Implementing Effective Clinical Care Management

MODERATOR: Nicole Van Borkulo, MEd, Practice Improvement Specialist, SNMHI, Qualis Health

SPEAKERS:
- Ed Wagner, MD, MPH, Director and Senior Investigator, MacColl Institute for Healthcare Innovation, Group Health Research Institute
- Kathryn Horner, MS, MacColl Institute for Healthcare Innovation, Group Health Research Institute
- Rebecca Ramsay, BSN, MPH, Senior Manager of CareSupport and Clinical Programs, CareOregon
- Casey Boland, RN, MSN, Disease Management Program Coordinator, Multnomah County Health Department
- Jody Reifenberger, MMS, PA-C, Chronic Disease, Education and Management Department, East Boston Neighborhood Health Center
Implementing Effective Clinical Care Management

July 11, 2011

Presented by:
• MacColl Institute for Healthcare Innovation, Group Health Research Institute
• CareOregon
• Multnomah County Health Department
• East Boston Neighborhood Clinic
Agenda

• History and evidence for care management
  – Ed Wagner and Kathryn Horner from MacColl Institute for Health Care Innovation, GHRI
• Health plan partnership with safety net clinics to build care management capacity
  – Rebecca Ramsay from CareOregon
• Clinical care management in practice
  – Casey Boland from Multnomah County Health Department
• Program to target diabetic patients at ED
  – Jody Reifenberger from East Boston Neighborhood Clinic
The Patient-centered Medical Home

Key Change Concepts:

1. Engaged leadership
2. Quality improvement strategy
3. Empanelment
4. Patient-centered interactions
5. **Organized, evidence-based care**
6. Care coordination
7. Enhanced access
8. Continuous, team-based healing relationships
Step Ladder of Care

Case Load

- High-risk, multi-morbid patients

Patients with common chronic illnesses

All patients in panel who are involved in referral or transition process

Clinical Care Management

- Logistical
- Clinical Monitoring
- Self Mgmt Support
- Medication Mgmt

Clinical Follow-up Care

- Logistical
- Clinical Monitoring
- Self Mgmt Support

Care Coordination

- Logistical

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Who are patients with complex health care needs?

- Multiple chronic conditions
- Frequent hospitalizations
- Many prescription medications
- Many care providers
- Limitation of daily functions
- High costs
Medicare spending for beneficiaries with 5 or more chronic conditions

Thorpe and Howard, Health Affairs, Aug 22, 2006
Average per capita spending by number of chronic conditions (2004)

Anderson, “Chronic conditions” Johns Hopkins, 2007
Depression More Common among Chronic Medical Illnesses

- Chronic Pain: 40-60%
- Geriatric Syndromes: 20-40%
- Heart Disease: 20-40%
- Diabetes: 10-20%
- Neurologic Disorders: 10-20%
- Cancer: 10-20%

E Lin, Group Health Cooperative, presentation on TeamCare Study
The Challenge of Multiple Comorbidity for the US Health Care System

Anand K. Parekh, MD, MPH
Mary B. Barton, MD, MPP

The aging of the US population, combined with improvements in modern medicine, has created a new challenge: approximately 75 million people in the United States have multiple (2 or more) concurrent chronic conditions, defined as “conditions that last a year or more and require ongoing medical attention and/or limit activities of daily living.” It is the 21st-century US health care spending is directed at the approximately 25% of US population who have multiple chronic conditions. Individuals with multiple chronic conditions also face financial challenges related to the out-of-pocket costs of their care, including higher prescription drug costs and total out-of-pocket health care spending.

The “Multi-Condition” Patient

- One-quarter US population
- Half of Medicare patients
- Two-thirds of Medicare Costs

...and encouraged applications that included a mental health comorbidity and 1 or more physical conditions. Grants funded under this program are supporting work in several high-interest areas, including diabetes mellitus, mental illness, and preventive services.

Diabetes is common (10% prevalence in the US adult popu-
Chronic Illness Care

Single disease care management
- Diabetes, asthma, CHF, depression

Multi-condition care management
- Natural clusters of illness
  - Diabetes/CAD/depression
  - Depression/chronic pain/substance abuse
What is care management?

