Embedded Case Manager

Joann Sciandra, RN, BSN, CCM

Medical Home Summit
ProvenHealth Navigator®

Geisinger Health System

An Integrated Health Service Organization

Provider Facilities

- **Geisinger Medical Center**
  - ***Danville Campus*** *– includes Hospital for Advanced Medicine, Janet Weis Children's Hospital, Women's Health Pavilion, Level I Trauma Center, Ambulatory Surgery Center*
  - ***Geisinger Shamokin Community Hospital***
- **Geisinger-Bloomsburg Hospital**
  - **Geisinger Wyoming Valley Medical Center** *with Heart Hospital, Henry Cancer Center, and Level II Trauma Center*
  - ***Geisinger South Wilkes-Barre*** *campus with Urgent Care, Ambulatory Surgery Center and Inpatient Rehabilitation*
  - **Geisinger Community Medical Center** *with specialized medical & surgical services, including Level II Trauma and comprehensive cardiac & orthopedic services*
  - **Marworth Alcohol & Chemical Trtmt Center**
  - **Mountain View Care Center**
  - **Bloomsburg Health Care Center**
  - **>72K admissions/OBS & SORUs**

Physician Practice Group

- **Multispecialty group**
  - **~1,000 physicians**
  - **~520 advanced practitioner FTEs**
  - **65 primary & specialty clinic sites (37 Community Practice Sites)**
- **Freestanding outpatient surgery center**
- **> 2.1 million clinic outpatient visits**
- **~360 resident & fellow FTEs**

Managed Care Companies

- **~298,000 members (including ~63,000 Medicare Advantage members)**
- **Diversified products**
- **~30,000 contracted providers/facilities**
- **43 PA counties**
- **PA Medicaid initiative**
- **Out of state TPA contracts**

Note: Numerical references based on fiscal 2012 budget plus impact of GSACH , GCMC and GBH acquisitions.

Partnership of PCP's & GHP provides 24/7 360 degree patient care and navigation

Geisinger's PHN model has five core components

Patient-centered primary care

- Patient and family engagement & education
- Enhanced access and scope of services
- ***PCP led team-delivered care***
- Chronic disease and preventive care optimized with HIT

Integrated population management

- Population segmentation and risk stratification
- Preventive care
- ***GHP employed in-office case management***
- Disease management

Medical Neighborhood

- Micro-delivery referral systems
- ***360° care systems*** – SNF, ED, hospitals, HH, etc

Quality outcomes

- Patient satisfaction
- HEDIS and bundled chronic disease metrics
- Preventive services metrics

Value-based reimbursement

- Fee-for-service with P4P payments for quality outcomes
- Physician and practice transformation stipends
- Value-based incentive payments
- Payments distributed on Quality Performance

PHN Expansion

	Sites	MA members	Commercial members	Medicare members	Total**
2006	3	3,100	800	2,000	31,000
2007	10	7,300	8,500	11,000	119,000
2008	12	4,600	7,000	7,800	94,000
2009	12	4,300	7,100	5,300	55,000
2010-11	9	1,100	4,600	3,000	61,000
Total	**46***	**20,500**	**28,000**	**29,100**	**360,000**

* 37 Geisinger CPSL practices & 9 non-Geisinger primary care practices

**Total Geisinger patients, non-Geisinger patients not quantified

Case Management

Identifying and Managing the Highest Risk in Your Population

Why Case Management?

- Fragmented care
- Poor care coordination
- Gaps in care
- Poor communication
- Health care is complex
- Aging population
- Multiple transitions of care

Medicare 30 Day Readmission Rates

- 30% readmitted from SNF to hospital
- 20% readmitted from home to hospital

N Engl J Med 2009; 360: 1418-28.

Causes of Readmissions

- Heart Failure
  - 37% readmitted in 30 days
- COPD
- Sepsis
- Pneumonia
- Psychoses

N Engl J Med 2009; 360: 1418-28.

The Acute Care Environment

- Unnecessary or short stay medical admissions
  - Pneumonia
  - HF
  - COPD
  - DM
  - UTI
  - A-fib
  - Dehydration

Ambulatory Care Sensitive Conditions (ACSC)

Geisinger's Approach to CM

- High risk identification
- Targeted populations
  - HF, COPD, oncology, multiple trauma, ESRD, frail elderly
  - TOC
- Comprehensive assessment
  - Driving issue behind case
  - Frequent follow-up with patient/family
- Daily interaction with Provider and team

Embedded Case Managers are Key to Success

- Embedded Case Manager
  - 1 CM / 800 Medicare or 5000 commercial lives
  - **High risk** patient case load 15 - 20% for Medicare
  - 3 to 5% of commercial
  - Total case load 125 - 150 pts
  - NOT traditional disease management – focus on those at most risk and what is driving issue with the care

Challenge of caseload management is gauging acuity and complexity

Targeting CM at High Risk Populations

- High risk
  - Post Hospital Discharge
  - Predictive Modeling
- PCP referral
  - Site team: Nurse, Ancillary staff, etc.
- Self referral
- Targeted medical management referrals
- Targeted conditions
  - HF
  - COPD

