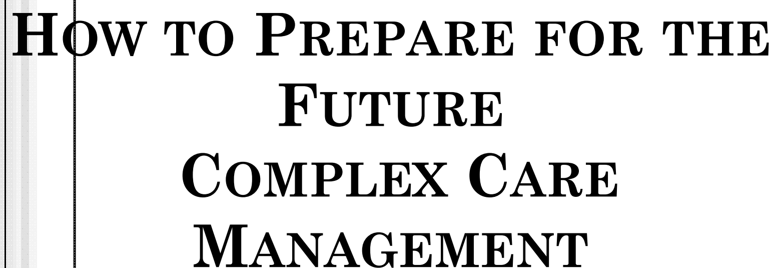

# How to Prepare for the Future Complex Care Management

**#607**
**Friday, October 30, 2015**

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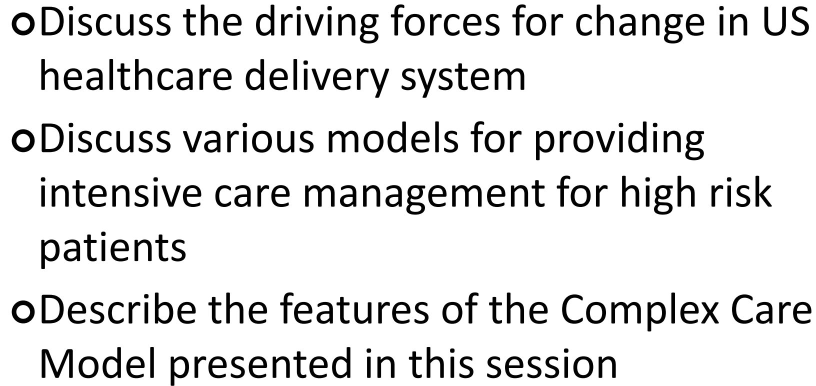
**Riverside HealthCare**
**Kankakee, Illinois**

**Affiliated with Rush System for Health**

## 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

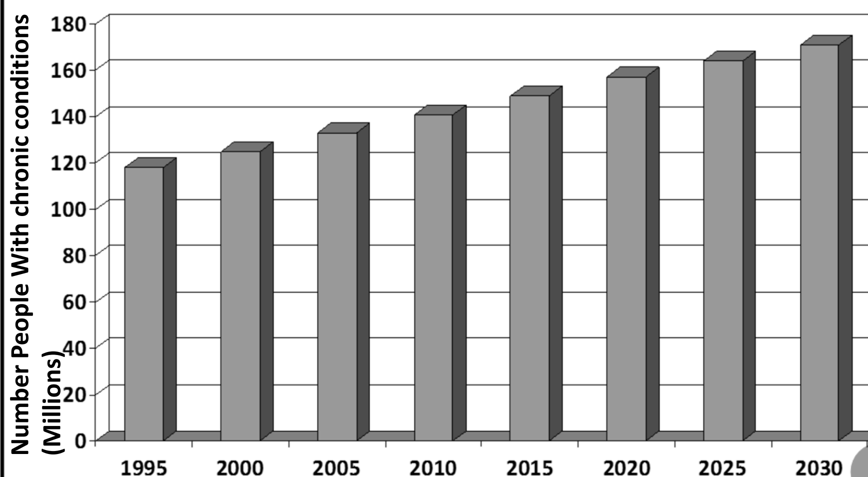
## Chronic Diseases: The Leading Cause of Death and Disability in the United States

- 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

(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

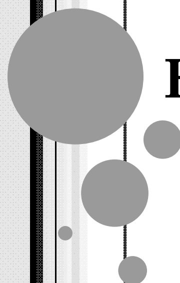
## Riverside Health System

- 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



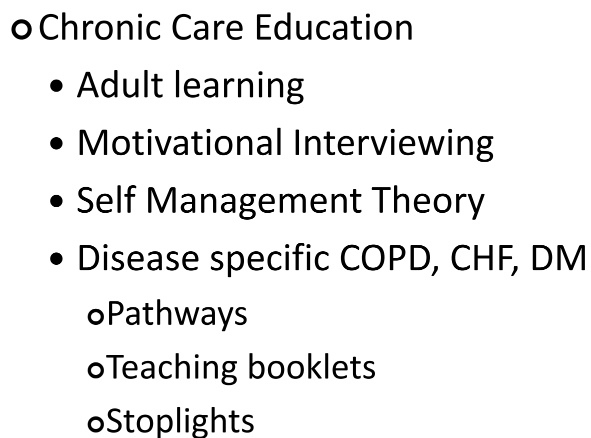
# Home Based Chronic Care Program

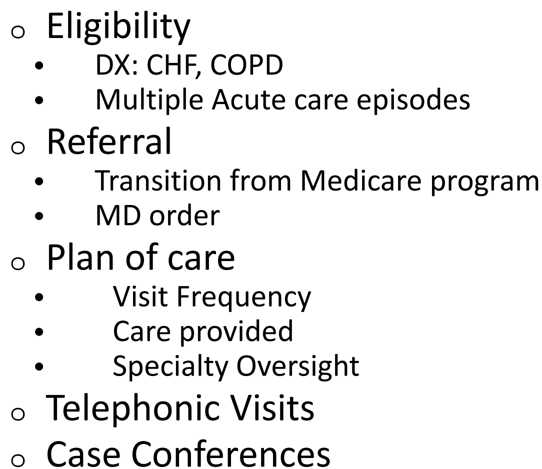
## EXPLORING THE NEED

- 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

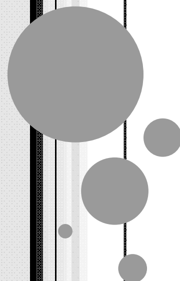

STAFF EDUCATION
Chronic Care Education
Adult learning
Motivational Interviewing
Self Management Theory
Disease specific COPD, CHF, DM
Pathways
Teaching booklets
Stoplights


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

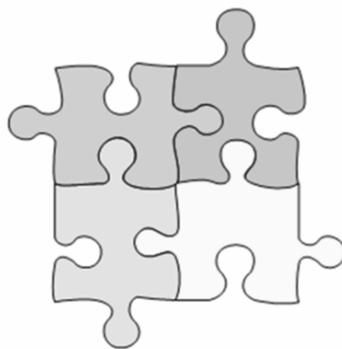


# Complex Care Program

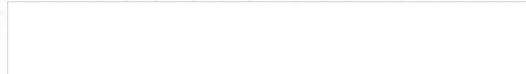
# Health System Challenge

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

# A Complex Care Management Program

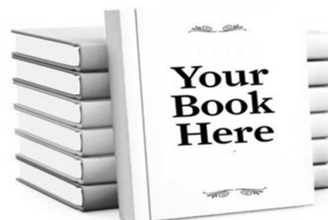


## WHY NOW?....WHY NOT?



## 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