• Activities that assist patients and their support systems to manage medical and psychosocial problems with the aim of improving health and reducing the need for expensive medical services

• The goals are to:
  – Improve patients’ functional health status
  – Enhance coordination of care
  – Eliminate duplication of services
  – Reduce the need for expensive medical services

“Care Management Definition and Framework” Center for Health Care Strategies, 2007
Care Management Settings

- Primary care
- Health plan
- Vendor supported
- Integrated multispecialty group
- Hospital-to-home
- Home-based

Bodenheimer and Berry-Millett, RWJF Synthesis Report No. 19
How are patients identified?

• Care management is an intensive, costly process requiring highly skilled personnel
• Care management shouldn’t be offered to people who are too healthy or too sick to benefit
• Some predictive models
  – Charlson Comorbidity Index
  – Chronic disease score
  – Hierarchical Condition Categories (HCC)
  – Adjusted Clinical Groups (ACG)
• Models work best if there is discussion with physician
Key Components of Care Management

1. Identify patients most likely to benefit from care management
2. Assess the risks and needs of each patient
3. Develop a care plan together with the patient/family
4. Teach the patient/family about the disease and their management, including medication management
5. Coach the patient/family how to respond to worsening symptoms in order to avoid the need for hospital admissions
6. Track how the patient is doing over time
7. Revise the care plan as needed

Bodenheimer and Berry-Millett, RWJF Synthesis Report No. 19
Do research-based care management programs improve quality and reduce costs?

<table>
<thead>
<tr>
<th>Site of study</th>
<th>Quality of care</th>
<th>Cost reduction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary care</td>
<td>7 out of 9 studies found improved quality</td>
<td>3 out of 8 studies found reduced hospital use for subpopulations</td>
</tr>
<tr>
<td>Vendor supported</td>
<td>Some evidence of improved quality</td>
<td>Inconclusive evidence</td>
</tr>
<tr>
<td>Integrated multispecialty group</td>
<td>2 out of 3 studies found improved quality</td>
<td>1 out of 3 studies found reduced costs</td>
</tr>
<tr>
<td>Hospital-to-home</td>
<td>Many studies found improved quality</td>
<td>Many studies found reduced hospital use and costs</td>
</tr>
<tr>
<td>Home-based</td>
<td>No clear evidence of improved quality</td>
<td>No evidence of reduced costs</td>
</tr>
</tbody>
</table>

Bodenheimer and Berry-Millett, RWJF Synthesis Report No. 19
Care Management in Primary Care

• 3 key studies
  – Geriatric Resources for Assessment and Care of Elders (GRACE) (Counsel)
  – Care Management Plus (Dorr)
  – Guided Care (Bolt)

• Common characteristics among studies:
  – Clinic visits, home visits, phone calls
  – Care management teams with extensive training led by RNs
  – Small case loads

• Reduced hospitalization for higher-risk subgroups participating in care management compared to control groups

Bodenheimer and Berry-Millett, RWJF Synthesis Report No. 19
Hospital-to-Home Care Management

• 2 key studies
  – Transitional Care Model (Naylor)
  – Care Transitions Intervention (Coleman)

• Key similarities:
  – Nurse care managers with extensive training
  – Patients visiting during hospitalization and at home post-discharge

• Key differences:
  – Intensity of the intervention
  – Use of coaching

• Reduced hospital use compared to control groups

Bodenheimer and Berry-Millett, RWJF Synthesis Report No. 19
Characteristics of Successful Care Management Programs

- Patient selection
- In-person encounters including home visits
- Specially trained care managers with low case loads
- Multidisciplinary teams including physicians
- Informal caregivers/family assisting the patient
- Use of coaching

Bodenheimer and Berry-Millett, RWJF Synthesis Report No. 19
How have care management programs been adapted to real-world settings?

- Medicare demonstrations: few show cost savings
- Program of All-Inclusive Care for the Elderly (PACE): hospital and nursing home utilization greatly reduced but it has been difficult to prove overall cost savings
- Hospital-to-home programs have been successful in real-world settings, but have required significant modifications
- High risk clinics have potential

Bodenheimer and Berry-Millett, RWJF Synthesis Report No. 19
Next: Rebecca Ramsay from CareOregon
Building care management capacity within a “transforming” primary care system

July 11, 2011
Rebecca Ramsay BSN, MPH
Senior Manager of Care Support and Clinical Programs -- CareOregon
The Chronic Care Model

This is a primary focus of our care management work.