Predictive Modeling

Site#	Forecasted Risk Index	AIS	CIS	Risk Rank	Sex	Age	Total Paid	Forecasted Cost	Primary ETG Group	Program Status
C101	4.1	91	35	5	M	82	$42,187.00	$44,456.00	Cerebrovascular Accident	MHOpen
C101	4	80	37	5	M	68	$46,972.00	$43,405.00	Cardiovascular Surgery	MH CL - Need met
C101	6.21	100	28	5	M	67	$137,724.00	$67,387.00	Infectious Disease	MHIdentified
C101	3.19	93	25	5	F	75	$70,344.00	$34,563.00	Degenerative Ortho disease	MHCL- Needs meet
C101	4.53	94	60	5	M	81	$49,157.00	$49,173.00	Cerebrovascular Accident	
C101	10.2	97	51	5	F	71	$133,870.00	$110,630.00	Renal Failure, Chronic & Nephrosis	MHOpen
C101	5.59	90	62	5	M	81	$25,981.00	$60,613.00	Renal Failure, Chronic & Nephrosis	MHIdentified
C102	8.87	95	50	5	F	79	$113,895.00	$96,235.00	Renal Failure, Chronic & Nephrosis	MHCL- CC

When to Refer to a Case Manager

- Complex chronic conditions
- Caregiver stress
- Coordination of services
- Psychosocial issues
- Home safety concerns
- Advancing Illness
- Outpatient management of an acute medical condition

Key Case Management Activities

- **Personal patient link**
  - Transitions follow up (discharges, ER visits)
  - Direct line access – questions, exacerbation protocols
  - Family support contact
- **Recognized site team member**
  - Regular follow ups for high risk patients
  - Facilitate access – PCP, specialist, ancillary
  - Facilitate special arrangements (emergency home care, hospice care)

Functions of Case Manager

- Transitions of care
- Chronic Care
- Exacerbation management
- Self management
- Telephonic and/or device monitoring
- Frequent follow up

Transitions of Care

- Pt contact within 24-48 hrs post discharge
- Telephonic outreach
  - Medication reconciliation and optimization
  - Ensure safe transition post discharge
  - with appropriate services in place
    - Home Health
    - DME
    - Safe to be in their home?
  - Facilitate post hospital PCP & CM appt within 3 - 5 days
- Close follow-up for 30 days

Chronic Care Management

Heart Failure

- Diuretic Titration Protocol
- Daily weights & Tele-monitoring
- Medication management
- Education
- Self management
- Outreach

COPD

- Rescue kit
- Symptom monitoring
- Medication management
- Education
- Self management
- Outreach

Target Ambulatory Care Sensitive Conditions (ACSC)*

- Angina
- Asthma
- Cellulitis
- COPD
- HF
- Dehydration
- Diabetes
- Gastroenteritis
- Seizures
- HTN
- Hypoglycemia

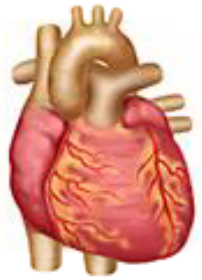
Conditions best managed in the outpatient setting

* AHRQ

Tele-Monitoring Tools

- Blue tooth scales
  - Managing HF
  - Transmits daily weights to EHR
- Nurse sees weight real time
  - Diuretic titration protocols
  - Trending
- Interactive Voice Response (IVR)
  - Outbound calls post discharge
  - HF IVR
- Blue tooth blood pressure cuff

Patient's Name: _____ MRN #: _____



Blood Pressure monitoring schedule: _____
Blood pressure goal: _____

"Eating Right" Plan:

-No added salt; choose products with < 300 mg of sodium per serving: _____
-Low fat, low cholesterol; choose products with 3 grams or < of Saturated fat per serving. Cholesterol intake should be < 300 mg per day: _____

Monitoring the Symptoms of Heart Failure:

