Essentials of Care Management Part 1

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Welcome

This webinar will be recorded.

Welcome

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Build and Strengthen your Care Management Program

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Learning Objectives

- Outline strategies to risk-stratify your patients
- Clarify the key operational and resource considerations involved in implementing or enhancing care management services
- Assess readiness and opportunities to deliver enhanced services to individuals with complex care needs
- Harvest existing solutions and best practices from colleagues

Questions from Registration

- How to treat patients with kindness, honesty and compassion?
- Engaging patients to come in – even virtually – given COVID-19
- How are care teams designed around CCM
- Best way to share patient information among all those involved with a patient's care.
- What do daily workflows look like for care teams
- Does a CM program require dedicated care managers (i.e., it’s their fulltime job)
- How to incorporate this work into existing care team roles without a dedicated CM role/team

Questions from Registration

- Tips and data to sell implementing a more robust CM program with dedicated resources
- How can I coach staff to maximize caseload without sacrificing the quality of care
- Strategies for continued growth
- Best practices with frequency of reviewing quality reports related to risk stratification and workflows to involve key team members for actionable outcomes for improving patient quality.

"Would love to hear how others went about getting this work started, how others have adapted during COVID, what roles are involved in care management at other organizations, how others are risk stratifying their populations, and how others outreach to their patients to engage them in this care."

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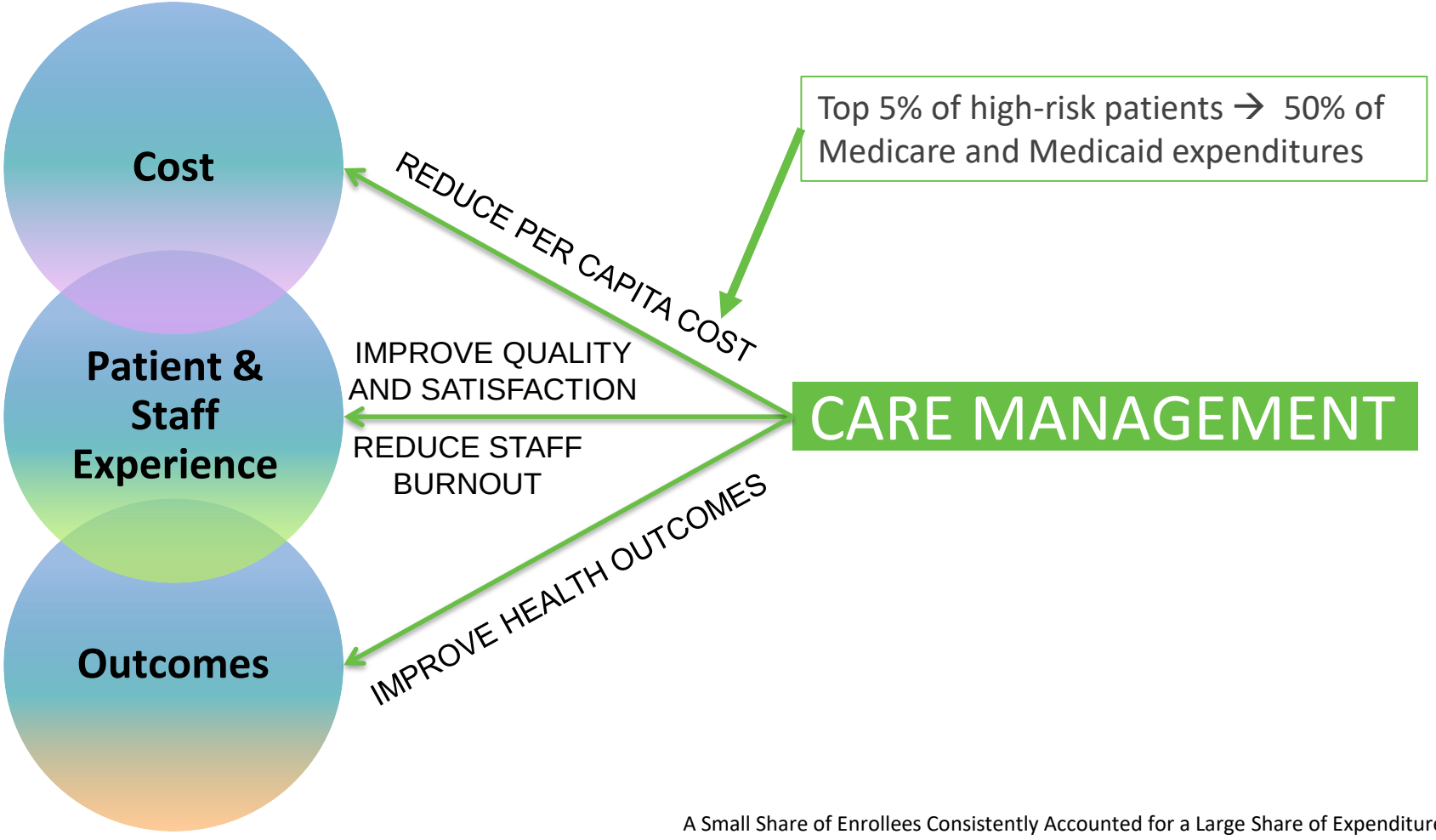
Questions from Registration