This may be foundational to successful medical disease and home work care started management.

Comprehensive Medical Home Model

Advanced Medical Services Model
Primary Care
Population Health Strategies

1. Panel Management
   - Registries
   - Gaps in Care
   - Outreach
   - Planned Visits

2. Care Management for Chronic Dz
   - Self Management Support
   - Medication Management
   - Care Coordination
   - Patient Education
   - Patient Activation

3. Complex Case Management
   - Complex Care Coordination
   - Problem Solving
   - Linking with Community Resources
   - Empowerment and Education
   - Transitional Care (post hosp/ED)

Usual Care in Medical Home
New Potential for Medical Home to Transform Patient Health Outcomes
2009

- Five learning sessions – once per month for 3 hours
- 50 + participants; primarily RNs with a few BH specialists and MAs
- Focused on defining and validating the practice, and creating common language and goals
- Spent three sessions building self-management support knowledge and skills
Lessons Learned from PCR Care Management Learning Collaborative (TAKE ONE)

• Care managers were engaged and enjoyed learning new skills; satisfaction with the sessions was very high, but...the clinic infrastructure was in transition...and had not changed enough YET to support this new practice

• Care managers wanted to step into this new world, but they needed more help...
Primary Care

Population Health Strategies

1. Panel Management
   - Care Management for Chronic Dz
   - Usual Care in Medical Home

2. Care Management for high risk/cost patients
   - New Potential for Medical Home to Transform Patient Health Outcomes

3. Complex Case Management

   • How do calls come in to the team? Who answers the phone for the team?
   • How do we free up time for care management? Who can do some of the work the team RN is doing now?
   • Creating care management schedule templates
   • How do we train for self management support? For disease-specific interventions?
   • What EMR tools do the care managers need? What new reports do they need to keep track of their caseloads?
   • Building a business/quality case for this work

   • How do we free up time for care management? Who can do some of the work the team RN is doing now?
Narrowed the focus: building the care management skills using depression and diabetes as the conditions of focus recognizing skills will be transferable to multi-condition

“Required” operational/infrastructure development first: structured process of workflow development and role clarification

Expanded the audience: encouraged the “primary care team” to participate in the learning sessions

Enhanced the incentives/drivers: Clinics as delegated DM entities for NCQA accreditation; new payment incentives for care management process and outcome measures

Developed EMR tools to support the work: leveraged OCHIN to work with CareOregon and the clinics
IMPACT
Integrated Depression Care

CareOregon Training
Portland, OR
May 13-14, 2010

Rita Havercamp, MSN, PMHCNS-BC, CNS
Rebecca Ramsay, BSN, MPH
A rational and practical approach to diabetes management

David K. McCulloch, MD
Clinic Diabetes and Depression Care Management Timeline

- **Jan-10** Preparatory Site Visits
- **2/26/10** Introductory IMPACT Webinar
- **5/14/10** IMPACT Training
- **7/19/10** Diabetes CM Training
- **7/30/10** 1st CM Reporting Cycle
- **9/30/10** CM Leadership Collaborative

- **3/1/10 - 5/12/10** Diabetes and Depression Team and Workflow Development
- **Jun-10 - Oct-10** Pilot Implementation and Coaching
- **Oct-10 - Dec-10** Spread of CM Programs
Clinic Diabetes and Depression Care Management Timeline

- **01/12/2011** Monthly IMPACT Coaching Calls Begin
- **01/05/2011** Monthly Clinical Diabetes Calls Begin
- **03/02/2011** 2nd IMPACT Training
- **06/15/2011** Diabetes Nutrition Learning Session

- Ongoing spread to new teams and new clinics
- Refinement of reports, metrics, and processes

01/01/2011 to 08/01/2011
Diabetes and Depression Care Management Metrics

- Program participation rates
  - Engaged or opting out

- Disease coaching intensity
  - Percent meeting minimum frequency targets

- Disease outcome metrics
  - Percentage of depressed patients with symptom reduction of 50% or greater (PHQ9 score change)
  - Percentage of diabetic patients with clinical indicators meeting or exceeding targets (HbA1c, LDL, BP)

