a carb controlled diet. She is checking FSBS 3-4 times weekly as demonstrated by her glucose log. She states one of her neighbors buys her groceries weekly based on her grocery list and then delivers to her home. Patient reports she has been unable to attend church for the last few months due to continued episodes of feeling dizzy, episodes of sweating and fear of falling. She states she really wants to get back to church as this is her primary source of companionship and support.

What are the outcome and goals?

- What is the patient's specific goal for HH service at this point?
- Outcome:
 - Patient will report no further episodes of hypoglycemia by the end of the episode.
- Goals:
 - Patient will verbalize & demonstrate correct use of metformin 500mg BID within 2 weeks.
 - Patient will demonstrate checking FSBS using correct technique and recording in her log 1 times daily within 4 weeks and BID checks within 9 weeks.
 - Patient will verbalize 2 diet modification to decrease carbs in her diet within 5 weeks.

Develop patient friendly teaching material

Again, per the CoPs:

- §484.50(f) Standard: Accessibility. Information must be provided to patients in plain language and in a manner that is accessible and timely to—
- “Plain language” (also referred to as “Plain English”) is communication the patient and/or his or her representative (if any) can understand the first time they read or hear it. Language that is plain to one set of readers may not be plain to others. Written material is in plain language if the audience can:
 - Find what they need;
 - Understand what they find; and
 - Use what they find to meet their needs.

A copy of your POC (or med profile) written in medical terms (which most of us do) is not a good way to convey what your agency will be doing for the patient.

Chronic Disease Management-Physician Perspective

Billing Code	Code Description	Summary Requirements	Average Payment	<p>Chronic Care Management Service Practitioners</p> <p>These physician and NPP may bill CCM Services</p> <ul style="list-style-type: none"> • Certified Nurse Midwives • Clinical Nurse Specialists • Nurse Practitioners • Physician Assistants
HCPCS G0506	Comprehensive Assessment & Care Planning	<ul style="list-style-type: none"> ▪ Patient enrolled in person ▪ Systematic assessment & care planning personally performed by the billing provider ▪ Add-on code to the standard E&M code (99212-99215), AWV or IPPE initiating visit 	\$64	
CPT 99490	Standard CCM	<ul style="list-style-type: none"> ▪ 20+ minutes of care management outside of office visits performed by clinical staff ▪ Care plan established and regularly reviewed 	\$64	
CPT 99439	Non-complex Add-on	<ul style="list-style-type: none"> ▪ Additional 20 minutes of "non-complex" CCM ▪ Reportable up to 2x per month (after 99490) 	\$48.45 x 2	
CPT 99487	Complex CCM	<ul style="list-style-type: none"> ▪ 60+ minutes of care management outside office visits ▪ Care plan created and/or significantly revised 	\$93	
CPT 99489	Complex Add-on	<ul style="list-style-type: none"> ▪ Billed incrementally for each additional 30 minutes spent beyond the first 60 minutes for Complex CCM case 	\$45	
CPT 99491	Physician-provided CCM	<ul style="list-style-type: none"> ▪ 30+ minutes of care management outside of office visits ▪ Provided personally by a physician or other qualified healthcare professional 	\$82	
CPT 99437 (New in 2022)	Physician-provided CCM	<ul style="list-style-type: none"> ▪ Additional 20 minutes of care management outside of office visits ▪ Provided personally by physician or other qualified healthcare professional 	\$61	

CCM Billing

For CCM services the billing practitioner doesn't personally furnish, the clinical staff furnish them under direction of the billing practitioner on an incident to basis (as an integral part of services furnished by the billing practitioner), subject to applicable state law, licensure, and scope of practice. Clinical staff are employees or working under contract with the billing practitioner and we directly pay that practitioner for CCM services.

Supervision

- CCM codes describing clinical staff activities (CPT 99487, 99489, and 99490) as general supervision under the Medicare PFS
- General supervision means when the billing practitioner doesn't personally furnish the service, it's done under their overall direction and control
- Don't require the physician's physical presence while service is furnished

Patient Eligibility

- Eligible CCM patients will have multiple (2 or more) chronic conditions expected to last at least 12 months or until the patient's death and or that place them at significant risk of death, acute exacerbation and or decompensation, or functional decline.
- These services aren't typically **face-to-face** and allow eligible practitioners to bill at least 20 minutes or more of care coordination services per month
- Although patient cost sharing applies to the CCM service, some patients have Supplemental Insurance (Medigap) to help cover CCM cost sharing. Also, CCM may help avoid the need for more costly services in the future by proactively managing patient health, rather than only treating severe or acute disease and illness.

Diagnosis-Example-Not Limited To...

- Alzheimer's disease or related dementia
- Arthritis (OA or RA)
- Asthma
- Atrial Fibrillation
- Autism Spectrum Disorders
- Cancer
- Cardiovascular disease
- COPD
- Depression
- Diabetes
- HTN
- Infectious Dz (HIV/AIDS)

Take Aways

- Research if a chronic disease program is for you
 - Physician, providers to assist in supporting the program
- Test each program you put in place
- Think outside the box
- Use evidence-based protocols
- Data, data data
- Utilize technology to your benefit

References

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<http://www.docturnal.com/articles/disease-management-programme-module-on-heart-failure-current-guidelines-indicate-some-need-for-revision/>

<https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/chroniccaremanagement.pdf>



Questions

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