



For Primary Care Practitioners

Making Chronic Disease Management Easier

Many practice guidelines for the management of chronic diseases are inconsistent with the time demands of a standard primary care practice. In a study published in the *Annals of Family Medicine* (Is there time for management of patients with chronic diseases in primary care? *Ann Fam Med.* 3(3): 209-214, 2005), Ostbye and colleagues calculated that managing just 10 of the top chronic diseases according to practice guidelines for a standard patient panel of 2,500 would require 10.6 hours of clinician time per day. This does not take into account any of the other chronic diseases this patient panel would have, preventive care, or acute care.

Baystate Visiting Nurse Association & Hospice (BVNAH) can serve as a useful team member to help support chronic disease management with your patients. The BVNAH patient education delivery model involves multiple visits for education of patients, education of caregivers, verification of successful adherence, and monitoring for results. The goal for referring chronic disease management to BVNAH for home health would be to improve the patient experience and enhance the patient's self-management skills by expanding the primary care encounter to include home-based follow-up and coaching. Patients who meet the Medicare homebound criteria may be referred to BVNAH for a comprehensive chronic disease management program. Medicare defines homebound as having a normal inability to leave home; leaving home requires a considerable and taxing effort for the patient; and absences are infrequent and of short duration.

When you have patients who demonstrate non-adherence to the management plan, who do not restate their instructions correctly, or who are not accomplishing disease management goals, a referral to BVNAH for follow-up chronic disease management may be beneficial. Health regimen teaching typically meets Medicare's skilled need requirement, but for it

to be a new skilled need, you would look for a situation such as:

- Recently documented worsening of measures (e.g. high glucose, high blood pressure, greater dyspnea, reduced function)
- Recently documented non-adherence to the health care regimen
- Recent exacerbation
- A documented likelihood of exacerbation in the next three weeks
- New medications
- New diagnosis
- New health care regimen instructions such as diet changes.

From a practice management perspective, partnering with BVNAH for chronic disease management services may merit consideration:

- Medicare pays 100% of allowable charges from BVNAH, so patients incur no additional costs related to our home health services.
- Chronic disease education referrals are usually straightforward cases requiring no care plan oversight work beyond the initial certification paperwork from a physician.
- Physicians can bill Medicare for the certification of the home health plan of care.

The biggest consideration, however, is the benefit to the patient. BVNAH provides quality, patient-centered home care services in conjunction with primary care physicians and other health care providers, while preventing disruptive and costly emergent care visits or re-hospitalizations for patients. In fact, BVNAH is ahead of the other Pioneer Valley home care agencies in minimizing how often their home care patients have to be admitted to the hospital.



Staff Certified in Integrated Chronic Care Management

Recognizing the increasing trend of patients with chronic conditions, BVNAH has been working for the past year to expand their effort beyond the current episodic care reimbursement focus to include management of chronic illness. To support this direction, BVNAH has implemented an Integrated Chronic Care Specialist training program for staff. In addition to providing for the specific skilled need, BVNAH staff also focuses on patient self management - helping patients and families learn to manage their chronic illness in a way that improves overall health and quality of life.

Call Baystate Visiting Nurse Association & Hospice to help with your patients who need to learn how to better manage their disease.