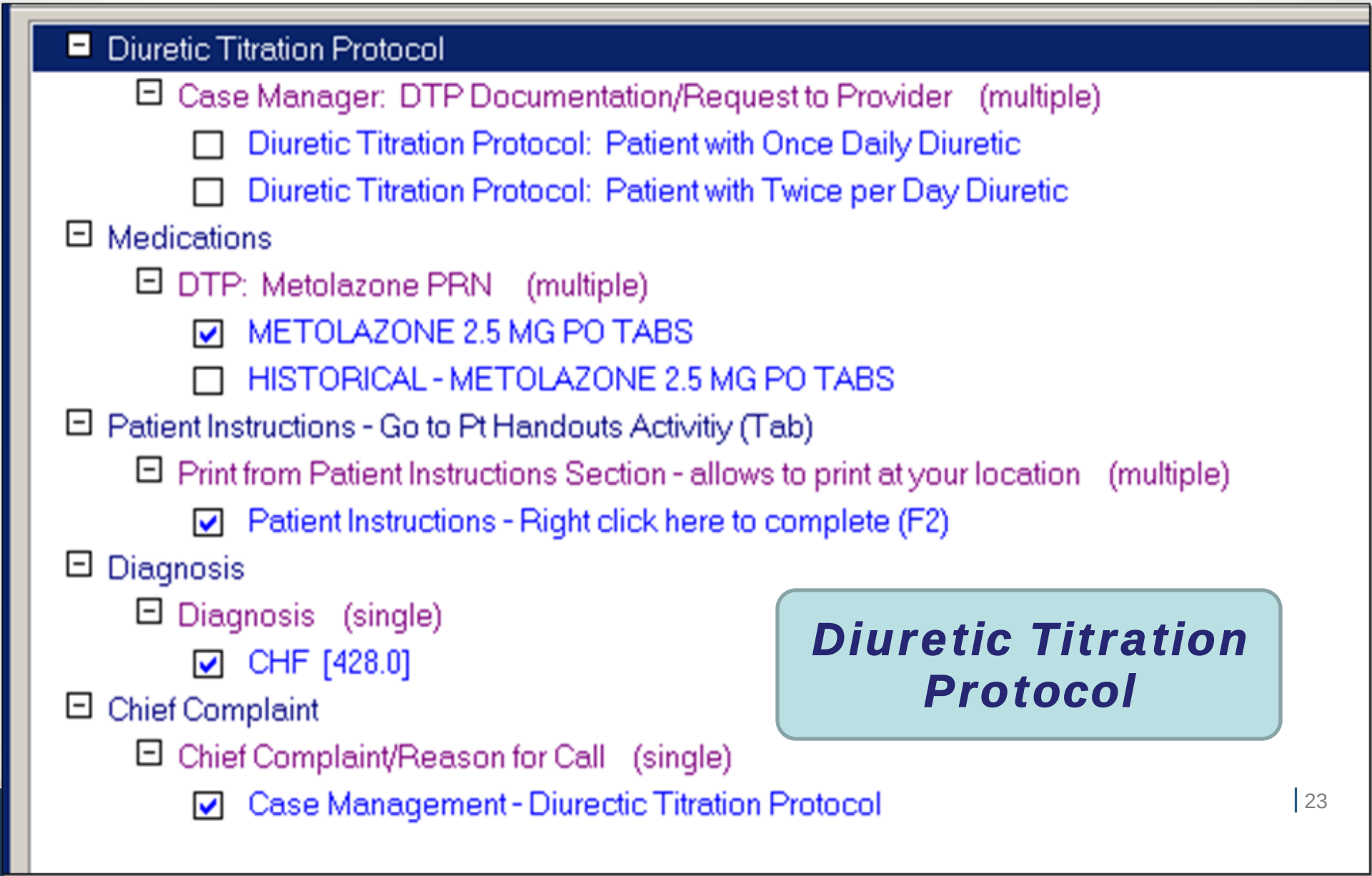
- Weight gain – weight gain of more than 2 lbs in one day or 5 lbs in 5 days
- Increased shortness of breath
- Increased swelling in feet, ankles or legs
- Chest pain or discomfort
- Increased cough – especially at night

Heart Failure Action Plan:

- Weigh yourself daily in the morning after emptying your bladder
- Record your weight daily
- Take all your medications as directed
- Call your health care provider if you experience any of the above listed symptoms of heart failure
- Diuretic titration protocol - Taking an extra dose of your diuretic (water pill) for one or two days when you experience weight gain or the above symptoms can be very helpful in the management of heart failure.

_____

DTP Smart Set Tool



COPD Smart Set Tool

- Rescue Antibiotics (multiple)
  - ☐ AUGMENTIN 875-125 MG TABS (10 days - start at onset of symptoms with your prednisone)
  - ☐ CEFTIN 500 MG TABS (10 days of therapy - start at onset of symptoms with your prednisone)
  - ☐ DOXYCYCLINE HYCLATE 100 MG CAPS (10 days of therapy - start at onset of symptoms with y
  - ☐ ZITHROMAX 250 MG TABS (5 days of therapy - start at onset of symptoms with your prednisone
- Rescue Antibiotics - HISTORICAL MEDS (multiple)
  - ☐ HISTORICAL - AUGMENTIN 875-125 MG TABS (10 days - start at onset of symptoms with your p
  - ☐ HISTORICAL - CEFTIN 500 MG TABS (10 days of therapy - start at onset of symptoms with your
  - ☐ HISTORICAL - DOXYCYCLINE HYCLATE 100 MG CAPS (10 days of therapy - start at onset of sy
  - ☐ HISTORICAL - ZITHROMAX 250 MG TABS (5 days of therapy - start at onset of symptoms with y
- Rescue Steroid (multiple)
  - ☑ PREDNISONE (PAK) 10 MG PO TABS (Taper Over 16 days start at the onset of symptoms with y
  - ☐ HISTORICAL - PREDNISONE (PAK) 10 MG PO TABS (Taper Over 16 days start at the onset of s
- Patient Instructions - Go to Patient Handouts Activity (Tab)
  - Print from Patient Instructions Section - Allows to Print at Your Location (multiple)
    - ☑ COPD Rescue Patient Instructions (right click to make changes)
- Chief Complaint/Reason for Call
  - Chief Complaint/Reason for Call (multiple)
    - ☑ Case Management - COPD Rescue Kit
- Documentation
  - Notes (multiple)
    - ☑ COPD Documentation
- Diagnosis

