Game Changer at the Primary Care Practice – Embedded Care Management

Ruth Clark, RN, BSN, MPA
Integrated Health Partners
October 30, 2012
Objectives

• To describe the recent evolution of care management at the primary care physician practice level
• To discuss the role of the care manager in the primary care practice setting
• To evaluate the impact of care management in the primary care practice setting on one’s current conceptual construct
Who Are You?

• Type of Care Provider
  ✓ Nurse
  ✓ Social Worker
  ✓ Pharmacist
  ✓ Other

• Location of Work
  ✓ Hospital
  ✓ Physician Practice
  ✓ Community Agency
  ✓ Other
How Did We Get Here?

- Identified Need
- Care Management Collaborative
- BCBSM Provider Delivered Care Management Pilot
- Michigan Primary Care Transformation Project (MiPCT)
Identified Need

- Physician Learning Collaborative
- Community Care Managers
Care Management Collaborative

• Collaborative #1
  ✓ Created cross organizational teams to address patient care experience
    ➢ Transitions of care
    ➢ Linkage to community agencies
    ➢ Cross-organizational communications
  ✓ Created charter, aim, and targets
  ✓ Metrics based on pilot populations
  ✓ Participants’ assessment was positive
Care Management Collaborative

- Collaborative #2
  - Areas of focus
    - Assessing and meeting the needs of the patient
    - Communicating across care settings
    - Medication reconciliation
    - Referral processes
    - Transitions of care
  - Metrics
    - Coleman Transition Measure (CTM-3® and CTM-15®)
    - Closed Loop Communication
    - Medication Reconciliation 100% Correct
Care Management Collaborative

• Collaborative #2 (cont.)
  ✓ Dynamic team of support – more patient centered
  ✓ Deeper provider engagement
  ✓ Addition of vulnerable population leadership
  ✓ Metrics gathered in sampling methodology instead of pilot population
Provider Delivered Care Management Pilot

• Pilot of BCBSM
  ✓ Five POs in Michigan
  ✓ IHP – six practices
• April 2010 – March 2012
• Goal – Increase patient engagement in care management/disease management
<table>
<thead>
<tr>
<th>All Pilot Participants</th>
<th>Variations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Target Population</strong></td>
<td>Diabetes, CHF, CAD, Asthma, COPD</td>
</tr>
<tr>
<td></td>
<td>Depression, CKD, ESRD</td>
</tr>
<tr>
<td><strong>Patient Selection/Care Plan Process</strong></td>
<td>PO decides which patients to accept for delegation</td>
</tr>
<tr>
<td></td>
<td>Care managers confer with PCP before deciding on appropriate interventions</td>
</tr>
<tr>
<td></td>
<td>PO-developed risk stratification</td>
</tr>
<tr>
<td><strong>Patient Selection Criteria</strong></td>
<td>Match to pilot site PCP</td>
</tr>
<tr>
<td></td>
<td>At least one chronic condition</td>
</tr>
<tr>
<td><strong>Types of Patient Encounters</strong></td>
<td>Patient outreach</td>
</tr>
<tr>
<td></td>
<td>Self-management support and training</td>
</tr>
<tr>
<td></td>
<td>Health education</td>
</tr>
<tr>
<td></td>
<td>Coordination of care</td>
</tr>
<tr>
<td></td>
<td>Chronic condition-focused clinical management</td>
</tr>
<tr>
<td><strong>Provider Types</strong></td>
<td>Care manager (R.N.), PCP</td>
</tr>
<tr>
<td></td>
<td>Care manager (LPN or MA), Health educator</td>
</tr>
<tr>
<td><strong>Location</strong></td>
<td>Practice Unit</td>
</tr>
<tr>
<td></td>
<td>PO (phone or travel teams), Community</td>
</tr>
<tr>
<td><strong>Delivery Mechanism</strong></td>
<td>In Person, Telephone</td>
</tr>
<tr>
<td></td>
<td>Mail, Email, Telemonitoring</td>
</tr>
</tbody>
</table>
IHP Model

- Target Population – DM, CHF, CAD, Asthma, COPD
- Patient Selection
- Integration of Practices into Care Management Collaborative
- “Dual Model” of Care Management
  - Ambulatory Care Management Nurse
  - Office Practice Care Management
- Regular Meetings
  - IHP
  - Practices
Results

• Engagement Rates at IHP >90%
• Patient Stories
Michigan Primary Care Transformation (MiPCT) Project

- 3 Year CMS Demonstration Project
- Focus
  - Patient Centered Medical Home
  - Care Management embedded in Primary Care Practice
- Expected Outcomes
  - Patient Satisfaction
  - Increased Evidence-based Care
  - Decreased Primary Care Sensitive Emergency Department Visits
  - Decreased Ambulatory Care Sensitive Admissions and Readmissions
Moderate Care Managers

• Moderate Care Managers
  ✓ Focus on patients with mild to moderate illness
  ✓ Work with moderate risk patients to optimize control of chronic conditions and prevent/minimize long term complications
  ✓ Assist patients who are at risk for developing chronic conditions to minimize risk
  ✓ Goal of optimizing patient’s health status
  ✓ Patient Caseload
    – One MCM per 5,000 patients
    – Caseload 500
    – Approximately 90 – 100 active patients
Complex Care Managers