- Patient satisfaction metrics
  - Annual survey of patient satisfaction with disease management from PCR clinics
Disease Management Stratification:

LEVEL 1:
Depression - Usual Care

LEVEL 2a:
Depression Care Mgmt Participating

LEVEL 2b:
Depression Care Mgmt Eligible

LEVEL 2c:
Depression Care Mgmt Opt Out

LEVEL 3:
Depression Complex / Excluded / Care Elsewhere

Stratified into level 2 but either:
• Haven’t yet attempted to engage
• Already participated in disease mgmt and discharged but didn’t meet graduation goals

Benefits of detailed categories:
• Care managers can keep track of what has happened or needs to happen with dz mgmt eligible patients
• Allows patients to be discharged from dz mgmt if adequate effort has not produced optimal outcomes

Stratified into level 2 but either:
• Actively opted out
• Passively opted out d/t inability to engage
FYI Flags developed in EPIC to support stratification tracking and reporting

<table>
<thead>
<tr>
<th>FYI Flag</th>
<th>FYI Flag Description/Crosswalk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression (Diabetes) – Usual Care</td>
<td>Level 1: not receiving dz mgmt bc patient is stable; receiving usual primary care</td>
</tr>
<tr>
<td>Depression (Diabetes) – Care Mgmt-Eligible</td>
<td>Level 2a: meets criteria for dz mgmt but is not currently engaged/participating bc the care manager hasn’t reached out to the patient yet or the patient was discharged (but hasn’t met clinical goals to move to Level 1)</td>
</tr>
<tr>
<td>Depression (Diabetes) – Care Mgmt-Participating</td>
<td>Level 2b: currently participating in dz management</td>
</tr>
<tr>
<td>Depression (Diabetes) – Care Mgmt- Opt Out</td>
<td>Level 2c: meets criteria for dz mgmt and the care manager attempted to engage but the patient either actively refused to participate or would not engage after the care manager tried</td>
</tr>
<tr>
<td>Depression (Diabetes) – Complex Care/Excluded/Care Elsewhere</td>
<td>Level 3: meets criteria for complex patient; usually means the patient is too complicated to enroll in a disease mgmt program but will receive a different intervention OR patient is receiving care outside of primary care setting for this condition</td>
</tr>
</tbody>
</table>
Basic Disease Management Process: Typical Coaching Activities

- **Preliminary Assessment**
  - Introductory conversation
  - Assessing for appropriateness of enrollment
  - Not a formal intake

- **Care Mgmt Intake**
  - Formal intake assessment once enrolled

- **Care Mgmt Follow-up (multiple)**
  - Self management coaching
  - Medication check-in
  - Teaching

- **Psych Consult (multiple)**

- **PST for Depression (multiple)**

- **Maintenance Plan**
  - Developing a plan to sustain dz remission or stability
Care Management Dashboard

OHSU Richmond -- Depression Disease Mgmt

Currently participating LEVEL 2 patients
Coaching & Symptom Reduction status as of last day of the reporting quarter

<table>
<thead>
<tr>
<th>Quarterly Period</th>
<th>% with at least 1 coaching session every 45 days</th>
<th>% with 5 pts+ reduction in INITIAL PHQ-9 score</th>
<th>% with 50%+ reduction in INITIAL PHQ-9 score</th>
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</thead>
<tbody>
<tr>
<td>Q3_2010 (total = 6 patients)</td>
<td>100%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Q4_2010 (total = 9 patients)</td>
<td>89%</td>
<td>67%</td>
<td>11%</td>
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### Depression Care Management Roster

**Service Area:**

**Roster Total as Selected:** 12

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>Sex</th>
<th>Birth Date</th>
<th>Age</th>
<th>WRN</th>
<th>Current EP</th>
<th>Last EP Visit</th>
<th>Last EP Visit with YPD</th>
<th>Last Depression Screen Date</th>
<th>Last FSD Score</th>
<th>Last EPDM Score</th>
<th>Initial Dep</th>
<th>Date Initial Dep</th>
<th>Date Initial Dep</th>
<th>Date Initial Dep</th>
<th>Date Initial Dep</th>
<th>Initial Dep</th>
<th>Diagnoses</th>
<th>Test of Depression</th>
<th>Depressions</th>
<th>Date Depressions</th>
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Final Conclusion re Implementing Care Management