- Would like to learn ways pharmacists can be more involved in chronic care management that is sustainable.
- Care Management in the time of COVID - measuring success?
  - The role of PAM
  - Social Determinants of Health?
  - Total Cost of Care
  - Health Equity
- How to combat pt.'s with SUD and achieving goals with DM.

The Quadruple Aim & Care Management



A Small Share of Enrollees Consistently Accounted for a Large Share of Expenditures. U.S. Government Accountability Office Report to Congressional Requesters. May 2015

Care Management
What is it?

"Care management is a set of activities designed to assist patients and their support systems in managing medical conditions more effectively."

Goodell, S, Bodenheimer, and Berry-Millet, R. Care management of patients with complex health care needs. The Robert Wood Johnson Foundation. Policy Brief, No. 19. 2009
https://www.rwjf.org/content/dam/farm/reports/issue_briefs/2009/rwjf49853

Terminology

- ***Care coordination*** seeks to coordinate care for all patients. Staff in care coordination roles do not need to have a clinical background or skill set.
- ***Care management*** includes delivery of enhanced services to a targeted population that is most likely to benefit from the intervention and generally requires a level of clinical expertise (e.g., registered nurse (RN)).
- ***Chronic disease management*** is an integrated care approach to managing illness which includes screenings, check-ups, monitoring and coordinating treatment, and patient education[1].

1. CMS: https://www.healthcare.gov/glossary/chronic-disease-management/

Do you have a care management program in place?

- If yes, how do you identify which patients to enroll in your care management program (i.e., what's your definition of "high-risk")?
- If no, what is your biggest barrier to implementing a care management program?

- Of 11 registered health centers, four said they are not risk stratifying patients.
- What are the benefits of Chronic Illness and Disability Payment System (CDPS) vs Prism vs other methods of stratification?

The question is not…

- Who needs care management?

FAQ: How many patients can a care manager support?

The question is…

- Who can benefit from and engage in care management and has modifiable risk factors (aka those for whom working together can make a difference)?

COMPLEX CARE

- All of the below bullets, and…
- Provide enhanced services & tracking

CHRONIC CONDITIONS

- All of the below bullets, and…
- Monitor, according to guidelines
- Identify and address chronic care gaps

WELL

- Provide screenings, immunizations, and follow-up
- Administer at-risk assessments
- Track referrals and test orders
- Connect with between-visit support
- Support during transitions, including…
- Follow-up after ED visits and hospital admissions