COPD Rescue Kit

Vertical Build of Case Management

Care Transitions – 360 degree

- SNF
- LTC
- Deep dive into causes of readmissions
- Advanced illness management

On-Call – 24 / 7

- Nurses linked to providers, hospitalists, inpatient case managers, patients, and community resources

Case Management

Finding the Right Person for the Role

Choosing the Right Case Manager

Must be a good fit for clinic
Providers need to be involved in selection

- Prior case management experience not a must
- Hospital
- Home health nursing
- SNF/ LTC experience
- Clinic nurse

Often don't find a case manager – rather you help create a case manager

Traits of a Good Case Manager

- Autonomous & self motivated
- Highly organized
- Good time management skills
- Understands and manages main driving force as well as all other complex issues

- Easily manages multiple tasks at one time
- Can shift focus easily, be pulled into different directions and still remain on task
- Willing to "nudge" the providers

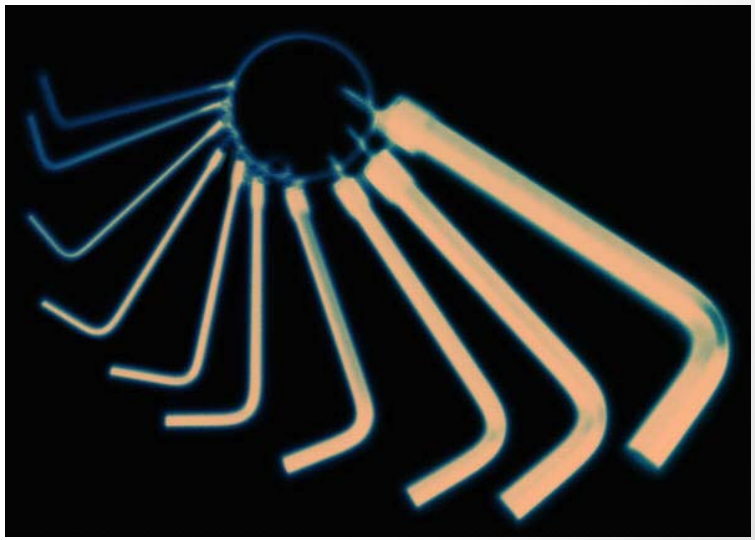
Essential Skills and Competencies

- Strong communication skills
- "People" skills
- Problem solving skills
- Critical thinking skills
- Patient engagement and activation skills
- Negotiating and conflict resolution skills

Must be able to think out of the box

Skill Set of a Case Manager

- Interpret clinical information and assess implication of treatment
- Develop and implement Plan of Care
- Determine appropriate level of care
  - PCP office
  - Hospital
  - Assisted Living /SNF/ LTC
  - Palliative Care, Hospice



Investment in Case Management

- Dedicated staff needed to drive outcomes
- Manager
- Trainer
- Resources to support development
- Dedicated clinic space
- Dedicated phone line
- Administrative support

Training for Success

Considerations for the Orientation Process

Orientation Process

Time frame - 6-8 weeks

- Learn basic CM/DM role; begin to understand CM/DM functions
- Build beginning relationships with clinic and staff
- Community resources, facilities
  - Hospitals, HH agencies, DME providers, Skilled nursing facilities, pharmacies
- Understand health plan activities & benefits
- Understand IT tools necessary to perform job role
  - EHR, CM platform, disease registries, etc.

Ensuring Success – Right Preceptor

- Has accountability to provide foundation to CM functions and provide guided oversight to the new Case Manager
- Works under direction of the Director
  - Structured learning environment
  - Ensure that the is exposed to the necessary elements required to perform in the CM role
- Completion of the orientation checklist
- Reports gaps and areas of need to Director at weekly progress check points

Making Orientation Count

- Primary preceptor for training
- 2 weeks – didactic training in group session with other new CM
- 4 weeks – in clinic with preceptor
  - Observation
  - Record review
  - Case finding
  - Case review & planning
  - Case management

Integration into the Practice Site

- Key clinic activities/operations
  - Time with front office
  - Nursing
  - Ancillary services
- Key HP departments
  - Customer service
  - Utilization management
  - Provider network

As the nurse gains experience…

- Alternate exposure with another CM
- Forging partnerships in the Medical Neighborhood
  - Home health, nursing homes, hospitals
  - Pharmacies, community agencies
- Disease management skills
- Further emphasis on EMR and other communication tools

Ready to Transition into CM Role

- Transition targeted referrals at week 6 of orientation while still with preceptor
- Assist with transition into practice meetings
  - Practice staff meetings (nurses and front desk)
  - Provider
  - Site Medical Home meetings
- Keep "buddy" system with preceptor for 3 – 6 months

