Implementing Care Management in an Academic Teaching Clinic

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AMERICAN ACADEMY OF FAMILY PHYSICIANS

What challenges do you have with care management?

Background

- Different goals among primary care team, institution and management care
- Inconsistent team members in large academic teaching clinic
- Patients are shares by multiple providers
- Coordinating care across diseases, settings and clinicians
- “Hot spot” patients

Objectives

- How to properly identify patient population with modifiable risks
- How to acquire resources for the implementation
- How to optimize process and tracking progress in order to align care management to the needs of clinic and the population (Patient and provider buy-in)
- How to actively involve learners in the process

Betty's Story

- 60 YO AA woman, resides in an apartment in Iowa City with her husband, "James." Her daughter and granddaughter also live in town. Unemployed, history of heavy alcohol use, smokes .25 PPD.
- PMH

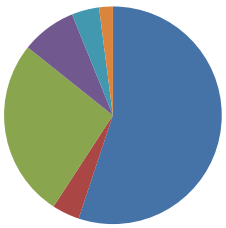
  HTN
  DM2
  Arthritis, limited mobility
  COPD
  Malnutrition
  Cirrhosis and portal hypertension secondary to alcohol abuse

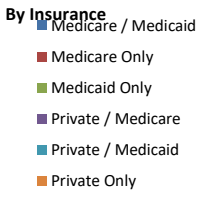
Her History with Our Clinic

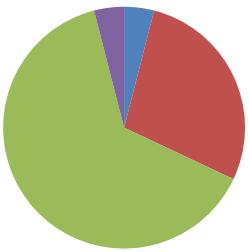
- **Established care with a faculty in 2009**
- **2015: Family Medicine**
  - **3** visits by **3** different providers
  - **8** phone contacts to clinic (forms, results, consults, refills, medical devices)
  - **5** No-Shows / Cancellations
  - **Specialists** (Eye, Hematology, Hepatology, Ordered Tests)
    17 No-shows / Cancellations
- **2016: Family Medicine**
  - **4** visits by **4** different providers
  - **25** phone contacts to clinic (acute issues, home health care, PA's, consults, medical device forms, results)
  - **14** No-Shows/ Cancellations
  - **Specialists:** She only had **one** Hepatology appointment made and cancelled it
  - **5 ER visits / Hospitalizations**

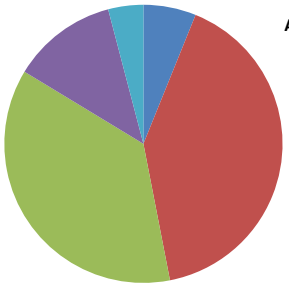
Identifying Patients

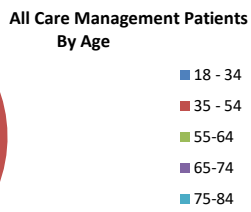
- Telephone calls
  - Total 9783 phone calls in the year
  - 440 patients who called clinic 12 times or more in FY16.(over 100 patients calls the clinic at least once every 2 weeks)
- Acute care clinic visits
  - 217 patients who had at least 5 ACC visits in FY 16.
  - Total 1307 visits
- Referrals by providers or nurses
- Global health assessment











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Care Management Team Tasks

- Pre-visit
  - Reminder calls
  - Huddle
  - Debriefing
- During visit
  - Pend orders for providers
  - Identify care gaps and needs
  - Navigating through healthcare system
  - Assist with appointment to ensure COC
  - Patient education/discharge planning
  - Determine goals of care
  - Support provider /visit efficiency
- Post-visit
  - Coordinate community services, orders, paper work
  - Intra-visit phone calls
  - Meet with multidisciplinary team as needed

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Pre-visit WORKSHEET

- **Visit date________/Time________** **Barcode sticker**
- **PCP________________**
- **Today's Provider____________ Reason for Visit: ________________**
- **Provider and date of last COC visit:_____________ _____________**
- ____
- **PRE VISIT**
- **Date Pre-Visit phone call made: _______**
- **Instructions from Provider to relay to patient during pre-visit phone call:**
-
- **
- **(DM)Last hgbA1c/date_______ (HTN) Last FM BP reading/date_________**
- **(Depression) Last PHQ score/date________/______**
- ****Date of all meds. last refilled for #90/4 refills_______________/Pharmacy___________**
- **(Since last visit) INCOMING Calls:**
- **ER/Hospital :**
- **Orders/appointments not fulfilled:**
- **DURING VISIT: Items to address**
-
-
-
- ____
- **POST VISIT: Follow-up needed/post visit activity required:**

