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# Complex Care Management: Meeting the Needs of Rural Patients with Multiple Chronic Conditions

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*As large health systems have had financial, leadership, and strategic resources to drive Value-Based Care models over the last 10 years, rural hospitals have focused on providing the basics: adequate staffing and resources to meet the demand for primary care and lower acuity surgical services to maintain their local clinical relevance.*

*Understanding where the opportunities lay for rural hospitals to be successful in their communities is critical to their long-term survival. To do that, we must understand the patient populations we treat and the changes in our delivery system we should undertake. Read on for a primer on the scope of the problem and a recommended approach for rural hospitals to survive and thrive while meeting the needs of this challenging care demographic.*

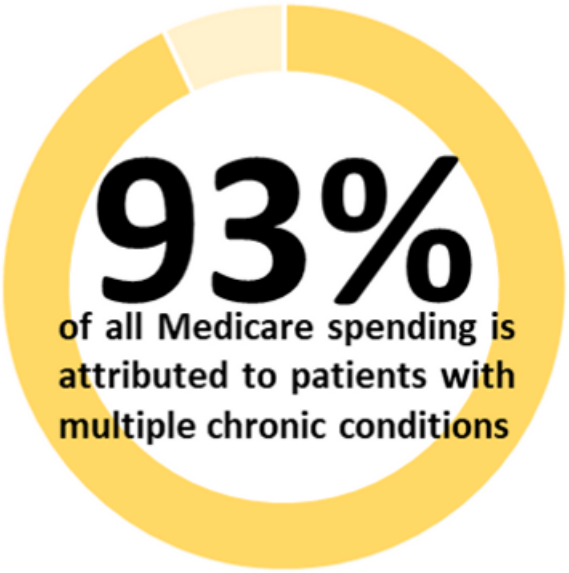
## A High-Value, High-Opportunity Demographic: Patients with Multiple Chronic Conditions

*What is a patient with multiple chronic conditions? Why are the needs of people with MCC so important? What unique challenges face health systems in delivering care to this group of patients? Are current models able to meet their clinical and social needs?*

Patients with multiple chronic conditions (**MCC**), typically defined as two or more chronic physical or mental health conditions experienced at the same time by the same individual for more than a year, comprise a disproportionate share of US health care spending. Nearly 1 in 3 Americans have multiple chronic conditions and the prevalence of MCC increases with age; 85% of the population older than 65 have MCC. These chronic conditions include heart and renal diseases, diabetes, asthma, arthritis, and depression.

Patients with multiple chronic conditions utilize health care services of all types at higher rates. 71% of all US healthcare dollars were spent on patients with MCC. In fact, 93% of all Medicare spending was attributed to patients with MCC. People living with multiple chronic conditions have worse clinical outcomes than those without. Interestingly, 88% of people hospitalized for COVID-19 had MCC.

Relative to people with zero or one diagnosed chronic conditions, patients with MCC experience tremendous burdens in navigating the health system and adhering to recommended care, including lifestyle changes and medication management. These patients also have significant health-related social and family needs, including social isolation, higher mood-related symptoms, and financial instability both from medical expenses and time lost from work.




Patients with MCC encounter fragmentation and poor coordination of care leading to higher levels resource utilization, including avoidable emergency department (ED) visits and hospitalizations. A patient with five or more chronic conditions sees an average of 14 physicians in 1 year and requires threefold greater number of medications, lab tests, and imaging studies, while suffering more adverse events. Elderly patients with no chronic conditions receive an average of 3 prescriptions per year, while patients with 5 chronic conditions receive 50.

Many of these factors impact the likelihood of poor outcomes, including exacerbation of illnesses and adverse events, disability, hospitalizations, and mortality. Patients with MCC have higher morbidity rates and lower socioeconomic status, with a disproportionate impact on racial and ethnic minorities.

### Managing Patients with MCC: Current State

Historically, the US reimbursement system and health care delivery system have failed to meet the needs of people living with MCC. Patients with multiple chronic conditions have complex case management needs. Health care systems originally designed to treat patients with episodic or single conditions are inadequate to support complex care needs patients who require more frequent monitoring and longer visit times..

The challenges with MCC coordination are well known. Transitions between primary care, specialty care, different clinic locations and hospitals, disparate scheduling systems, and multiple EMRs with little interoperability expand the spectrum of each patient's health care delivery system.

Patients with MCC often require multiple providers. Impaired communication between providers can result in contradictory advice and guidelines for patients, insufficient chronic care coordination, a lack of prioritization of care for each condition, and missed opportunities to leverage patient self-management.

Patients are regularly left to integrate and coordinate visits, tests, and treatments across siloed specialist services, to make sense of disparate information and recommendations, to complete administrative and medical errands, to figure out reimbursement systems, and competently implement significant recommended behavioral and lifestyle modifications.

The current primary care ambulatory workflow is best suited for either single disease management or addressing acute conditions. Visit-based care delivery models are unlikely to succeed as the point of care for long term disease management, especially when local primary care resources are full.  These systems are poorly designed for providing collaborative, team-based care necessary for frequent patient monitoring for variance identification. Each MCC patient needs an individualized, whole person approach to management. Current clinic operations do not match the complexity of the care required for this patient population.