Maximizing Success of Your Staff

- Monthly 1:1 time with each staff
  - Reviewing cases/documentation
  - Evaluating CM's understanding of the driving force of cases
  - Provider/staff interaction
  - Troubleshooting
- Productivity and caseload management
  - Nurse visit summary sheets
  - Areas of opportunity – Readmissions trending up - Why?
  - Gaps in role
  - Patient engagement and ongoing follow-up

Ongoing Staff Development

- Four CE days per year
  - All staff come on site for training
  - CE and CCM credits
  - Outside speakers
  - Topics relevant to disease and case management
- Learning packets
  - Current articles pertinent to chronic condition
  - Medications
- Outside CE programs

Local Team Building

- Regional meetings monthly
  - Less time away from office for staff
  - Provide updates, mini educational sessions
  - Pharmacy integration
  - Round table to discuss cases in more informal setting
  - Develop staff relationships
- 3 nurse educators

Management Tools

GEISINGER HEALTH PLAN

Medical Home Case Manager
Visit Summary

Name : Nurse Name
GHP/PGP Open Members : 150 **Average:** 118 **Reporting Month :** August 2010

GHP WISDOM REVIEW		Average
Total News	6	6
Total Returns	68	59
New or Return Caseload	30	38
Screened	5	7
Referrals	5	9
Touches >2	12	12
Coordinates	13	27
Follow Up Nursing Home	0	5
Caseload for this month	36	54
Current Identified Caseload	8	7
Current Open Caseload	76	72

PGP WISDOM REVIEW		Average
Total News	6	5
Total Returns	61	36
New or Return Caseload	25	23
Screened	4	5
Referrals	6	5
Touches >2	11	8
Coordinates	20	22
Follow Up Nursing Home	2	3
Caseload for this month	32	36
Current Identified Caseload	7	4
Current Open Caseload	74	46

GHP WISDOM REVIEW (FACILITY)		
Total News	0	0
Total Returns	0	0
Total Coordinate	0	0
Touches >2	0	0
Facility Follow Up Nursing Home	0	1
Facility Caseload for this month	0	1

PGP WISDOM REVIEW (FACILITY)		
Total News	0	0
Total Returns	0	0
Total Coordinate	0	1
Touches >2	0	0
Facility Follow Up Nursing Home	0	1
Facility Caseload for this month	0	1

GHP BUNDLE REVIEW		
3 Month F/U	14	12
6 Month F/U	19	9
Surveys Due	0	0
Post Hospital D/C Note	14	2

PGP BUNDLE REVIEW		
3 Month F/U	13	8
6 Month F/U	26	7
Surveys Due	0	0
Post Hospital D/C Note	14	2

GHP TELEMONITORING		
Heart Failure Caseload	25	19
Heart Failure	14	11
TOM	0	1
% of pt enrolled in HF monitoring	56.0%	

PGP TELEMONITORING		
Heart Failure Caseload	19	12
Heart Failure	5	7
TOM	0	0
% of pt enrolled in HF monitoring	26.3%	

