

**A Clinical Perspective on Chronic Care**  
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## **INTRODUCTION**

I am the Medical Director of the Philadelphia Geriatric Center and Chief of the Section of Geriatric Medicine at Temple University Hospital and School of Medicine. Philadelphia Geriatric Center and Temple are members of the National Chronic Care Consortium and I am very pleased to represent the NCCC today. Philadelphia Geriatric Center is a not for profit organization that provides housing and health care services for elderly Jewish clients across continuum of health care settings. These include: Long Term Care services, inpatient and outpatient rehabilitation services, congregate housing, medical hospitalization, Adult Day Care and community based geriatrics clinical practices. At Temple University Hospital, I am the Medical Director of the Acute Care Geriatric Unit. I have the fortune of being positioned to provide a leadership role in geriatrics for both acute care and long term care settings. I see the challenges that geriatricians face that as they help their patients negotiate the health care system on a daily basis.

## **CHALLENGE TO HEALTH CARE PROVIDERS.**

Persons with chronic illness compose a heterogeneous group with varying degrees of disability and reliance on others for care. Over the course of their chronic illness, they may decline in function and experience bouts of superimposed acute illnesses. Their changing care needs require a variety of health care settings including inpatient and outpatient arrangements. At times they may need home health care services or hospice services. The professional services that persons with chronic illnesses may utilize include not only primary medical care and subspecialty medical care, but also nursing and rehabilitation services as well as psychology and social work services. Most people with chronic illness would benefit from some degree of case management services and most do not receive them. In the course of a chronic illness, a range of equipment and treatment needs are utilized and diagnostic testing services including laboratory and radiology are frequently necessary.

The challenge to health care providers is to ensure that their patients are being treated in the right setting with the right services and that there is a system in place to make sure that these settings and services will be flexible and can be changed as needs change. This coordination of care over time and across settings is usually the responsibility of the primary health care provider.

## **INGREDIENTS FOR SUCCESS.**

- Shared vision between clinical and administrative leadership in all health care settings.
- Quality health care settings and quality health care services.
- Access to these settings and services.
- Effective information management.
- Longitudinal follow up with reassessment.
- Evaluation of health care outcomes, functional outcomes, patient satisfaction and total costs to achieve these outcomes.

## **ROLE OF PRIMARY CARE PHYSICIAN PRACTICES.**

Physicians in most primary care practices, care simultaneously for Fee For Service Medicare patients as

well as managed care Medicare patients. They constantly deal with different financial incentives that can create barriers to good care and fragment service delivery. They usually identify care and service needs for their patients and try to work with existing benefit packages and community services (they know about) to meet those needs. Some practices are more successful than others in committing resources and energy to "figuring it out as they go along." What I mean by this, is that a primary care office that is most successful in managing persons with chronic illness is one that has a system in place that includes not only effective assessment of an individual patient's need, but also an excellent working knowledge of benefits covered by a variety of health care plans, how to access services in the most effective way, and knowledge of a patient's own resources and community resources that also might be utilized. Practices that do this effectively have generally committed a great deal of time and energy (uncompensated) with the goal of improving the overall care provided to their patients while maintaining financial viability. This "cost of doing business" has increased dramatically in recent years. Many busy practices have had to hire a full time "HMO" person to enable them to accomplish this. Practices that are particularly successful at managing patients with chronic illnesses might be considered "best practice" examples. I do not mean to suggest that these practices that are capable of working within the existing fragmented health care system are gaming the system, but merely that they have been able to provide coordinated services and remain financially sound. There is a genuine limit to altruism, however, and the reality for most practices is that uncovered services are undelivered services.

## **CASE EXAMPLES.**

**Case 1:** An 82 year old woman was admitted to our nursing home with a history of chronic heart disease and stroke. She was confined to a wheelchair and had mild cognitive impairment. She complained to her physician that she was having more trouble with her breathing and intermittent chest pain. The physician wanted to obtain a chest x-ray and an electrocardiogram. The patient's insurance coverage was through a Medicare managed care program. Although the nursing home had portable radiology available, her managed care radiology services were provided off site at an area several miles away. Additionally, EKG services were covered only at a site that was a twenty minute drive away. The physician attempted to arrange coverage for onsite EKG and chest x-ray and played voice mail tag with the HMO for several hours. The physician did not want to transport the resident outside of the facility because he thought this would be too burdensome. He had to decide whether he could make a treatment decision without the benefit of these diagnostic studies or if he should send the patient to an emergency room (at higher cost) to have these tests performed. This case is an example which is not uncommon in long term care settings where capitated laboratory and radiology services are not always available on site. In this regard, Fee For Service Medicare provides better service for elderly clients. The plan inflexibility and the difficulty accessing the powers-that-be at the insurance company also represent a problem for clinicians who are trying to coordinate care for their patients.

