Motivating Patients and Encouraging a Healthy Lifestyle with a Chronic Care Management Program

According to the CDC, one in four adults in the United States had two or more chronic conditions as of 2012. In addition to being extremely prevalent, chronic conditions can often be challenging to effectively manage, as primary care may not always offer services to help patients cope with or control their symptoms outside of the healthcare setting. To better assist patients with chronic conditions, hospitals and healthcare systems have begun to develop programs that address the individual needs of this patient population and help promote their overall wellness.

Greene County General Hospital (GCGH)—a 25-bed critical access hospital located in Linton, Indiana—has recently started a chronic care management (CCM) program in which health coaches work with patients to provide motivational support and help set personalized goals to encourage a healthy and happy lifestyle. To learn more about the CCM program at GCGH, The Academy spoke with Teresa Hutton, RN, Program Coordinator of the CCM program, and Brenda Reetz, Chief Executive Officer.

Greene County General Hospital

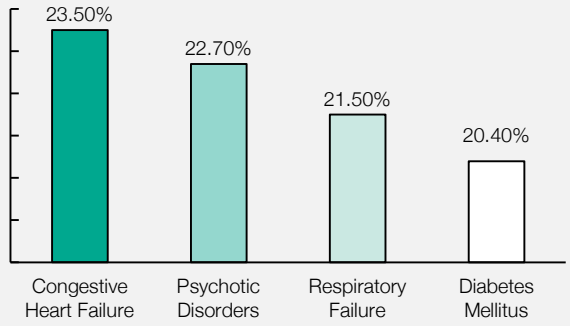
"Chronic care management is a combination of case management, coaching, and motivational interviewing, all driven by the client's needs, wishes, and personal goals," Hutton says. "We are helping the patient establish ways to work through and accomplish each of their individual goals."

Setting Goals

The CCM program at GCGH stemmed from leadership at the organization wanting to offer a model of care in which patients with chronic diseases could be followed-up with and checked on after they were discharged from the hospital, but finding a model that was cost effective was a challenge. Once CMS began reimbursement for chronic care management, though, the organization was able to fully develop the program. Additionally, the organization received a grant from the Indiana Rural Health Association for both online courses and in-person classes to certify staff members as professional health coaches.

30-Day Readmission Rate for High-Volume Conditions in 2013

Source: Agency for Healthcare Research and Quality (2015)



By offering medication management and motivational interviewing, the CCM program at GCGH assists in preventing readmissions for prevalent chronic conditions such as diabetes.

With funding and staff considerations in place, GCGH began enrolling patients in the CCM program. To be eligible for the program, patients must have two or more chronic illnesses that are expected to be present for least one year, as part of the criteria set by CMS. These patients are usually referred to the program by their case manager or physician during their annual wellness visit. The program is currently only offered to patients who see a specific primary care provider at GCGH and receive insurance coverage primarily through Medicare, but the organization hopes to one day offer the program to additional patient populations.

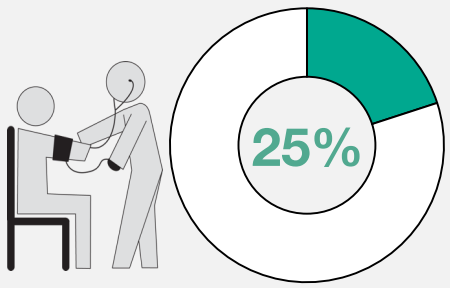
The core component of GCGH's CCM program is a certified professional health coach working with a patient in a series of motivational conversation sessions intended to encourage accountability and promote routine in the patient's management of their chronic diseases. This is achieved through phone calls between the coach and patient to discuss and create health goals.

For example, if a health coach is working with a diabetic patient, a goal that may be established during the first session is getting more exercise to assist in managing blood sugar. The health coach has a conversation with the patient to determine what form of exercise they are most comfortable with, such as walking. This is usually identified by the health coach asking questions about what exercise the patient may already enjoy or had previously done regularly. Once determined, a specific goal is set, such as walking two times a week for 30 minutes. From this goal, additional goals can be created or built upon as the patient works to achieve them.

More goals will then be established or modified in follow-up sessions. In the case of a diabetic patient, a goal to walk three times each week may be extended to five days per week, depending on the patient's schedule. To reach these goals and promote adherence, the coaches give patients frequent encouragement and motivation during each session to keep at their goals and not give up.

In addition to goal setting, the health coaches help patients identify barriers that may prevent them from achieving their goals and assist in developing plans to overcome those issues. For example, if a patient does not have access to transportation and is thus unable to pick up a prescription, the health coach can assist in coordination so that the patient's prescriptions can be delivered to their house through a community pharmacy.

% of Adults That Had Multiple Chronic Conditions in 2012
Source: CDC (2012)



The high prevalence of patients with two or more chronic conditions highlights the need for programs that offer symptom management and wellness strategies outside of primary care.

"We're helping the patient work through some issues that may be a jumble of thoughts, and they can't really grasp what is really getting in their way," Hutton says. "We focus on overcoming obstacles for living healthy lifestyles."

Structuring the Program

In order to avoid administrative complications and ensure smooth program operation, GCGH emphasizes the importance of having a clear foundation of leadership and processes for capturing revenue within the CCM program. The program itself is structured through Hutton, who acts as the centralized case manager for the program. Once a patient is referred or identified for CCM, they will meet with Hutton, who will have them sign a consent form for the program, which is signed again every 12 months.

Patients are billed for every 20 minutes per month of utilizing the CCM program, which includes everything covered during the phone conversations and additional features such as updating a patient's care plan. At the end of each month, Hutton makes a list of all of the patients who have had 20 minutes of phone sessions or care plan changes and sends it to the hospital's billing department. There, a staff member who handles billing for the primary care provider that oversees CCM patients sends the charges out for reimbursement. The program also requires a co-pay of eight dollars per month, but this fee can be covered if the patient has supplemental insurance.

To keep track of the time spent working with patients in the CCM program, Hutton utilizes a program separate from GCGH's EHR. This web-based program houses the patient's information and is capable of recording how long each session takes, in order to ensure each patient has reached their allotted 20 minutes.

Also stressed within GCGH is the ability to offer 24-hour access to care for patients in the CCM program. To achieve this, patients can call the organization and ask for a house supervisor or charge nurse if their health coach is unavailable, or if the patient is calling outside of the program's office hours. These house supervisors or nurses can then utilize the organization's EHR to access the patient's information, including their goals, so that they can fully address the patient's needs. By offering care to CCM program patients whenever they need assistance, GCGH is able to further encourage the health and wellbeing of their patients.

"This is one of those projects that's really hard to measure your return on investment, but the other benefits come in so many other ways," Reetz says. "The health coaches are helping to prevent a lot of other things from happening and you're gaining patient trust in your organization. Those are difficult things to measure, but seeing a patient's wellness improve is incredibly rewarding."

Through the CCM program, GCGH has been able to successfully promote healthier lifestyles for a number of patients. For example, one of the first patients to be part of the program was initially struggling with chronic obstructive pulmonary disease (COPD), but after one month of regularly speaking with a health coach who was able to modify the patient's treatment plan, the patient has not been hospitalized for COPD since and is in good spirits and health.

For other organizations looking to establish or restructure their own CCM program, the practices of Greene County General Hospital can serve as a valuable example. By providing motivation and continuously focusing on improving each patient's overall wellness, other organizations may achieve similar success.

"Just having someone that calls and checks on them, someone who they know that cares, can make a big difference for the patient," Reetz says. "The program helps the patient in staying compliant with their treatment regimen, and in their day to day lives."