AMERICAN ACADEMY OF FAMILY PHYSICIANS

Betty's Story Continued

- Care Management Team sees Betty has made an appt. Recognizing she is on the High Risk list, they **alert** the Provider through Epic prior to the encounter that she is coming in on his schedule.
- **PCP stress sets in!**

Care Team Involvement: First Visit **10/18/2016**

- Re-established care with staff PCP
- Physician **huddles** with CM the day of visit before seeing patient.
- CM and PCP go in initially to see patient together.
- Patient consented to be involved with care management team
- Care Managers step out and PCP completes his assessment.

Once PCP done,

- CM performs the initial nursing assessment and the results of each assessment discussed in a **debriefing** outside exam room.

It is determined PCP will see Betty every two weeks with a phone call by the CM Team the every other week in between visits.

All Family Medicine managed medications renewed #90 / 4 refills

Results of RN Initial Assessment 10/18/2016

- **Food insecurities**.
- She rates her health as "**fair**."
- **Lost her eye glasses** and is having difficulty reading,
- **Lack of transportation**.
- **Limited mobility** got wheelchair at home
- **VERY confused about her medications:** pill box, and closely works with pharmacy

- Subsequent visits: 10/27, 11/22, 12/13
- Crisis intervention

  11/2/2016 All communication lost with patient. Multiple voicemails being left on Betty's phone and are going unanswered.

  Missed next scheduled appointment on **11/11/2016** with PCP.

  11/12/2016 ER Visits for chest pains

  RN sent Betty a **letter on 11/14/2016**

  PCP comes to CM Office and states, "Don't give up on her!"

  Meanwhile, **11/15/2016** Patient makes contact with clinic to set up next appt. with **same PCP for 11/22/2016** on her own and requests to speak with the CM Team as she has **lost the transportation number for rides.**

- All four visits in 10 weeks with her PCP
- CM assisted PCP with:
  - Reminder calls
  - Pre-order labs
  - Patient initial intake and prepare PCP for the visit
  - Discharge assistance
  - Appointment scheduling

- CM assisted patient with
  - **Food insecurities**. Got patient on “Meals on Wheels”
  - **Lost her eye glasses:** received donated pair of temporary eyewear
  - **Lack of transportation**. SW involved, got Taxi voucher
  - **Limited mobility** with 4-5 falls in her home within the last 12 months. Does not like to use her walker all the time in her home.
  - Admits to being **VERY confused about her medications** and she is really not sure what she takes for medications or why she takes them.

What this all means…..

Multidisciplinary approach (RN, Care Managers, Provider, Patient, Pharmacist, Social Worker)

- Improved **continuity of care**. (Same Care Team, provider-or providers if co-managed).
- Identification of **care gaps**.
- **Improved communication** among the patient and their healthcare team.
- Team effort (TeamSTEPPS)

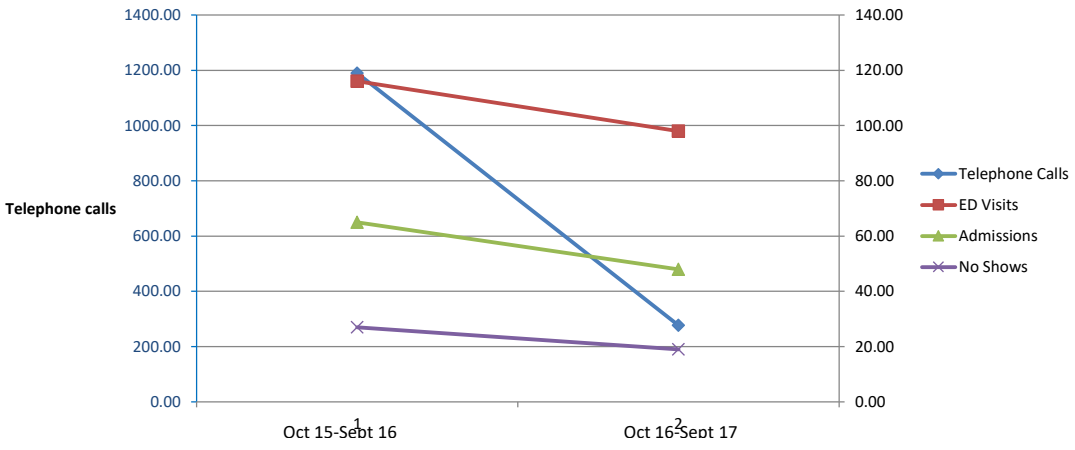
Tailored focused care plans for each individual patient

- Improved **monitoring** for the "high-risk" FM patient.
- **Decreased stress and anxiety** patients may experience while navigating through a confusing healthcare system.