### Creating an Integrated MCC Management System: Between-Visit Care

*How might health systems better support primary care providers in delivering patient-centered complex care? Are there ways the workflow can be augmented to more effectively meet the needs of our patients living with MCC, who are arguably our most important population segment? How can models incorporate the specific skillset and capabilities of each care team member to deliver an integrated solution to this subset of patients?*

A sustainable healthcare system for people living with MCC will deliver a primary care-based, high-value, coordinated and integrated, patient-centered program, optimizing individual and population health by successfully managing MCC and monitoring Social Determinants of Health (SDOH). Health outcomes for individuals with MCC in an increasingly virtual world will ultimately depend on the complexity of their care needs and their personal abilities and resources. Under this model, there is great potential for more effective use of healthcare dollars while improving quality of life and population health.

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Current models addressing patients with MCC emphasize the importance of the relationship between the patient and the entire care team. MCC interventions focus on coordinating treatments and communication across the continuum of care (e.g., primary to specialty care, inpatient to medical home, patient to clinic support staff). Multidisciplinary teams and integrative practice units augment the patient-provider relationship and help align the approach to each complex patient's treatment plan. A whole-person approach recognizes the importance of migration from encounter-based to between-visit care. Providers and system leadership teams recognize that we need be in contact with our patients far more frequently than to 3-5 days per year.

Between-visit care requires coordinated outreach and reporting to minimize patient burden and improve system efficiency. Complex care management models designed to automate patient contact are now coming online. Supporting technology can monitor daily or every-other-day patient symptoms. Systems automatically make 100 contacts per year, using telehealth and new communication platforms to closely monitor disease status through both remote patient monitoring and self-reporting, effectively creating an **Early Detection Warning System**.


The clinic's role in managing patients with MCC changes from in-person visits at regularly defined intervals for long-term management to close monitoring and surveillance. Significant variance from steady state triggers escalation to the Case Manager, who confers with the patient's Primary Care Provider to determine an action plan and disposition (e.g., ED/Urgent Care, same- or next-day clinic/telehealth visit, escalate to daily monitoring, or maintain steady-state monitoring). This distinction of between-visit care and an Early Detection Warning System markedly expands clinicians' abilities and available resources to meet the varied needs of this population.

### Addressing Behavioral Health as Part of Complex Care Management

*Is primary care where mental and behavioral health needs should be addressed? How can providers expand their capacity to serve the mental health needs of patients with MCC?*

Unaffiliated Rural and Critical Access hospitals have a nearly universal gap in providing behavioral health services in an integrated fashion. Behavioral health care management systems, supported by Medicare, can now create effective bridges supporting the primary care physician's overall treatment goals, that include both behavioral health managers and psychiatrists to routinely evaluate and make recommendations for primary care provider psychiatric medication utilization.

The Early Detection Warning System described for chronic disease management works for higher risk behavioral health patients as well. For a higher risk patient with depression where there is a change in patient medication, monitoring the patient every 2-3 days with a simple 5 question depression survey and using wearable tracking devices, the behavioral care manager can track the patient's progress looking for deterioration in resilience, mood, behavior, sleep, or exercise. A similar escalation notification triggers a communication with the patient and provider to determine if escalation or reevaluation is warranted.

In addition, these technology systems can provide support for psychological testing when providers are trying to differentiate certain disease states or differentiate organic cognitive decline from reversible causes. Lastly, these programs can provide similar tracking for patients who are placed into outpatient alcohol and drug abuse programs.

### Looking Ahead

More than 90% of rural hospitals do not have systems in place to manage complex patient care needs. And there is a reason for that. Achieving integrated care management is not a scientific issue, but one of leadership, strategy, and real-time management.

Unfortunately for rural hospitals, developing the solutions to addressing complex care management needs is not simple. Developing these programs takes time, effort, experienced resources, and an organized design methodology. Major barriers to program development include lack of an integrated care model. In an environment with insufficient provider resources, system infrastructure, supporting technology, services coordination, and investments. Independent organizations may struggle to provide the necessary services to realize the benefits.

Payment incentives and penalties encouraging systems and providers to provide more high-value, person-centered care is dependent on redesigning the system to meet the needs of the patient with MCC. The opportunity to create these programs has been markedly improved by new care coordination models that CMS has introduced.

These recent programs provide the funding methodology to begin the journey to an integrated solution for our patient populations. With CMS' introduction of care coordination reimbursement, these complex care systems models are now plausible. With a team-based strategies built into pathways via the Early Detection Warning System, people living with MCC using both chronic care and behavioral health management infrastructure and supporting technology applications, virtual care and new supporting technology systems can become the hallmark for multiple complex disease management systems in our rural communities.

References

AHRQ Research Summit on Transforming Care for People Living With Multiple Chronic Conditions | Agency for Healthcare Research and Quality

## About Rural Health Solutions

RHS continues to focus on delivering integrated prevention/wellness, chronic care and behavioral health management programs to improve rural hospital financial viability and rapidly reverse primary care outmigration. We have over 30 years of experience working with more than 200 hospitals and ambulatory care organizations across North America to improve care coordination, staffing, patient access, operating margins, quality of care and patient experience. To learn more about our programs' value to hospitals like yours, visit rhcsol.com.

Contact us for information on how we can help your organization thrive.