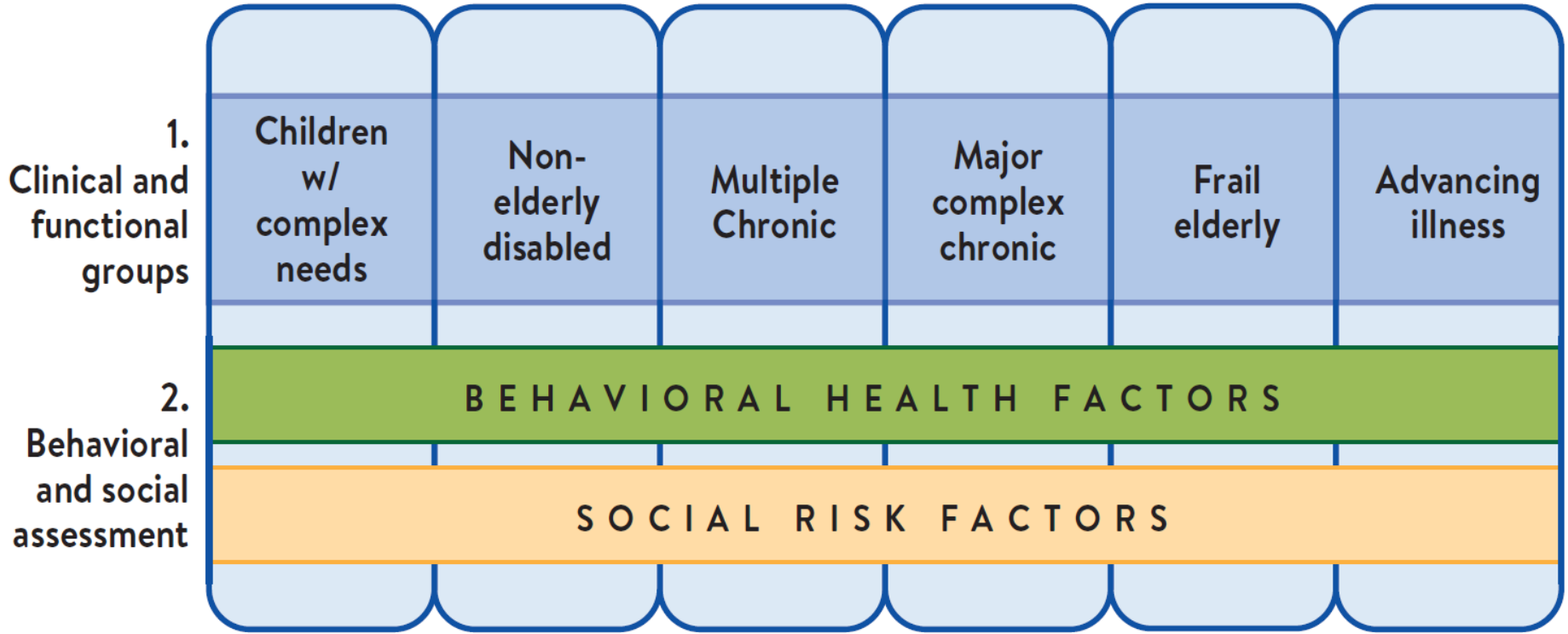


Figure 3.1 A conceptual model of a starter taxonomy for high-need patients
Effective Care for High-Need Patients – National Academy of Medicine p. 41
https://nam.edu/wp-content/uploads/2017/06/Effective-Care-for-High-Need-Patients.pdf

Mongolia – Risk Stratification

I – Healthy
II – Some health issues
III – Chronic disease but not any active issues
IV – Active chronic problems
V – Very sick/invalid

Operational Definitions - Examples

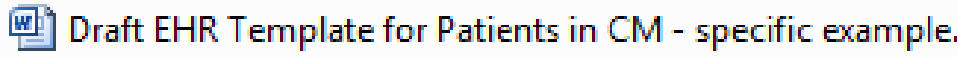
- Individuals age 65 or older with diabetes and A1C > 8% with hypertension and at least one additional sequelae from diabetes (chronic kidney disease, peripheral vascular disease, diabetic retinopathy, etc.) OR At least four emergency department visits or two hospital admissions in past 12 months
- Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient OR chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline

Risk Level	# Conditions	Total	Cumulative Total
Highly complex	7+		
Highly complex	6		
High-risk	5		
High-risk	4		
Rising-risk	3		
Rising-risk	2		
Low-risk	0 or 1		

Population Health Management – Risk Stratification; National Association of Community Health Centers July 2019 http://www.nachc.org/wp-content/uploads/2019/03/Risk-Stratification-Action-Guide-Mar-2019.pdf

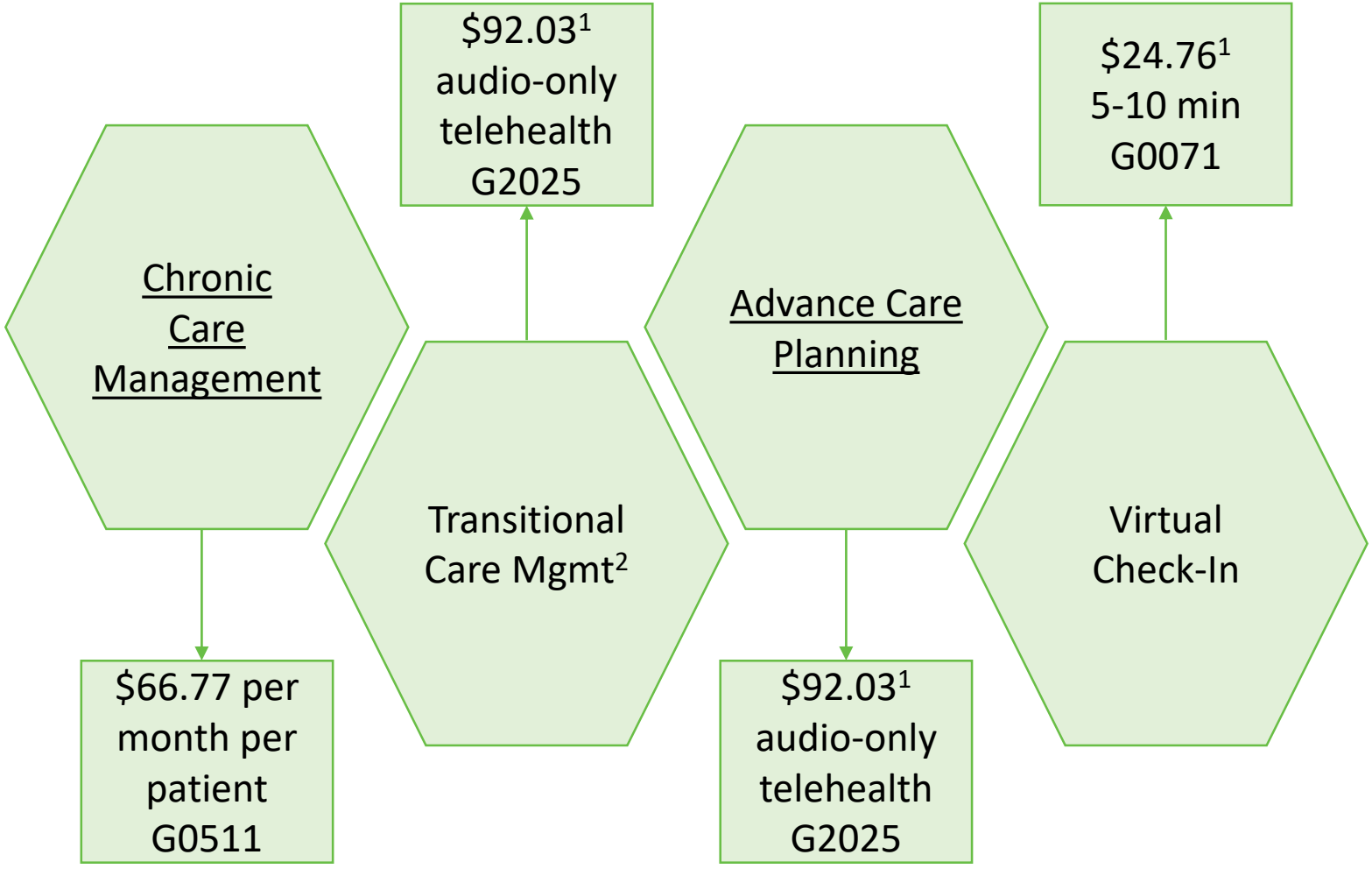
Case Study

75-year old male with uncontrolled diabetes (09/30/2019 A1C 12%), frailty, heart failure and obesity, recently started on insulin. In ED two times in past six months for BG > 400 and once for s/p fall, one hospital admission for DKA and one for volume overload.



EHRs	Health Centers	
Allscripts	• COMMUNITY HEALTH OF CENTRAL WA • NEW HEALTH PROGRAMS ASSOCIATION	• SEA-MAR COMMUNITY HC • SEATTLE INDIAN HEALTH BOARD, INC
athenahealth	• COLUMBIA VALLEY COMMUNITY HEALTH • COMMUNITY HEALTH ASSOC. OF SPOKANE	• FAMILY HEALTH CENTERS • PENINSULA COMMUNITY HEALTH SVS
Centricity	• COLUMBIA BASIN HEALTH ASSOCIATION • MOSES LAKE COMMUNITY HC • UNITY CARE NORTHWEST	
Epic	• COUNTRY DOCTOR COMMUNITY CLINIC • COWLITZ FAMILY HEALTH CENTER	• SEATTLE-KING CO. PUBLIC HEALTH DEPT • YAKIMA VALLEY FARMWORKERS CLINIC
Intergy	• THE N. A. T. I. V. E. PROJECT	
McKesson	• MATTAWA COMMUNITY MEDICAL CLINIC	
NextGen	• COMMUNITY HEALTH CARE • COMMUNITY HC OF SNOHOMISH CO. • HEALTHPOINT • INTERNATIONAL COMMUNITY HEALTH SVS	• LEWIS CO. COMM. HEALTH SVS VALLEY VIEW HC • NEIGHBORCARE HEALTH • TRI-CITIES COMMUNITY HEALTH • YAKIMA NEIGHBORHOOD HEALTH SERVICES
RPMS	• LAKE ROOSEVELT COMMUNITY HC/ COLVILLE CONFEDERATED TRIBES	

