2g. Best Practices: The Role of Chronic Disease Management in VBP

Presented by:

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The Role of Disease Management in VBP

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Objectives

The learner will understand:

1) Strategies to evaluate current disease management programs

2) The role of telehealth and remote patient monitoring in disease management programs

3) How to succeed under HHVBP using disease management programs
### History

<table>
<thead>
<tr>
<th>Measure</th>
<th>HHVBP Effect</th>
<th>Relative change (%) vs 2013-2015 average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unplanned Hospitalization</td>
<td>Decrease</td>
<td>-1.6%</td>
</tr>
<tr>
<td>ED Use (no Hospitalization) among First FFS HH Episodes</td>
<td>Increase</td>
<td>2.5%</td>
</tr>
<tr>
<td>Discharged to Community</td>
<td>Increase</td>
<td>1.3%</td>
</tr>
<tr>
<td>Total Normalized Composite Change in Self Care</td>
<td>Increase</td>
<td>2.9%</td>
</tr>
<tr>
<td>Total Normalized Composite Change in Mobility</td>
<td>Increase</td>
<td>2.3%</td>
</tr>
<tr>
<td>Improvement in Management of Oral Medications</td>
<td>Increase</td>
<td>4.8%</td>
</tr>
<tr>
<td>Improvement in Dyspnea</td>
<td>N.S.</td>
<td>-0.1%</td>
</tr>
<tr>
<td>Professional Care</td>
<td>Decrease</td>
<td>-0.2%</td>
</tr>
<tr>
<td>Communication</td>
<td>Decrease</td>
<td>-0.3%</td>
</tr>
<tr>
<td>Specific Care Issues / Team Discussion</td>
<td>Decrease</td>
<td>-0.4%</td>
</tr>
<tr>
<td>Overall rating</td>
<td>N.S.</td>
<td>-0.05%</td>
</tr>
<tr>
<td>Likelihood to recommend</td>
<td>N.S.</td>
<td>-0.01%</td>
</tr>
</tbody>
</table>

### Measures

<table>
<thead>
<tr>
<th>Measure Type</th>
<th>Measure Name</th>
<th>Category</th>
<th>Measure</th>
<th>TPS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claims Based</td>
<td>Acute Care Hospitalization</td>
<td>35%</td>
<td>75.00%</td>
<td>26.25%</td>
</tr>
<tr>
<td></td>
<td>ED Use</td>
<td></td>
<td>25.00%</td>
<td>8.75%</td>
</tr>
<tr>
<td>OASIS Based</td>
<td>Dyspnea</td>
<td></td>
<td>16.67%</td>
<td>5.83%</td>
</tr>
<tr>
<td></td>
<td>Discharge to Community</td>
<td></td>
<td>16.67%</td>
<td>5.83%</td>
</tr>
<tr>
<td></td>
<td>Management of Oral Medications</td>
<td>35%</td>
<td>16.67%</td>
<td>5.83%</td>
</tr>
<tr>
<td></td>
<td>TNC Self-Care</td>
<td></td>
<td>25.00%</td>
<td>8.75%</td>
</tr>
<tr>
<td></td>
<td>TNC Mobility</td>
<td></td>
<td>25.00%</td>
<td>8.75%</td>
</tr>
<tr>
<td>HHCAHPS</td>
<td>Professional Care</td>
<td></td>
<td>20.00%</td>
<td>6.00%</td>
</tr>
<tr>
<td></td>
<td>Communication</td>
<td></td>
<td>20.00%</td>
<td>6.00%</td>
</tr>
<tr>
<td></td>
<td>Specific Care Issues / Team Discussion</td>
<td>30%</td>
<td>20.00%</td>
<td>6.00%</td>
</tr>
</tbody>
</table>
Chronic Disease in Home Health

- The 10 most common primary diagnoses in early periods for CY 2021 are below:

