IT'S TIME!

CHRONIC DISEASE MANAGMENT:
IT'S TIME TO FOCUS ON PREVENTIVE CARE

Primaris
Healthcare Business Solutions

Chronic diseases are the leading cause of death and disability in the United States, according to the Centers for Disease Control and Prevention. The CDC also reports that as of 2012, about half of all adults had one or more chronic health conditions, ranging from obesity to diabetes to arthritis to heart problems.

It's pretty clear from those statistics that few physicians or institutions are exempt from dealing with patients

suffering from such ailments. What's also pretty clear is that doctors need to change the way they traditionally have handled these cases. Close to 90 percent of national healthcare costs are related to chronic conditions.

Lowering those costs, while improving quality of care, is a big focus for both government programs and commercial insurers that are driving accountable care initiatives and offering value-based reimbursements as incentives for participation.

It will be difficult for medical professionals and facilities to benefit under these circumstances unless they put a bigger emphasis on helping patients with chronic conditions better manage them, so that they're less likely to become ill enough to wind up in the hospital – again, and again, and again. At the same time, they need to increase their focus on keeping at-risk patients from developing a chronic condition in the first place. To achieve that, they'll need to move away from an episodic care approach to a more holistic model.

That model will depend upon a number of factors – changing physician mindsets; healthcare business cultures, practice workflows and staffing; and technology and data, with standardization and visibility as a priority.

As Dan McDaniel, president and CEO of Sage Growth Partners, has described it, the U.S. healthcare business is moving from a pre-industrial state characterized by variability in processes, a lack of transparency, and limited division of labor, among other features, to an industrialized state that's being catalyzed by revenue redistribution.

Evidence of industrialization already can be seen in better-integrated patient information, increased stratification of population risks and illnesses, a focus on the creation and management of care plans, more coordination across care teams, greater engagement with patients, and a drive to analytics and clinical performance measurements.

Ready for Healthcare's Industrial Revolution

It's not too soon to become part of the industrial revolution. In fact, waiting any longer to transition your

healthcare organization so that its primary focus is on preventive care and better management of existing chronic conditions puts its own future in jeopardy. Making the move now, however, opens the door wider to possibilities – whether that's being able to continue as an independent entity or group or become part of a larger practice, group, network or hospital system that is the best fit for you, not the only option left to you.

Here are some steps you can take to get started:

1. **Maximize your use of patient data.** A primary care doctor managing 400 diabetics in her practice of 2,000 patients would find it impossible to consistently track their blood sugars, blood pressure, lipids, and other vital statistics, or associated issues such as vascular or eye problems, using a paper-chart driven system.

More doctors coming out of medical school these days understand the value of data and modern data management techniques to improve chronic disease care.

But with a properly loaded and up-to-speed electronic medical records system, it's entirely feasible to pull reports, get alerts and perform queries not only about individual patients, but to analyze a particular patient population as a group. That can lead to insights, for example, that a new treatment is having a positive impact on a segment of the diabetic population in the doctor's practice, and may be worth discussing with other members in that subgroup who potentially could benefit from its use.

More doctors coming out of medical school these days understand the value of data and modern data management techniques to improve chronic disease care – and to helping lower the costs of that care – but many physicians and physician groups still need to be educated about the possibilities. That's especially true as it relates to managing a population of patients that have something in common, like diabetes or congestive heart failure or COPD.

2. **Be proactive, not reactive.** People at risk of developing a chronic condition, or who already have one, won't do well if they don't follow their doctors' advice. The problem is that most doctors don't know about patient non-cooperation until the next time the patient comes in with a problem or, even worse, reports to a local emergency room and is admitted to the hospital. Most physicians

haven't been trained to think that their job is to check in with these patients on a regular basis, and their workflows aren't set up to accommodate that.

To that end, physician practices and healthcare systems need to think about how to craft workflows and create or revise staff roles in ways that foster better and more proactive patient engagement. That might mean, for example, that a physician practice would train its receptionist to call diabetic patients on a regular schedule to ask if they've measured their blood sugar, get that reading, and enter it into the EMR system. Having that dialogue is a good way to encourage compliancy in patients who might otherwise shrug off doctors' orders. It might also mean that an office's nursing staff gets involved in reviewing such data every week and calling in patients when their blood sugar is getting a little high. That gives the doctor greater freedom to captain the ship and problem-solve.

A larger healthcare system would have to do the same, drilling down to how workflows and roles would differ for the primary care doctors vs. the orthopedic surgeons in their networks vs. a hospital's radiology department. The key thing is starting with the patient up, not with the institution down, to then define, on a micro-level, the workflows, data management, and analytics that need to happen.

3. **Fit your plans to your budgets and resources.** It's understandable if a physician practice that wants to do a better job supporting populations with or at risk of chronic disease feels hampered by a lack of funds or resources to make it happen. Think, for example, of all the other pressures it's under when it comes to dealing with a changing healthcare environment and seeing more patients in a day to stay alive amidst declining insurance reimbursements.

One critical way around this issue is to organize new processes and roles around the physicians, nurse practitioners, nurses and others already on staff, always driving the work down to the lowest paid segment that can perform the function. It's the $10-an-hour receptionist calling patients about following their care regimens, for example, not the $30-an-hour nurse. Furthermore, nurse

practitioners can see their own batteries of patients with specific chronic conditions for which they can bill and generate revenue for the practice, while improving patient quality management, so that physicians can do the things that they need to do at the top of that food chain.

No one is saying that some of this won't take getting used to. There's so little organization of workflows and roles now in most organizations. And only in recent years have nurse practitioners even been allowed to see their own panel of patients, and many doctors still are reluctant to let them.

4. Connect with the pharmacist community. At the most basic level, that could be automatically renewing a patient's prescription for them, and letting the patient know you took care of it. But there are efforts to take things further. The Missouri Million Hearts Coalition, for example, is working to get pharmacists and physicians more connected, so that there is some kind of trigger to alert a doctor that a patient has stopped picking up his prescription. Right now, that connection generally doesn't exist.

One can't underestimate the importance of this because medication control – or the lack of it – is a major factor in everything that's going right and wrong when it comes to managing chronic diseases and helping keep patients living with them at optimal health levels.

A commitment at the very top levels of a practice or healthcare system is going to be required to make a difference in chronic disease management. So, too, will education for all parties involved, and the patience to see it through.

But it's a difference that matters a lot: Strategically aligning healthcare practices and systems with chronic disease management initiatives means that the patients who live with them or who are at risk of getting them will receive better care, and medical practices and facilities will realize financial rewards via the value-based programs that require that they improve the costs of managing these populations.

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