Contents lists available at www.innovativejournal.in

JOURNAL OF MEDICAL BIOMEDICAL AND APPLIED SCIENCES

homepage: http://innovativejournal.in/jmbm/index.php/jmbm

JMBAS
ISSN: 2349-0748

The Future of Chronic Care Management and New Tools for the Physicians

Nik Tehrani, Ph.D.
Argosy University
E-Mail: nik@niktehrani.com

DOI:

Abstract: Due to the aging American population, healthcare patients and providers are seeking new solutions to lower costs. Today's patients, including those with chronic maladies, have taken on the role of the consumer who looks for affordable prices for their healthcare. This has created new opportunities for chronic health care management, such as remote health monitoring for home use.Non-face-to-face services, such as medication reconciliation, provider coordination, social services, and remote patient monitoring, is available to beneficiaries of Medicare for significant chronic health conditions. However, payments are not sufficient to pay for staffing and technological investments that are a necessity for chronic care management, so providers normally do not provide such services (PYA, 2015). This results in patients with chronic diseases having to fend for themselves between necessitated care, which translates into distressed patients and higher costs. Remote Health monitoring from the home can alleviate costs and eliminate trips to the doctor or hospital.

Keywords: Remote patient monitoring, health care costs, new healthcare tools, Medicare Sunshine Act.

INTRODUCTION

The American population is aging, and persistent chronic diseases such as asthma, diabetes, and hypertension are ubiquitous. Thus, healthcare providers and patients are lookingfor new solutions to lower their healthcare costs. Healthcare today is driven by patients who are acting more like consumers as they seek the best care at the most affordable prices. This also applies to patients with chronic maladies. This evolution has created new opportunities and conditions in chronic care management such as remote health monitoring using devices for use in the home, a successful strategy for maintaining medication adherence and ensuring that patients view management of their disease seriously (Bresnick, 2014).

In the last few years, varied forms of managed care have emerged as an approach toward healthcare improvement, as well as controlling spiraling costs. However, the focus on costs, as well as failures in addressing the complexities of chronic conditions, is also compounded by the coordination of care spread over multiple environments (Halsted & Lorig, 2004). These entail the efforts of either healthcare improvement or cost control, but the objective of chronic care management remains the same.

Non-face-to-face services, such as medication reconciliation, provider coordination, social services, and remote patient monitoring,is available to beneficiaries of Medicare forsignificant chronic health conditions. However, payments are not sufficient to pay for staffing and technological investments that are a necessity for chronic care management, so providers normally do not provide such services (PYA, 2015). This results in patients with chronic diseases having to fend for themselves between necessitated care, which translates into distressed patients and higher costs. Remote Health monitoring from the home can alleviate costs and eliminate trips to the doctor or hospital.

CHALLENGES OF CHRONIC ILLNESS

The costs of chronic illness to the economy have doubled to exceed $1 trillion annually, due to the number of cases of chronic disease diagnosed from 2007 with the expectation being held of an increment by 42 percent in the coming 15 years. The healthcare expenditure by Americans was $1.6 trillion, equal to nearly 15 percent of the gross domestic product, as compared to 11 percent in the past 15 years. Furthermore, the costs of health insurance have increased to an average of 12.5 percent on an annual rate. Since patients with chronic diseases have a 100 percent likelihood of having preventable hospitalization, the implementation of health prevention and wellness strategies is still the approach that is most viable for raising the quality of health care and cost control (Vogeli, et al. 2007).

SOLUTIONS

The 2015 Sunshine Act Medicare proposed fee schedule includes a "per patient, per month payment for chronic care management (CCM) services for patients with two or more chronic conditions" (AAFP, 2014). Beginning in 2015, Medicare will make a separate payment of $41.92 no more than once a month to physicians for CCM services. Also, supervision of clinical staff that provides CCM services will be more flexible.

Many elderly and incapacitated patients have multifaceted, chronic health conditions that require individual medical attention from a primary care physician. The new code places value on addedintellectual and office work occurring outside the exam room, but necessary for all-inclusive, synchronized healthcare (AAFP, 2014).

In other areas, services, such as patient communication and other health professionals offering treatment can be augmented by visits to a medical practitioner that are billed separately. Medication prescriptions are available via the phone or electronically, and patients have access to health

care providers or other clinical staff 24/7 (Stellefson, Krishna & Stopka, 2013).

Partly in response to workplace absenteeism which, as in Ohio cost an estimated $27 billion in 2010, hospitals are now providing outpatient services to chronic care patients to reduce the necessity of costly hospital visits. Mercy Memorial Hospital, Urbana, Ohio, has opened a new Chronic Care Clinic that will provide patients with options to manage their chronic conditions, such as diabetes, congestive heart failure and chronic obstructive pulmonary disease. The goal is to achieve better healthcare management and lower costs (Sanctis, 2015).

Eighty percent of health system issues today are related to chronic diseases, so transitioning healthcare from the hospital to the home is key to lowering costs (Bresnick, 2014). The development of electronic healthcare is a major aspect of chronic care management. Chronic care management clinicians are required to place, implement, revise or monitor and manage within the electronic care plan that connectspatient physical, mental, cognitive, and psychosocial needs with functional and environmental requirements.Thus, if healthcare can shift to the population level, quality and costs of care will be favorably impacted. There is a chronic disease epidemic, so the focus is on how to keep patients out of hospitals and clinics, yet allow them to stay in contact with their healthcare provider. Patients need to take responsibility of taking care of themselves and stay in contact with their doctors so if an emergency arises or care is needed, the physician can step in immediately and resolve the situation (Bresnick, 2014).