Caseload Summary

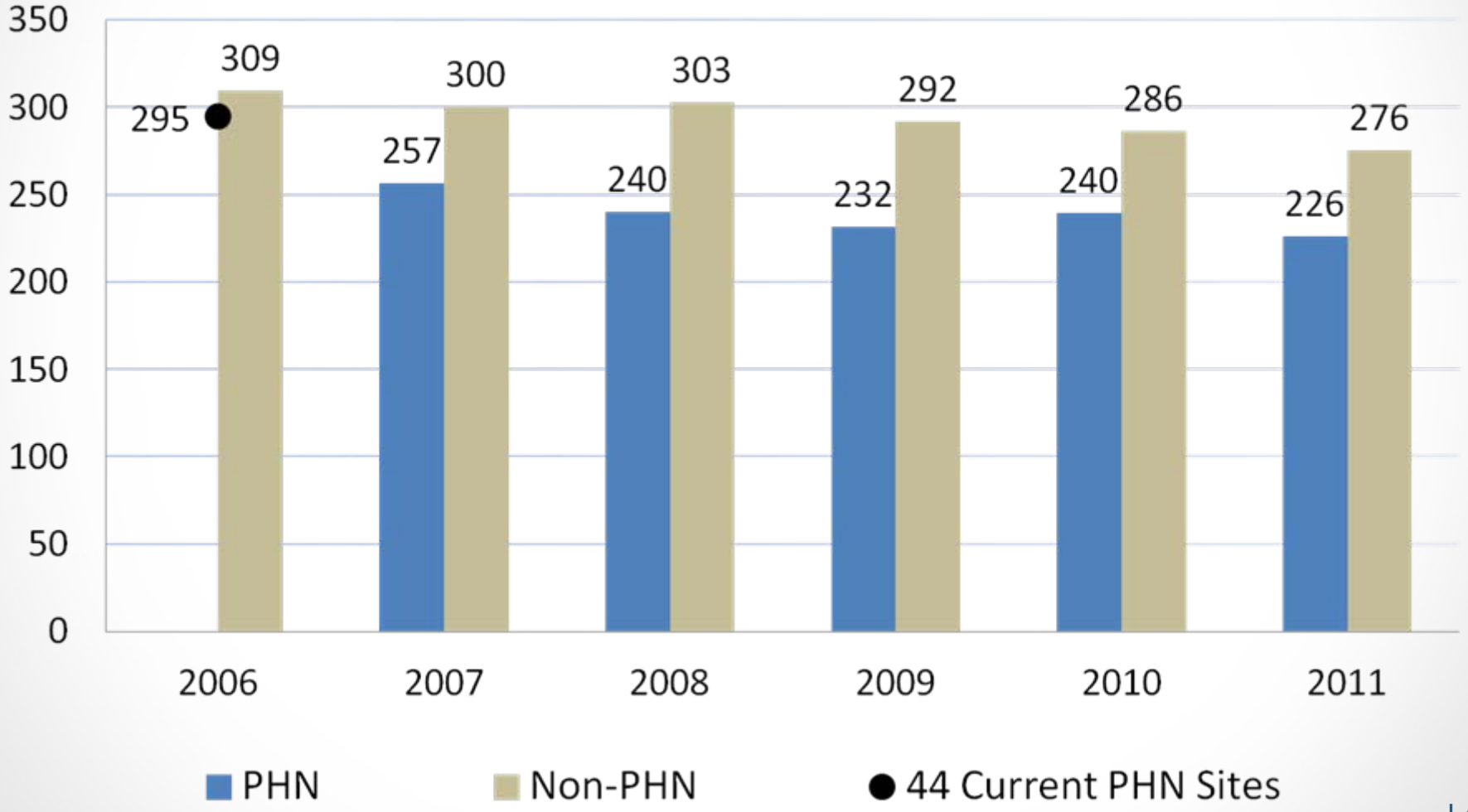
A2 fx Current Caseload for Nurses

	A	B	C	D	E	F	G	H	I
1	Geisinger Health Plan								
2	Current Caseload for Nurses								
3	March 30, 2010								
4									
5	CC_MH	(All)							
6	Nurse_Flag	(All)							
7									
9		Open		Identified		Facility		Total Open	Total Identifie
10	Nurse	GHP	PGP	GHP	PGP	GHP	PGP		
11	ANITA MCCOLE	68	66	11	12	2	1	134	23
12	ANNE SNYDER	85	31	6	1	1	3	116	7
13	BRENDA MAIDA	81	67	38	14	2	15	148	52
14	CAROL BATH	90	58	4	3	1	0	148	7
15	DANIEL MCCOLLUM	81	53	11	4	0	0	134	15
16	DANIELLE PHELPS	105	54	5	4	1	1	159	9
17	DAVE AUGUSTINE	84	27	6	2	2	0	111	8
18	DEB TEMARANTZ	83	93	5	6	1	1	176	11
19	DEBORAH BIELSKI	59	73	1	9	0	0	132	10
20	DEBORAH RUSSO	45	29	1	2	1	4	74	3
21	DIANA JACKSON	50	43	53	15	0	0	93	68
22	DIANE PACHUCY	336	0	28	0	0	0	336	28
23	DOTTIE GURSKY	115	55	72	4	0	0	170	76
24	FAMILY PRACTICE MIFFLINBURG	1	1	2	0	2	0	2	2
25	FAMILY PRACTICE SELINSGROVE	0	0	7	0	1	0	0	7
26	FRANCES M LLANSO	57	73	0	2	1	0	130	2
27	GINGER KEHLER	54	53	2	8	0	1	107	10

