



## Best Practice: Disease Management

# Medical Social Worker Track



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## Medical Social Worker Track

This best practice intervention package track is designed to familiarize medical social workers with disease management.

### Objectives

After completing the activities included in the Social Worker Track of this **Best Practice Intervention Package–Disease Management**, the learner will be able to:

1. Identify the role of home health in disease management and reducing avoidable acute care hospitalizations
2. Describe the medical social worker’s role in a disease management program

Complete the following activities:

	Activity	Location	Estimated Time
<input type="checkbox"/>	Read <b>Disease Management and Home Health</b>	Page 61	5 minutes
<input type="checkbox"/>	Read <b>‘The Business Case for Disease Management Programs in Home Care’</b> by Lisa Remington	Page 62	10 minutes
<input type="checkbox"/>	Listen to <b>“Disease Management and Reducing ACH”</b> podcast featuring Dr. David Nash	Page 64	15 minutes
<input type="checkbox"/>	Complete the social worker post-test	Page 65	10 minutes
	<b>Total time for completion</b>		<b>40 minutes</b>



# Disease Management and Home Health

## Definition:

Disease Management is a system of coordinated health care interventions and communications for populations with conditions in which patient self-care efforts are significant (DMAA, 2007).

## BUILDING UPON THE BASICS

How do medical social workers support disease management in home health? Build upon the basics!

### Intervention:

### Disease Management:

<i>Hospitalization Risk Assessment</i>	↔	Be alert for risks for hospitalization
<i>Emergency Care Planning</i>	↔	Reinforce when to call the agency
<i>Medication Management</i>	↔	Assist with financial issues
<i>Telehealth</i>	↔	Support patient with submitting data
<i>Immunizations</i>	↔	Be a role model; Get your flu shot!
<i>Communication</i>	↔	Help patient and caregiver communicate with healthcare providers across settings
<i>Patient Self-Management</i>	↔	Community resource linkage

Home health provides only a small piece of chronic illness management. The medical social worker plays a key role in extending ongoing disease management beyond discharge from home care services. Link patients and caregivers with community resources and disease specific support groups.

# The Business Case for Disease Management Programs in Home Care

By Lisa Remington, Healthcare Business Strategist and Publisher of *The Remington Report*

The annual economic impact on the U.S. economy from the most common chronic diseases is more than \$1 trillion, which could balloon to nearly \$6 trillion by the middle of the century, according to a study by the Milken Institute. Much of this cost is avoidable, the study found. “An Unhealthy America: The Economic Burden of Chronic Disease” attempts to quantify the economic loss associated with preventable illness and the cost to the nation’s Gross Domestic Product (GDP) and American businesses in lost growth.

The study found that:

- Seven chronic diseases — cancer, diabetes, hypertension, stroke, heart disease, pulmonary conditions and mental illness — have a total impact on the economy of \$1.3 trillion annually.
- Of the total economic impact, \$1.1 trillion represents the cost of lost productivity.
- In ranking all 50 states by the reported number of these diseases per capita, researchers found that West Virginia, Tennessee, Arkansas, Kentucky and Mississippi have the highest rates of chronic disease, while Utah, Alaska, Colorado, New Mexico and Arizona have the lowest rates.
- Assuming modest improvements in preventing and treating diseases, by 2023 the nation could avoid 40 million cases of chronic disease and reduce the economic impact of chronic disease by 27 percent, or \$1.1 trillion annually.
- A decline in obesity rates could lead to \$60 billion less in treatment costs and \$254 billion in increased productivity.

Staggering statistics alone support reasons for the home care industry to have business and clinical disease management models. However, there are more compelling issues that impact the future of the health care delivery system when it comes to disease management...it is the shift in market share of who is overseeing the chronically ill population.

There are the four big trends in disease management that directly impact home care.

1. **Moving to a Pay for Performance Model Across the Health Care Delivery System** – The entire health care delivery system is redefining health care business around medical conditions and specialization. Hospitals, physicians and home care payments are changing to reflect accuracy of payments and outcomes. More data-rich information is being collected from providers in an effort to better understand the complications of the chronically ill population. For home care, a pay for performance model will rally around an agency having

the ability to be a partner in the coordination of patients across the health care delivery system and triaging patients to the best place of care based upon their illness.

