

Disease Management and Home Care

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Objectives

- Describe the six components of a disease management program.
- Discuss strategies for implementing disease management concepts in home care.
- Utilize tools from the Home Telehealth Disease Management Series (HF, COPD, cancer, and diabetes) in agency practice.

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Disease Management Defined

A system of coordinated health care interventions and communications for populations with conditions in which patients' self-care efforts are significant.

Disease Management Association of America; www.dmaa.org

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Advantages of Assessing and Promoting Self-Management Education

- Comfortable patient setting
- Patient trust and confidence
- Ability to directly observe activities
- Opportunity to understand non-adherence issues

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Disease Management

The focus is shifted away from **treatment** of acute exacerbations of disease, instead focusing on **prevention**.

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Focus on Disease Management

- 7 of 10 American deaths each year are from chronic diseases
- Chronic diseases associated with functional limitations, pain/suffering, diminished quality of life
- Account for > 75% of medical care costs (CDC)

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Disease Management, Home Care Agencies, and Acute Care Hospitalization

Formal disease management programs were used by 38% of agencies who had the lowest Acute Care Hospitalization (ACH) rates of 19% or less.

Briggs National Quality Improvement/Hospitalization Reduction Study, 2006

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Home Care Challenges

- Identify and address:
 - Inconsistencies in care delivery
 - Level of staff clinical knowledge in relation to disease process, interventions, and evaluation

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Components of Disease Management Programs

1. Population identification processes
2. Evidence-based practice guidelines
3. Collaborative practice models to include physician- and support-service providers

Components of Disease Management Programs

4. Patient self-management education
5. Process and outcomes measurement, evaluation, and management
6. Routine reporting/feedback loop (may include communication with patient, physician, health plan, and ancillary providers; and practice profiling)

Components of Disease Management Programs

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1. Population Identification Processes

- Generally focus on chronic conditions
 - Require significant self-care management
 - High risk for problems adhering to self-care management needs
 - High risk for disease exacerbation
 - High risk for complications
 - High risk for hospitalization/emergent care
 - High costs associated with condition

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Example: Heart Failure (HF)

A condition associated with lack of knowledge and often inadequate self-care management

Lockwood, EE, Hervas-Malo, M, Guitierrez et al. (2004) Patient knowledge of self-care activities in congestive heart failure. Abstract from Heart Failure Society of America 8th Annual Scientific Meeting

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Population Identification

- HF
- Cardiac care
- Diabetes care
- Wound care
- Joint replacement
- COPD

Briggs National Quality Improvement/Hospitalization Reduction Study, 20066

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Population Identification: Agency Specific

- What are the prevalences of certain diagnoses within your agency?
- What are your outcomes? (e.g., ACH rate for HF patients)
- What type of market exists within your community?
- Could you be a key component of an overall disease management program or could you develop a complete program?

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2. Evidence-Based Practice (EBP) Guidelines

- EBP:
 - Using the best evidence available to guide clinical decision making (Benefield, 2002)
 - The conscientious use of current best evidence in making decisions about patient care (Sackett, Straus, et al., 2000)
 - De-emphasizes practice based on “tradition” and “ritual”



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Implementing EBP Guidelines into Agency Practice

- Are staff educated in evidence-based practice? Do they know what it means?
- Are agency policies, procedures, protocols, pathways, etc. based on, and referenced to, existing EBP guidelines that are applicable and appropriate to home care practice?
- Does documentation system support consistent processes or utilize tools (e.g., pathways) for care based on EBP?

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Translate Research/Evidence into Practice

- Little or no effectiveness
- Intermittently effective
- Consistently effective
- Most effective

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3. Collaborative Practice Models to Include Physician and Support Services Providers

- Coordination between levels and sites of care, types of providers
 - Outpatient
 - Inpatient
 - Subacute
 - Primary MD
 - Specialist MD
 - Therapists
 - Behavioral health services

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4. Patient Self-Management Education

- Patients become their own primary “caregiver” when they have a chronic illness
 - Considerable portions of self-management are under direct control by the patient
- Self-management support empowers and prepares patients to manage their health and health care

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4. Patient Self-Management Education

- Effective self-management support strategies include assessment, collaborative goal setting, action planning, problem solving, and follow-up.
- Internal and community resources should be organized to provide ongoing self-management support to patients.

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4. Patient Self-Management Education

- Home care clinicians can/should implement
 - Involves **collaboration with** the patient
- Self-management support \neq patient education

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4. Patient Self-Management Education

- Traditional—and often typical—home care patient education
 - Clinician’s agenda
 - Assumes that ↑ knowledge will create patient behavioral change
 - Goal of “compliance”

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4. Patient Self-Management Education

- Collaborative interactions
 - Patient’s agenda
 - Assumes that ↑ confidence in ability to change plus knowledge will create patient behavioral change
 - Goal of increased confidence in ability to change

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Considerations in Patient Self-Management Education

- Identification of barriers to learning
- How do patient and family best learn?
- Educational materials are evidence based and used consistently within disease management program
- Availability of educational materials in variety of formats
 - Written vs. audiovisual vs. computer
 - Low literacy levels
 - Cultural considerations

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5. Process and Outcomes Measurement, Evaluation, and Management

- Broad utilization measures such as ACH rate, emergent care use
- Look at specifics of ACH or emergent care use
 - Reasons for hospitalization
 - Preventable vs. not
 - Related to primary disease process vs. secondary clinical problem

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5. Process and Outcomes Measurement, Evaluation, and Management

Patient satisfaction

- Evaluate specific interventions for effectiveness
- Examples
 - Potentially averted hospitalizations—s/s and clinician-initiated interventions (what worked and what did not)
 - Self-care behavior improvement—frequency of weight monitoring in patients with HF

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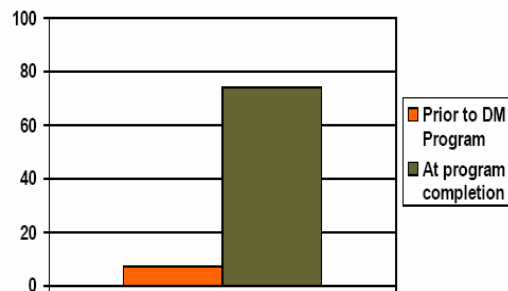
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Percentage of Patients Performing Daily Weight Monitoring (n = 51)

(Gorski & Johnson, 2003)



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6. Routine Reporting/Feedback Loop

May include communication with:

- Patient
- Physician
- Health plan
- Ancillary providers

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Summary

- Disease management programs offer great potential for improving clinical outcomes and quality of care, and decreasing overall cost of care.
- By improving overall self-care management for the chronically ill patient, the risk for disease exacerbation is reduced and the patient can be managed in the safe and cost-effective home setting.

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