Care management needs to be part of the value equation for the primary care system

- They “want” to do it, but the current incentives haven’t fostered it as a “need”
- Health plans have a “need” because we have found that care management effects our bottom line
The Build and Spread of Disease Management “1.0”
Multnomah County Health Department

Casey Boland, RN, MSN
Program Coordinator, Chronic Disease Management
Aim

• Standard clinical guidelines for Diabetes and Depression disease management
• All primary care Nurses transitioned to Care Manager Role
• New standing orders to promote staff working at the top of their license
• Improved patient outcomes
Measures

• Outcome Measures
  – % of Diabetic pts with D3 Bundle in control
  – % of Depressed pts achieving 50% decrease in PHQ-9 score:

• Process Measures
  – 3 care management referrals per team, per week (1 nurse on each team)
  – 2 Intakes per nurse, per week
Process Accountability

- Visual Management of referrals & intakes
- Chart audits by clinic leadership team
- Referral and Caseload reports
- Weekly conference calls
- Risk stratification reports
- Elbow support for staff and clinic leaders
Risk Stratification

Risk Stratification - Clinic #1

- Diabetes:
  - Not Stratified: 6%
  - Complex/Care Elsewhere: 37%
  - Care Management - Elsewhere: 18%
  - Usual Care: 55%

- Depression:
  - Not Stratified: 20%
  - Care Management - Elsewhere: 23%
  - Usual Care: 39%

Legend:
- Not Stratified
- Complex/Care Elsewhere
- Care Management - Elsewhere
- Usual Care
# Referral Reports

## Referrals / Intakes

<table>
<thead>
<tr>
<th>Team</th>
<th>Refs Last WK</th>
<th>Intakes Last WK</th>
<th>Refs All</th>
<th>Intakes All</th>
<th>Participating</th>
<th>Graduated</th>
<th>Complex/Excluded</th>
<th>Opt Out</th>
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<tbody>
<tr>
<td><strong>CASCADE TEAM</strong></td>
<td></td>
<td></td>
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<td>Hogan, Katherine</td>
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<td>Sheren, Emily</td>
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<td>18</td>
<td>14</td>
<td>-</td>
<td>12</td>
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<tr>
<td><strong>HOOD TEAM</strong></td>
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<td>8</td>
<td>5</td>
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</table>
Early Results

Chronic Disease Management - Early Results

% panel patients

Clinic 1 - D3 Bundle  Clinic 1 - 50% Reduction PHQ-9  Clinic 2 - D3 Bundle  Clinic 2 - 50% Reduction PHQ-9

October 2010  April 2011
Caseload Build

Total Caseload by Clinic

# participating patients


Clinic 1
Clinic 2
Clinic 3
Clinic 4
Lessons Learned

• Support for clinic leadership is key

• Many challenges are shared across clinics

• Pilot Teams set the stage
Project Team

• Pilot teams and clinical champions
  – Northeast and East County health centers-based teams

• Epic Optimization
  – Jennifer McClure

• Internal Trainers
  – Amy Henninger, Jessica Sosso-Vorpahl, Lisa Sprague, Joanne Serna, Teri Erickson, Kathy Thomes-Rhew, Florence Gerber, Kimmy Figueroa

• Visual Mgmt/Reporting Support
  – Mindy Stadtlander, Monica Gration

• Patient Education Materials
  – Andrea Deen, Sylvia Ness

• External Trainers
  – Rebecca Ramsay, Ariel Singer, Legacy Mt. Hood Diabetes Center
Next Steps

• Collate feedback into revised standard work and improved materials

• Adapt process and materials for sustainability (new staff orientation, easier shared drive access)

• Support clinics by supporting clinic leaders
Implementing Effective Clinical Care Management

Jody Reifenberger, MMS, PA-C
Lieutenant Team Leader SNMHI
Chronic Disease, Education and Management Department
East Boston Neighborhood Health Center