<table>
<thead>
<tr>
<th>National Primary Diagnosis</th>
<th>Percent</th>
<th>Texas Primary Diagnosis</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Z47 Ortho aftercare</td>
<td>9.6%</td>
<td>Z47 Ortho aftercare</td>
<td>10.9%</td>
</tr>
<tr>
<td>Z48 Other postprocedural aftercare</td>
<td>7.1%</td>
<td>E11 Type II Diabetes</td>
<td>6.1%</td>
</tr>
<tr>
<td>E11 Type II Diabetes</td>
<td>5.0%</td>
<td>Z48 Other postprocedural aftercare</td>
<td>5.8%</td>
</tr>
<tr>
<td>U07 COVID-19</td>
<td>3.7%</td>
<td>U07 COVID-19</td>
<td>3.8%</td>
</tr>
<tr>
<td>I69 Sequelae of cerebrovascular disease</td>
<td>3.6%</td>
<td>I69 Sequelae of cerebrovascular disease</td>
<td>3.6%</td>
</tr>
<tr>
<td>S72 Femur fracture</td>
<td>2.8%</td>
<td>S72 Femur fracture</td>
<td>3.0%</td>
</tr>
<tr>
<td>I10 Essential hypertension</td>
<td>2.7%</td>
<td>I44 COPD</td>
<td>2.6%</td>
</tr>
<tr>
<td>I11 Hypertensive heart disease</td>
<td>2.7%</td>
<td>I1 Hypertensive heart disease</td>
<td>2.6%</td>
</tr>
<tr>
<td>J44 COPD</td>
<td>2.5%</td>
<td>I13 Hypertensive heart and renal disease</td>
<td>2.1%</td>
</tr>
</tbody>
</table>

What is Chronic Disease Management?

- Healthcare.gov defines Chronic Disease Management as “An integrated care approach to managing illness which includes screenings, check-ups, monitoring and coordinating treatment, and patient education. It can improve your quality of life while reducing your health care costs if you have a chronic disease by preventing or minimizing the effects of a disease.”
Monitoring and Coordinating

• Communication
  • Interdisciplinary
  • Patient/Caregiver
  • Physicians / NP / PA

• Visit utilization

• Socioeconomic factors and support systems

• Telehealth and Remote Patient Monitoring

Telehealth and Remote Patient Monitoring

• Telehealth – all care provided without an in-person visit; this can include phone calls, video chats or text messages

• Remote Patient Monitoring – frequent monitoring of one or more aspects of patient’s health status which this may include vital signs, blood glucose, or weight
Patient Education

- Medications – remember the 5 rights
- Home safety – what can we do to keep them at home
- Diet – what is their current diet
- Exercise – determine activity tolerance

Medications and Equipment

COPD
- Inhalers
- Oxygen
- Pulse ox

Hypertension
- Parameters
- BP monitoring
- Scale

Diabetes
- Insulin
- Glucometer
- Strips
- Lancets
**Diet and Nutrition**

**COPD**
- Portions
- Frequency
- Fluid intake

**Hypertension**
- Sodium restriction
- Limit alcohol

**Diabetes**
- Portions
- Carbohydrates
- Sugar

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**Exacerbation**

**COPD**
- Increased cough or shortness of breath
- Swelling in legs or ankles
- Trouble sleeping
- Lower pulse ox readings

**Hypertension**
- Blood pressure outside physician established parameters
- Headache
- Blurred vision
- Nausea

**Diabetes**
- Hypoglycemia
- Shakiness
- Sweating
- Headache
- Dizziness
- Hyperglycemia
- Frequent urination
- Increased thirst
How does this pertain to HHVBP

• ACH, ED use, Discharge to Community

• Leverage technology to supplement visits – frequent touch points are vital

• Instruct when to call the agency

• Review logs during visits – blood pressure, weight, glucometer, nutrition

• Regular team communication

How does this pertain to HHVBP

• ACH, ED use, Discharge to Community

• Discharge planning should begin at SOC – what do we need to do for the patient to remain safe at home once we discharge them?

• One of the goals of disease management is to reduce the impact of a disease on the patient’s life
How does this pertain to HHVBP

- Dyspnea and Medication Management
  
  - Accurately determine the patient’s baseline and any barriers at SOC or ROC so we can implement appropriate interventions
  
  - Modify the home environment as much as we are able and allowed by the patient/caregiver

How does this pertain to HHVBP

- Dyspnea and Medication Management

  - Educate
    
  - Teach-back
    
  - Demonstration
How does this pertain to HHVBP

• Patient Satisfaction – Professional Care

<table>
<thead>
<tr>
<th>Care of Patients Composite (&quot;Patients who reported that their home health team gave care in a professional way.&quot;)</th>
<th>Response Categories</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q9. In the last 2 months of care, how often did home health providers from this agency seem informed and up-to-date about all the care or treatment you got at home?</td>
<td>Never, Sometimes, Usually, Always</td>
</tr>
<tr>
<td>Q16. In the last 2 months of care, how often did home health providers from this agency treat you as gently as possible?</td>
<td>Never, Sometimes, Usually, Always</td>
</tr>
<tr>
<td>Q19. In the last 2 months of care, how often did home health providers from this agency treat you with courtesy and respect?</td>
<td>Never, Sometimes, Usually, Always</td>
</tr>
<tr>
<td>Q24. In the last 2 months of care, did you have any problems with the care you got through this agency?</td>
<td>Yes, No</td>
</tr>
</tbody>
</table>