Athena platform risk stratification. Are some people using it successfully? what about other platforms like Azara.



1. Only during the public health emergency
2. Note that as of Jan 1, 2020, CCM and TCM can be billed in the same month for the same beneficiary

Care Management Program
The 10-Step Program for Clinics

1. Develop operational definition of high-risk, complex care, high-need, high-cost – whatever your terminology! And identify how many and which individuals are in your target population.
2. Define care management program & care manager role & responsibilities, including what happens before, during, after and between visits
3. Identify the necessary resources for the care management program and scale accordingly
4. Provide necessary training (e.g., evidence-based guidelines, motivational interviewing, red flags, etc.)
5. Establish criteria for admission and “graduation”
6. Sort out care plans (create/update, template in EHR, reviewed by PCP, provided to patient/caregiver, required components, MEANINGFUL, etc.)
7. Ensure care management is integrated into the care team and the EHR
8. Track patients in the care management program – report, registry, data
9. Capture reimbursement for your work
10. Measure. Improve. Measure.

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Thank You

Join us for Part 2!

Getting Paid for Chronic Care Management
June 17, 12:00 – 1:30 pm

Upcoming Training

Learning from Experience: Diabetes Prevention Programs at FQHCs
June 16, 12:00 – 1:00 pm

Partnering with Patients to Improve Blood Pressure through Self-Monitoring
June 24, 12:00 – 1:00 pm