TEAMHealth®

The Value of Chronic Care Management: 3 Datapoints Every SNF Should Study

Chronic condition management is central to the success of long-term care patients, and providers are increasingly finding care solutions within their collection of patient data.

According to the Centers for Disease Control and Prevention (CDC), about 60% of U.S. adults suffer from at least one chronic condition. This is a costly problem to say the least: the CDC notes that 90% of the nation's annual $4.1 trillion health care spend is for people with chronic conditions.

To help health care providers combat this, Centers for Medicare and Medicaid Services (CMS) has established a separate payment for the additional time and resources post-acute care clinicians spend providing chronic care management (CCM) services to both Medicare patients and dual-eligible Medicare-Medicaid patients.

Chronic condition management is central to the success of long-term care patients, and providers are increasingly finding care solutions within their collection of patient data. Here are three patient datapoints that every post-acute provider should study:

- **Antipsychotic use**
- **Fall risk**
- **Readmission risk**

If not managed properly and proactively, a patient's complex chronic conditions can lead to high-risk, costly outcomes, such as frequent emergency department visits, hospital readmissions and higher rates of mortality. Fortunately, more SNFs are turning to CCM programs that enable skilled facilities and clinicians to make a meaningful difference in the long-term care population.

"The chronic care management program that TeamHealth has designed is focused on the proactive approach of using data aggregation for long-term care patients in the skilled nursing environment," says Dr. Darren Swenson of TeamHealth, an organization that provides physicians and advanced practice clinicians across a range of hospital-based clinical services, as well as the post-acute setting, urgent and ambulatory care and telehealth.

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Why — and how — a CCM program works

With the TeamHealth CCM program, long-term care providers can collect data on patients with two or more chronic diseases, and use that data to build an individualized, holistic, evidence-based care plan. While skilled patients are not eligible for the program due to their short length of stay, the program is ideal for long-term patients, as they typically have multiple chronic conditions and are among the health care system's most vulnerable parties.

"From a historical perspective, I believe these patients have missed out on some of the resources and programs to proactively address their complex medical conditions and improve their quality of life, and allow us to treat them in place at our partner facilities," Swenson says.

The program is fueled by its patient-centric approach. The clinician uses aggregated data and evidence-based predictive programs to engage the patient or the patient representative in the development of measurable treatment goals, while including psychosocial ADLs and the patient's desired outcome for their overall health and quality of life.

"We encourage all of our facilities and clinicians to use the CCM outcome data at the Quality Assurance and Performance Improvement Committee (QAPI) meetings to drive performance improvement activities to improve the systems of care delivery," Swenson says. "For example, the falls risk indicator and 12-month mortality indicators focus our clinicians on proactively reducing polypharmacy, increasing goals of care conversations from a facility perspective, but also allow us to drill down to the unique patient level."

3 datapoints every post-acute provider should study

In designing its CCM, TeamHealth focused on three quantitative analytics to track over time. The first metric: each patient's use of antipsychotics, which TeamHealth logs and analyzes. Next, TeamHealth looks at fall risk, breaking them into three categories: high, moderate and low.

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Those two metrics — antipsychotic use and fall risk — lead to the third key metric: the risk of readmissions. By studying each patient's use of drugs combined with their fall risk, TeamHealth can anticipate and predict the degree to which that person is at risk of being readmitted to a hospital.

"Readmissions are multifactorial — lots of literature shows that there's not one direct cause for readmission," he says. "Causes can be communication between the facility and the provider. It can be medications involving polypharmacy. Readmission can be related to a fall. It can be related to a family's request and desire to have further evaluation. What we're saying at TeamHealth is, how do we try to anticipate the risk factors from a population health-based approach that would determine that a patient is at high risk or moderate risk for readmission?"

By tracking these figures, TeamHealth has found ways to help clinicians and skilled nursing providers intervene with high-risk patients proactively, before they experience a health event that would send them into a hospital. This results in a lower cost of care, better outcomes and a better patient experience.

"We use all of this to inform how we proactively intervene and bend that clinical curve to better outcomes," Swenson says.

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