Outcome

- Decrease no-shows, ER/ACC visits, hospitalization
- Increase medication compliance, healthcare/chronic disease outcomes.
- Increase patient involvement in their healthcare decisions.

Outcome



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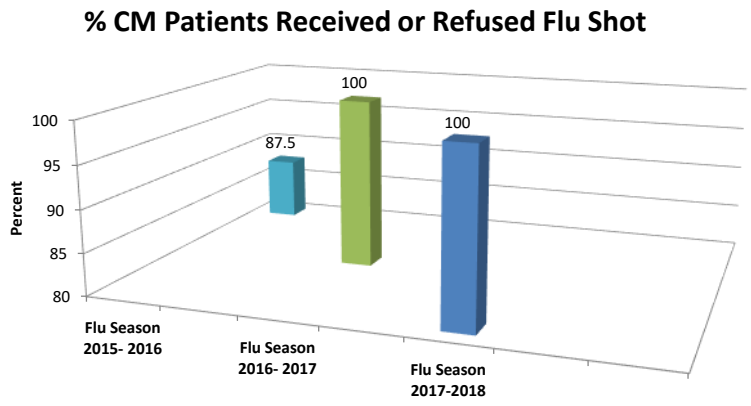

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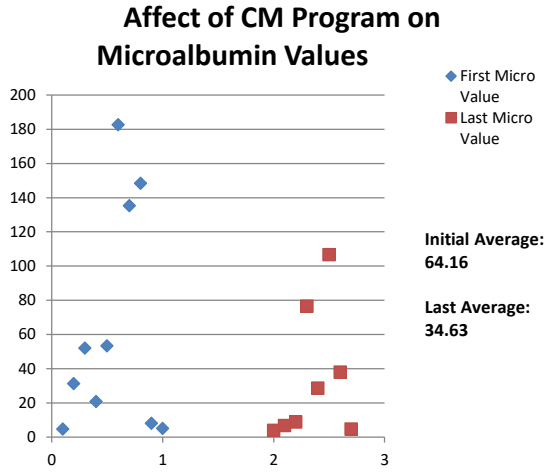
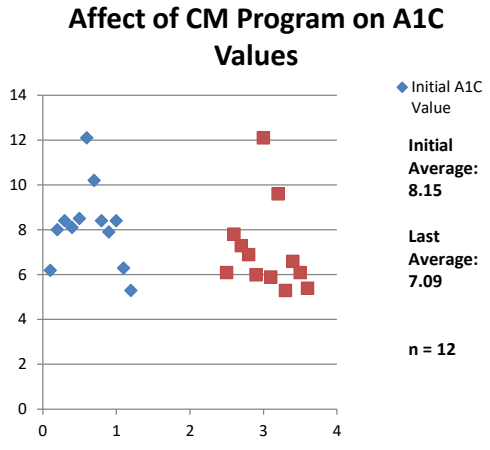




Learner Involvement

- QI
- Patients enrollment
- Education sessions

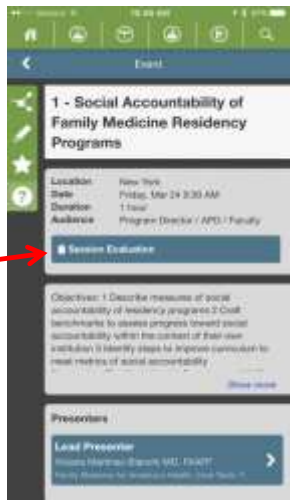
Next Step

- Sustainability
- Rolling out
- Data collection
- Expending:
  - Transition of care
  - Behavioral Health
  - Pain Management
- Deliberate involvement of learners

Please

complete the

session evaluation.



Thank you.

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