**Case 2:** A 78 year old woman living in the community had diabetes and visual impairment. Although she was legally blind, she was still able to live by herself and had limited mobility using a cane. Her primary care physician wanted her to receive preventive podiatry services (which were certainly covered by her Medicare managed care insurer). Unfortunately, the only capitated podiatrist was ten miles away from her home and was not on a public transportation line. She could not afford other transportation and insisted on cutting her own toenails, which in a blind diabetic, is a recipe for disaster. This physician did not decide to pursue the problem with the managed care company to arrange for another podiatry option or to see if transportation services might be arranged. Perhaps a case management system could have negotiated a more flexible and appropriate outcome.

**Case 3:** A 79 year old man with Alzhiemers Disease was being cared for by his daughter in her home. He had been living with her for approximately one year and t~e daughter was developing progressive stress, exacerbated by his poor sleeping habits and difficult behaviors. The primary care physician

ordered medication to treat the agitation which was intermittently successful. The daughter was referred to the Alzhiemers Association for support group and education, but was unable to take advantage of any services provided by the Alzhiemers Association because she was unable to afford respite care. The father had traditional Fee For Service Medicare coverage. The daughter was unable to manage the situation successfully and decided to put her father in a nursing home. He did not have enough funds to pay for nursing home care privately and the daughter applied for Medicaid. There were not beds available immediately. Several weeks later her father's agitation became so severe that she brought him to an emergency room. Although he did not have a serious medical illness, the daughter refused to take him back home and he was hospitalized with a diagnosis of possible urinary infection. During his hospitalization he declined further. He was restrained, developed a pressure sore and, stopped eating. A nursing home referral was made from the acute hospital and he was now eligible for Medicare coverage for short term SNF care. The daughter felt dissatisfied and very guilty about not be able to manage her father at home.

This man's doctor tried to connect his caregiver with helpful supports that may have enabled him to continue living at home for a longer time. Unfortunately, without any means to access respite services, the daughter was unable to take advantage of an existing resource. Flexibility, case management and respite care benefits would have helped.

How can we better manage these and other similar scenarios? The three cases would all have benefited from an effective system of case management that could evaluate the need for a variety of clinical services, evaluate the need for a change in setting and provide ongoing longitudinal monitoring and adaptation. Physicians are not trained to provide case management and even those who have "figured it out" do not have the tools to manage optimally and are not usually compensated to provide this service. Case management and care management systems have worked effectively in many managed care environments. Some HMO's provide disease management systems that are effective in decreasing recurrent hospitalization and functional decline. However, not every individual with chronic illness is eligible for these services. The Chronic Care Act of 1998 describes criteria for an effective policy to manage persons with chronic illnesses over time that include a care coordination and care management component for every delivery system for chronically ill individuals. The act recognizes that a health care system for persons with chronic illness must use care management to empower consumers to maximize their own responsibility regarding their care to avoid creating unnecessary dependencies on caregivers or case managers. However, without an effective care management system with flexibility regarding access to services and coverage of services, it is impossible to imagine how we can improve the overall management of individuals with chronic illnesses. Such a program could focus on disability prevention, not crisis intervention. Such a program could deal with the inflexibility of existing coverage benefits and arrange coverage when it makes sense for an individual to improve their long term function and health care. Thank you for your attention.

### **Examples of Chronic Illnesses Which May Lead to Disabilitiy and Care Dependency**

- Arthritis
- Chronic Lung Disease
- Congestive Heart Failure
- Dementia
- Depression
- Diabetes
- Hip Fractures
- Parkinson's Disease
- Renal Failure
- Stroke

# **Health Care Settings and Services for Persons with Chronic Illnesses and Disabilities**

## **Health Care Settings**

- Acute Hospital
- Inpatient Rehabilitation
- Subacute Rehabilitation
- \*Nursing Facility
- Adult Day Care
- \*Senior Centers
- \*Assisted Living

## **Community Health Service Programs**

- Home Health Services
- Hospice Care
- PACE Programs

## **Professional Services**

- Medical
- Nursing
- Rehabilitation
- \*Psychology
- \*Social Work
- \*Case Management
- \*Spiritual
- \*Support Groups

## **Diagnostic Services**

- Laboratory
- Radiology

## **Equipment / Treatments**

- Wound Care Supplies
- Tube Feedings
- \*Medications
- Durable Medical Equipment
- \*Hearing Aids
- \*Eyeglasses

\* Not covered or incompletely covered by FFS, sometimes covered by Managed Care