2. **Payors** – Payors are systematically developing disease management programs based on specialization. Trends in disease management are changing the initial face of managed care. For example, many managed care organizations have carved out Medicare Advantage Plans. Today, these plans are already shifting agency's revenues. In some markets, Medicare Advantage plans comprise 38 percent of Medicare revenues. Home care should expect to see more contracts under these plans.
3. **Disease Management Companies** – American Healthways, the largest disease management company, and others are developing disease management programs to oversee the chronically ill populations. Models under these programs include health coaching, patient education, phone calls to patients and medication compliance. Special Needs Plans and Chronic Care Improvement Plus programs designed for the chronically ill, and Medicaid dual eligibility are capitated programs that accept full risk from Medicare for all of the health expenses of enrollees. These programs are rolling-out statewide. Some programs are contracting with home care...others are not.
4. **Government Moving Patients Out of Nursing Homes Into Community-Based Care** – Billions of dollars have been allocated to move patients out of nursing homes into community-based programs. The transition of these patients will equate to longer stays in home care supporting the case for disease management programs and the need to develop long-term care management programs beyond 60-day episodes of care.

These trends are indicators of the shift in the health care delivery system's business and clinical models, also the key roles that companies are establishing as major players in disease management. It is important for home care agencies to make sure they are developing disease management programs to be able to partner across the health care delivery system, and position their agencies to partner with payors and disease management companies. However, clearly the underlying factor of these new trends is for home care to figure out how they will show these major players the value and role of home care in disease management. Of greater concern, is the new competition entering home care's market share. The question is does this shift mean your agency will strategically align with these new players...or will they be your direct competition?



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# Disease Management Multi-Media Activities

## Podcast\*



### Disease Management and Reducing Acute Care Hospitalization

This 15-minute audio recording offers a brief overview of disease management. **David Nash, MD, MBA**, offers his expert perspective on the role of home health in reducing acute care hospitalizations. Dr. Nash is internationally recognized for his work in outcomes management, medical staff development and quality-of-care improvement. His work has appeared in more than 100 articles featured in major journals.

Disease Management Clinician Podcast Instructions:

Title	Description	Link
<b>Disease Management and Reducing Acute Care Hospitalization</b>	A 15- minute podcast featuring Dr. David Nash discussing disease management and acute care hospitalizations.	<a href="http://www.homehealthquality.org/hh/hha/interventionpackages/dm.aspx">http://www.homehealthquality.org/hh/hha/interventionpackages/dm.aspx</a>

There are several ways to listen to the podcast:

- Visit the link above and listen directly through the Web site
- Download the podcast by right clicking on the audio file and selecting “Save Target As ...” This will save the file to your hard drive. Once you have saved the file, you can listen to it on your computer or can save the audio file to a CD or MP3 player

\*A podcast is a digital media file, for use on a home computer or personal digital recording device for convenience.



# Medical Social Worker

## Post-test

### Disease Management



Clinician Name \_\_\_\_\_

Date \_\_\_\_\_

**Directions: Choose the ONE BEST response to the following questions. Circle your answer that identifies the ONE BEST response.**

1. Disease management is a system of coordinated health care interventions and communications for populations with conditions in which patient self-care efforts are significant.
  - A. True
  - B. False

Your answer:

2. Medical Social Workers can support disease management by utilizing the following interventions:
  - A. Hospitalization risk assessment
  - B. Emergency care planning
  - C. Medication management
  - D. Telehealth
  - E. Immunizations
  - F. Communication
  - G. Patient self-management
  - H. All of the above

Your answer:

3. Which of the following social worker activities can support disease management:
  - A. Identifying hospitalization risk factors
  - B. Reviewing the patient emergency care plan
  - C. Assisting with financial issues that could impact appropriate disease management
  - D. Modifying medication regimen
  - E. Locating community resources to assist patient with chronic illness self-management
  - F. All of the above

Your answer:



4. Heart failure patients need to manage their weight effectively to prevent exacerbations. Medial social workers could do any of the following to assist with improving patient self-management of daily weights, **except**:
- A. Reviewing the patient emergency care plan which defines the specific number of pounds/day in weight gain that requites notification of agency, physician or going to the emergency department
  - B. Assisting patient to obtain an accurate scale through family, agency or local programs if assistance is needed with purchase
  - C. Locating available caregiver or neighbor to assist patient with daily weights , if patient is unable to accurately/safely weigh themselves
  - D. None of the above, this is a nursing responsibility

Your answer:

5. In Dr. David Nash’s “Disease Management and Reducing ACH” podcast, he talks about three significant ways to improve chronic disease management. The improvements include all the following **except**:
- A. Provider coordination across the continuum
  - B. Communication with patient and all providers
  - C. Patient empowerment
  - D. Using specialized outpatient clinics for disease management instead of home care

Your answer:

**Answers to the post-test are located in the Leadership Section on page 24.**