HOW TO PREPARE FOR THE FUTURE COMPLEX CARE MANAGEMENT

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OBJECTIVES

- Discuss the driving forces for change in US healthcare delivery system
- Discuss various models for providing intensive care management for high risk patients
- Describe the features of the Complex Care Model presented in this session

HEALTH CARE TODAY
**Health System Focus**

- Data/Increased Transparency
- Drug Costs
- Changing Payor Systems
- Utilization/LOS
- Complex Patients
- VBP

**Changing Demographic**

- Reaching 90—chances have doubled in past 40 years
- 55 years and older
- Volume will almost double between now and 2030
CHRONIC DISEASES: THE LEADING CAUSE OF DEATH AND DISABILITY IN THE UNITED STATES

- More common among older adults
- About 117 million Americans—nearly 1 in 2 adults—one or more
- More than 75% of health care costs are due to chronic conditions
- Approximately one-fourth of persons living with a chronic illness experience significant limitations in daily activities

(Population: Centers for Disease Control and Prevention [CDC], 2015)

PREVALENCE OF CHRONIC ILLNESS INCREASING

(Anderson, 2010)
HOSPITAL VALUE BASED PURCHASING PROGRAM

MOTIVATION FOR CHANGE

- Clinical/Outcome/Experience=1 composite score
- Hospital Acquired Condition Reduction Program
- Hospital Readmissions Reduction Program
  - Readmission penalties
  - Expansion continues
    - CABG in 2017

VBP home health

(CRS Report for Congress)

MODELS AND TRENDS

- Coordinated Care Interventions
- Transitional Care Models
  - Coleman and Naylor
  - IHI Starr
  - Bridge
  - RED
  - BOOST
- Medical Home Model

(AHRQ, 2012)
CARE TRANSITIONS

• Care Transitions
  “The movement patients make between healthcare practitioners and settings as their condition and care needs change during the course of chronic or acute illness”
  ...Dr. Eric Coleman

• Multiple transitions
  MOST Critical: Hospital to Home

FOCUS ON TRANSITIONS

• Complex Care Management Action Community
  • California Quality Collaborative

• Community Care of North Carolina’s care management model
  • NC DHHS funded/Medicaid pts at high risk
  • Aged, blind, disabled

• Comprehensive Care Physician Model
  • University of Chicago
  • Replaces hospitalist with specialist in CDM
RIVERSIDE HEALTH SYSTEM

- Core Concepts
  - Patient centered
  - Interdisciplinary
- Post acute Care services play a significant role
  - Incorporates chronic disease management
  - Foster communication/collaboration

Pilot Programs Proposed
- Home Based Chronic Disease Management
- Center for Complex Care Management

REMOVING BARRIERS TO CARE

Home Based Chronic Care Program
EXPLORING THE NEED

- Aging population
- High risk for readmission
- Multiple chronic illness
- Chronic Illness stable under current payment guidelines
  - Need for continued medical support

MAKING THE CASE

- Mobility limitations
- Transportation difficulties
- Low income
- Frailty
- High risk for acute care admissions
STAFF EDUCATION

- Chronic Care Education
  - Adult learning
  - Motivational Interviewing
  - Self Management Theory
  - Disease specific COPD, CHF, DM
    - Pathways
    - Teaching booklets
    - Stoplights

KEY ELEMENTS

- Eligibility
  - DX: CHF, COPD
  - Multiple Acute care episodes
- Referral
  - Transition from Medicare program
  - MD order
- Plan of care
  - Visit Frequency
  - Care provided
  - Specialty Oversight
- Telephonic Visits
- Case Conferences
RESULTS

- Improved self management skills
- Therapeutic relationships
- Motivation Building skills
- Decreased acute care admissions
  - Data
- Development of Complex care program
  - Connecting services to remove barriers to care

THE BOAT IS LEAVING THE DOCK

Complex Care Program
HEALTH SYSTEM CHALLENGE

- Fee for service
- Value Based Care
- MCO/ACO
- And so many more options

A COMPLEX CARE MANAGEMENT PROGRAM
WHY now?...WHY not?

WHAT'S CCP look like in real life?

Versus
LESSONS LEARNED
WE ARE MAKING A DIFFERENCE

- Don’t base the program purely on dollars
- Utilize the programs you have in place and implement a timeline in which you reach out to each supporting service
- Use protocols which are evidence based and disease specific. Make sure roles are clearly defined in order to optimize efficiency
- Use metrics carefully and base them on patient centered outcomes

HOW SHOULD YOU PREPARE FOR THE FUTURE