Utilizing the EHR management codes for billing of chronic care, aclinician can bill for any specific patient,but at this point, it may be required to link coordination with sub-specialists who provide a significant measure of care, as well as treatment for one to more of the medical conditions of the patient (Julie, Stephen & Rundall, 2006). Overall, these management codes have been established with the intention of being applied by clinicians that are providing the major part of the services of care coordination. Often, these can be elementary care internists, although particular specialists can possibly provide the required services for qualification for billing of chronic care management codes, but not within the same month as the elementary care physician.

More than 75 percent of the complete health care expenditure in the U.S. places emphasis on chronic care with improvements to health care purchasers. This includes health care plans that are aggressive in the form of profiling and benchmarking in practice and performance of medical institutions. Medicare precedes private payment in the directional shift of the value based purchases of medical institutions and the services of physicians (Hudon, Fortin, & Haggetry, 2012). Traditionally, chronic care management meant that the providers of professional health care provided oversight, as well as education in assistance to patients with chronic diseases to live their lives with an understanding of their conditions. It also motivatedpatients to sustain required therapies as well as interventions that would assist in moving forward towards a better quality of life.

Increasingly, employers are taking an interest in the provision of chronic care management to their employees because chronic conditions account for 25 percent of medical costs. This is due to employees havinglong-lasting illnesses, increasing healthcare expenses and reduced productivity (Vogeli, Sheilds. Lee & Teresa, 2007).Currently, nearly all companies provide some form of chronic care initiatives, but not all of these programs are equal. Certain companies can contract with their insurers or an external vendor, to ensure that medical care is available if an employee needs help for achronic illness.

PREVENTION USING ROBUST CARE MANAGEMENT

Chronic care management entails the convergence of several medical tactics in proper application to the particular population. These are comprised of stratified medical risks in the population health plan, clinical guidelines, preventative health in primary and secondary care, case management, use of predictive models, plan design, and incentives for the provider in augmentation of prescription drug management (Halsted &Lorig, 2004). Abeneficial system should be developed on the basis of integration of claims payment, management of care, reimbursement of providers, identification of members with no screening of claims data, patient data sharing with providers, and incentive model sharing with providers.

Source:*MagnaCare Publication, 2011*

CONCLUSION

Care for chronically ill patients is expensive, and overall leads to unnecessary hospitalizations,augmented by placements in nursing homes, as well as duplication of diagnostic tests. The greatest portion of costly and preventable maladies can be managed with simplified and affordable measures. The major portion of these measures as effective approaches is the control of chronic illness, as well as revamped reimbursement based models to providers through behavior that is an incentive to the patient and the physician (Halsted &Lorig, 2004). This leads to improved health management in combination with technological investment that delivers a snapshot of robust health data. With this information, health care providers can identify of shortcomings in care, as well as have a positive effect on patient behavior and lifestyle.

REFERENCES

[1]. AAFP. (2014). New Chronic Care Management Payment Included in Proposed 2015 Medicare Fee Schedule. Retrieved from http://www.aafp.org/news/government-medicine/201407092015mpfs.html

[2]. Bresnick, J. (2014). Remote monitoring brings chronic disease management home. HER Intelligence. Retrieved from https://ehrintelligence.com/2014/03/05/remote-monitoring-brings-chronic-disease-management-home/DynoSense. (2015). DynoSensor. Retrieved from http://dynosense.com/products/

[3]. Halsted, H. Lorig, K. (2004).Patient self-management as a key to effective and efficient chronic disease care. Public Health Reports.119 (3), 239-243.

[4]. Hudon, C. Fortin, M. Haggetry, J. (2012).A thematic analysis of family medicine in literature and patient centered care in chronic disease management. Patient Education and Counseling.88 (2), 170-176.

[5]. Julie, A, Stephen, M. Rundall, T. (2006).Impact of primary health care orientation and chronic care management.Annals of Family Medicine.4 (2), 117-123.

[6]. PYA. (2015). Providing and billing medicare for chronic care management. Retrieved from http://www.pyapc.com/resources/collateral/white-papers/Chronic-Care-Whitepaper-PYA.pdf

[7]. Sanctis. M. (2015). Mercy to open new chronic care unit. Springfield news sun. Saturday, May 2, 2015 | 1:50 p.m. Retrieved from http://www.springfieldnewssun.com/news/news/mercy-to-open-new-chronic-care-unit/nk6bR/

[8]. Stellefson, M. Krishna, D. Stopka, C. (2013).A systematic review of chronic are model management in primary care settings in the U.S.Preventing chronic disease.Patient Education and Counseling10 (1), 3-26.

[9]. Vogeli, C. Sheilds. A. Lee, T. Teresa, G. (2007).Multiple chronic conditions in the prevalence, health outcomes and quality implications in care management and costs. Journal of General Internal Medicine.22 (3), 391-395.