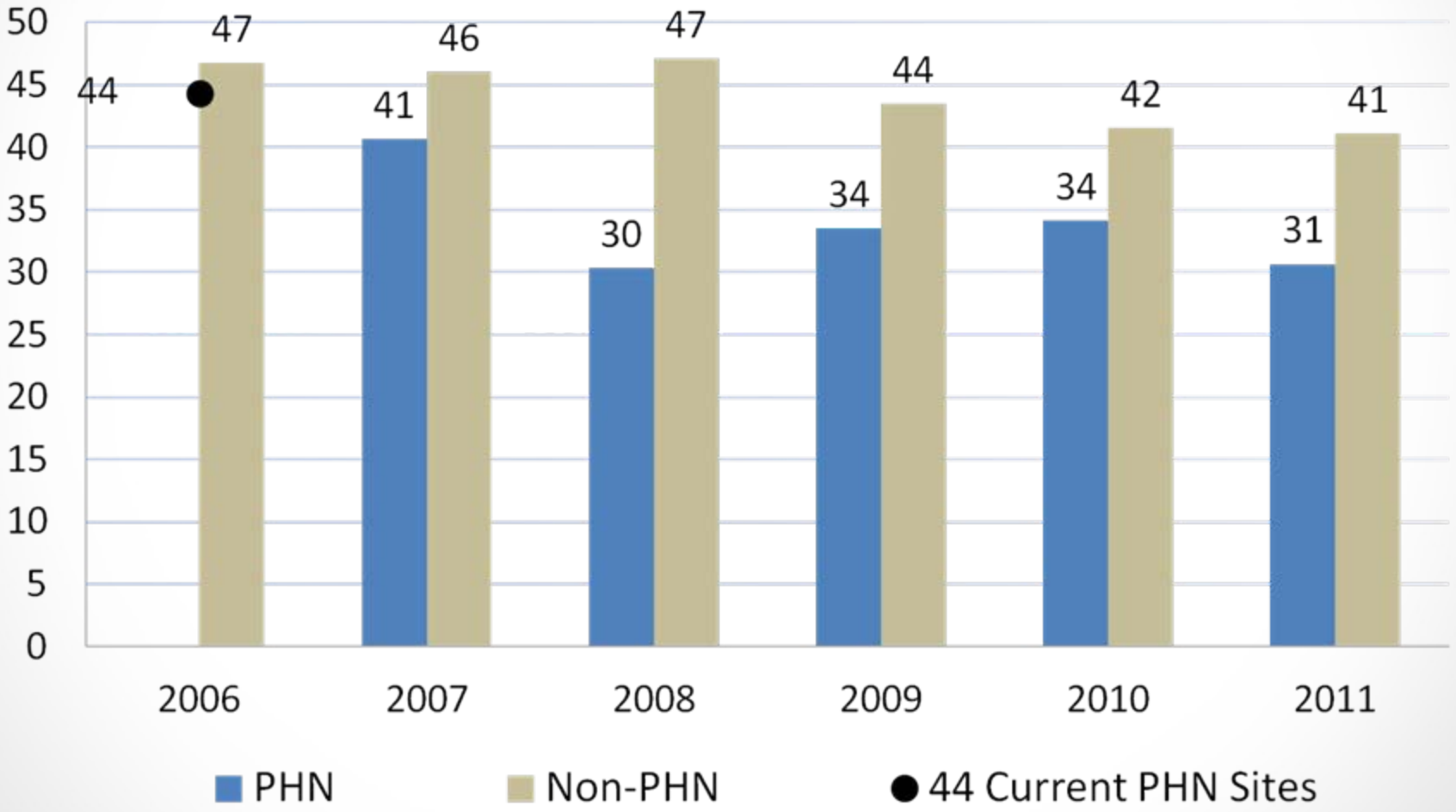
Notes | Nurse caseload summary | Nurse referral summary | ITC Referral Summary

PHN Outcomes

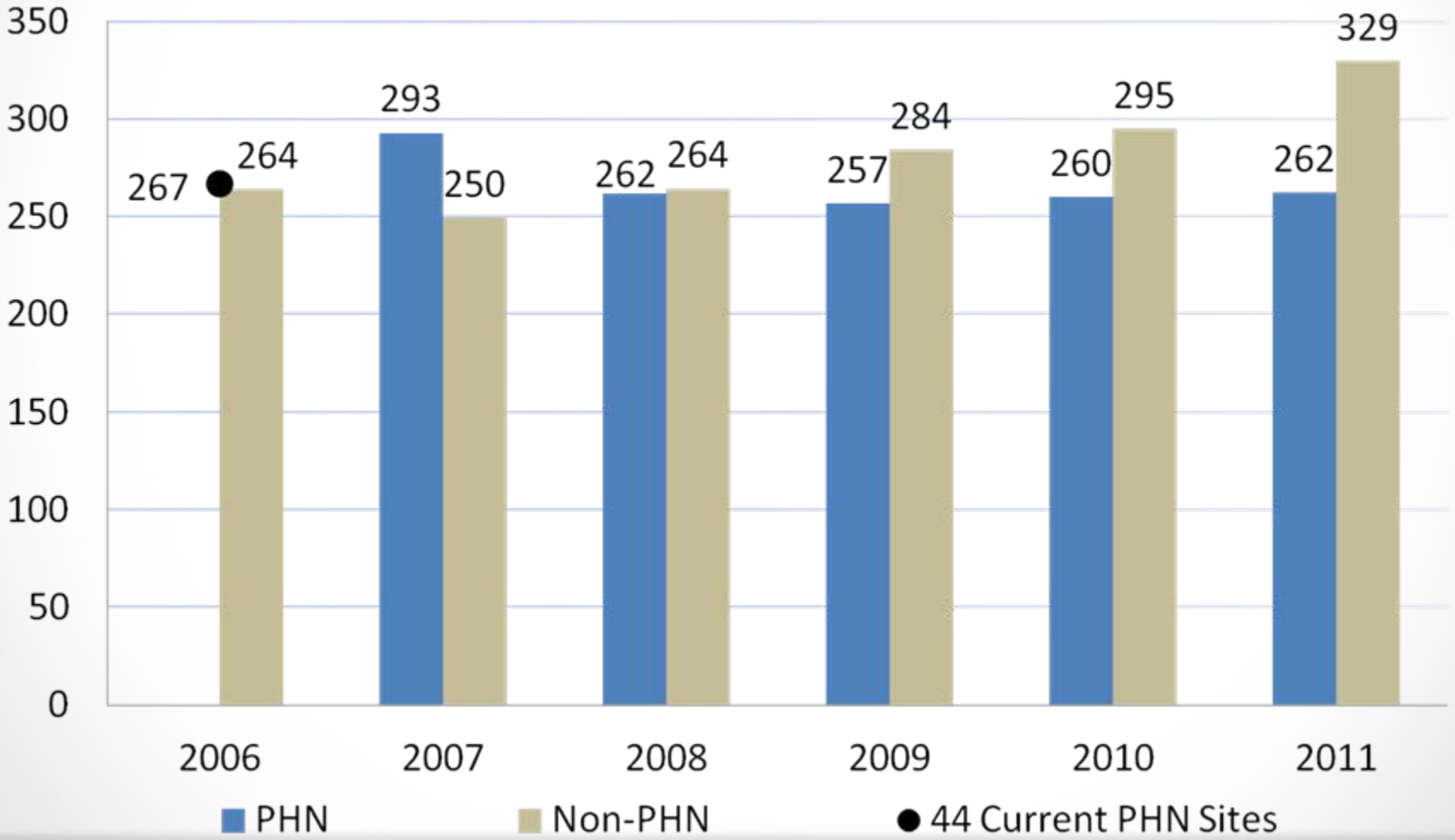
Medicare
Risk Adjusted Acute Admissions / 1000