How does this pertain to HHVBP

• Patient Satisfaction – Professional Care

• Review the patient’s history, medications and previous note prior to the visit

• Inform the patient when procedures may be uncomfortable

• Seek the patient’s input when providing education and instruction
How does this pertain to HHVBP

• Patient Satisfaction – Communication

<table>
<thead>
<tr>
<th>Communications Between Providers and Patients Composite (&quot;Patients who reported that their home health team communicated well with them.&quot;)</th>
<th>Response Categories</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q2. When you first started getting home health care from this agency, did someone from the agency tell you what care and services you would get?</td>
<td>Yes, No</td>
</tr>
<tr>
<td>Q15. In the last 2 months of care, how often did home health providers from this agency keep you informed about when they would arrive at your home?</td>
<td>Never, Sometimes, Usually, Always</td>
</tr>
<tr>
<td>Q17. In the last 2 months of care, how often did home health providers from this agency explain things in a way that was easy to understand?</td>
<td>Never, Sometimes, Usually, Always</td>
</tr>
<tr>
<td>Q18. In the last 2 months of care, how often did home health providers from this agency listen carefully to you?</td>
<td>Never, Sometimes, Usually, Always</td>
</tr>
<tr>
<td>Q22. In the last 2 months of care, when you contacted this agency’s office did you get the help or advice you needed?</td>
<td>Yes, No</td>
</tr>
<tr>
<td>Q23. When you contacted this agency’s office, how long did it take for you to get the help or advice you needed?</td>
<td>Same day, 1 to 5 days, 6 to 14 days, More than 14 days</td>
</tr>
</tbody>
</table>

How does this pertain to HHVBP

• Patient Satisfaction – Communication

• If performing the SOC/ROC instruct the patient on all disciplines ordered, on subsequent visits ensure other disciplines have seen the patient and inquire about those visits

• Call the day before or in the morning of visits; provide updates if running late

• Establish what time is good for the patient to have visits
How does this pertain to HHVBP

• Patient Satisfaction – Communication

• Ask the patient to explain what was reviewed earlier in the visit or on previous visits

• Close the laptop or put away devices at some point during the visit and engage the patient in how their disease is impacting their life, use this time to connect with the patient and determine how best to meet their needs and goals

How does this pertain to HHVBP

• Patient Satisfaction – Specific Care Issues / Team Discussion

<table>
<thead>
<tr>
<th>Specific Care Issues Composite (&quot;Patients who reported that their home health team discussed medicines, pain and home safety with them.&quot;)</th>
<th>Response Categories</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q3. When you first started getting home health care from this agency, did someone from the agency talk with you about how to set up your home so you can move around safely?</td>
<td>Yes, No</td>
</tr>
<tr>
<td>Q4. When you started getting home health care from this agency, did someone from the agency talk with you about all the prescription medicines you were taking?</td>
<td>Yes, No</td>
</tr>
<tr>
<td>Q5. When you started getting home health care from this agency, did someone from the agency ask to see all the prescription medicines you were taking?</td>
<td>Yes, No</td>
</tr>
<tr>
<td>Q10. In the last 2 months of care, did you and a home health provider from this agency talk about pain?</td>
<td>Yes, No</td>
</tr>
<tr>
<td>Q12. In the last 2 months of care, did home health providers from this agency talk with you about the purpose for taking your new or changed prescription medicines?</td>
<td>Yes, No</td>
</tr>
<tr>
<td>Q13. In the last 2 months of care, did home health providers from this agency talk with you about when to take these medicines?</td>
<td>Yes, No</td>
</tr>
<tr>
<td>Q14. In the last 2 months of care, did home health providers from this agency talk with you about the important side effects of these medicines?</td>
<td>Yes, No</td>
</tr>
</tbody>
</table>
How does this pertain to HHVBP

• Patient Satisfaction – Specific Care Issues / Team Discussion

• Address home safety every visit and reinforce any previous recommendations

• Discuss pain by using various words and phrases such as “discomfort”, “soreness”, “aching”, “trouble sleeping”, or “unable to complete”

How does this pertain to HHVBP

• Patient Satisfaction – Specific Care Issues / Team Discussion

• Review all medications by asking to see all bottles in the patient’s home

• Ask about any changes after provider appointments

• Use key phrases – “purpose of this medication”, “this is when to take this medication”, “the side effects of this medication are…”

• Leave written medication information in the home
**Summary**

- Identify the most common diseases managed by your agency

- Develop specific plans to limit the impact of these diseases on patients

- Clinician specialization when possible

- Provide ongoing education to field staff

- Communication with patients, caregivers, team members, providers

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