• Complex Care Managers
  ✓ Focus on patients with complex illness; usually have high cost or high utilization within health care system
  ✓ Develop individualized care plans that are patient-centric
  ✓ Provide targeted interventions to avoid hospitalization and emergency department visits
  ✓ Coordinate care across settings
  ✓ Goal of optimizing patient’s health status
  ✓ Patient Caseload
    – One CCM per 5,000 patients
    – Caseload 150
    – Approximately 30 – 50 active patients
Care Manager Roles/Responsibilities

- Use registry or other means (PCP referrals, data, etc.) to identify target population
- Provide care based on evidence-based practice guidelines
- Use collaborative practice models that include the PCP and other care team providers in developing and implementing care management plan
- Provide patient self-management support
- Complete timely coordination of transitions between settings (IP, ED), including medication reconciliation
Care Manager
Roles/Responsibilities

• Provide post-discharge phone calls
• Provide patient education with teach back
• Identify targeted high risk population, including patients with repeated social and/or health crises (use risk stratification tool)
Care Manager
Roles/Responsibilities

• Assess the needs of the patient and family
• Create comprehensive, proactive plan of care
• Work with patients to optimize control of chronic conditions, improve functional status, and prevent/minimize long-term complications
• Closely monitor patients to prevent and/or intervene early during acute exacerbations
• Coordinate care with specialists, hospitals, and other community resources
• Assist with advance directives, palliative care, hospice, and other end-of-life care coordination
Self-management Support

Ask – Don’t Tell
Self-management Support and Care Management

- You can’t do care the “old way”
- Patient engagement is key
- Use self-management (behavior) goal setting and motivational interviewing
- Enhance educational efforts – education (knowledge) is needed, but not sufficient
- Empowered patients, those engaged in their care, are more likely to have positive outcomes
Eggbert, on the advice of his doctor, starts slowly on his exercise program by pumping balloons.
Self-Management Enhances Patient Education

• Patient Education
  ✓ Information and skills are taught
  ✓ Usually is disease or topic specific
  ✓ Assumes that knowledge creates behavior change
  ✓ Goal is compliance
  ✓ Health care professionals are teachers
Self-Management Enhances Patient Education

• Self-management Support
  ✓ Skills to solve patient-identified problems are taught
  ✓ Skills are generalizable
  ✓ Assumes that confidence yields better outcomes
  ✓ Goal is increased self-efficacy
  ✓ Teachers can be professionals or peers
Key Components of Successful Care Management Programs

• Targeting
  ✓ Access to patient health records
  ✓ Access to information on patients at risk for high health care costs

• In-person encounters
  ✓ Regular, face-to-face interaction
  ✓ Supplement with phone calls, e-mails

• Access to timely information on hospital admissions and emergency room visits – allows transitions of care intervention
Key Components of Successful Care Management Programs

• Close interactions between care managers and primary care practitioners
  ✓ Part of care team
  ✓ Integrated patient-centered care plan

• Services provided
  ✓ Interplay of multiple medical issues
  ✓ Proper use and reconciliation of medications
  ✓ Social support, access, and coordination of care

• Care Management staff – appropriate training and education
Needed Data

- Emergency Department Visits
- Frequent Missed Physician Appointments
- Inpatient Admissions
- Inpatient Readmissions
- Patient Needs Assessment
- Polypharmacy
- Risk Factors
  - Age
  - Multiple Chronic Conditions
  - Co-morbid Psychosocial Issues
  - Lack of Financial Resources
  - Lack of Social Support
Needed Skills/Attributes of an Effective Care Manager

• Communication
  ✓ Motivational interviewing
  ✓ Teach back

• Education

• Collaboration
  ✓ Community organizations
  ✓ Other providers of care

• Compassion
Why Would We Do This?
“Let's play doctor. You be the primary care giver and I’ll be the doctor you refer patients to.”
Benefits of Care Management at the Primary Care Practice

• Patient care is improved
  ✓ Care management assessment
  ✓ Transitions of care
  ✓ Continuity of care
  ✓ Linkage to community resources
  ✓ Self-management support
  ✓ Patient engagement in care
  ✓ Follow up on evidence-based care
Benefits of Care Management at the Primary Care Practice

- Patient satisfaction increases
- Physician is able to focus on medical issues
- Care Managers find more job satisfaction
Barriers to Effective Care Management in the PCP Practice

- Lack of provider engagement
- Lack of understanding of role of Care Manager
- Multiple responsibilities
- Time needed for planning
- Failure to redesign processes
- Complex relationship with patient
- Lack of appropriate coordination – hospital, care managers, other community grants/initiatives
- Lack of reimbursement
Process Changes Needed at the Practice Level

- Case reviews with physicians
- Communication within the office
- Coordination between MCM and CCM
- Documentation
- Follow up calls with patients for primary care sensitive conditions
- Referrals to care managers
- Transitions of care
- Working the patient lists
Time for Self-Reflection

• What do I need to be an effective care manager in a primary care practice?
• How do I obtain those needed attributes?
• Identify the one thing you will do this week to use something you learned today.
"C'mon, Sylvia ... where's your spirit of adventure?"
Questions?