Medicare
Risk Adjusted Readmissions/1000

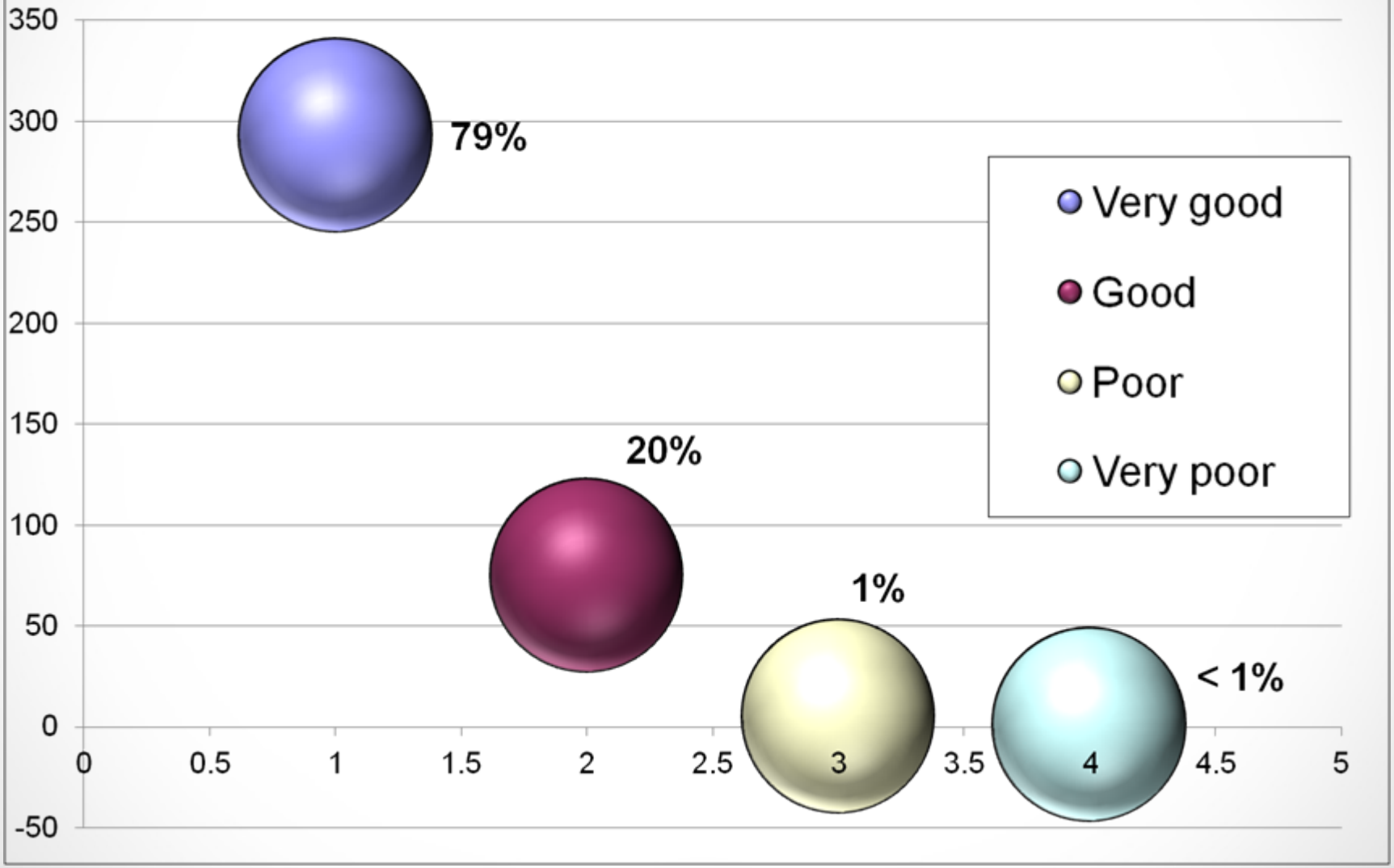


Medicare
Risk Adjusted ER Visits / 1000

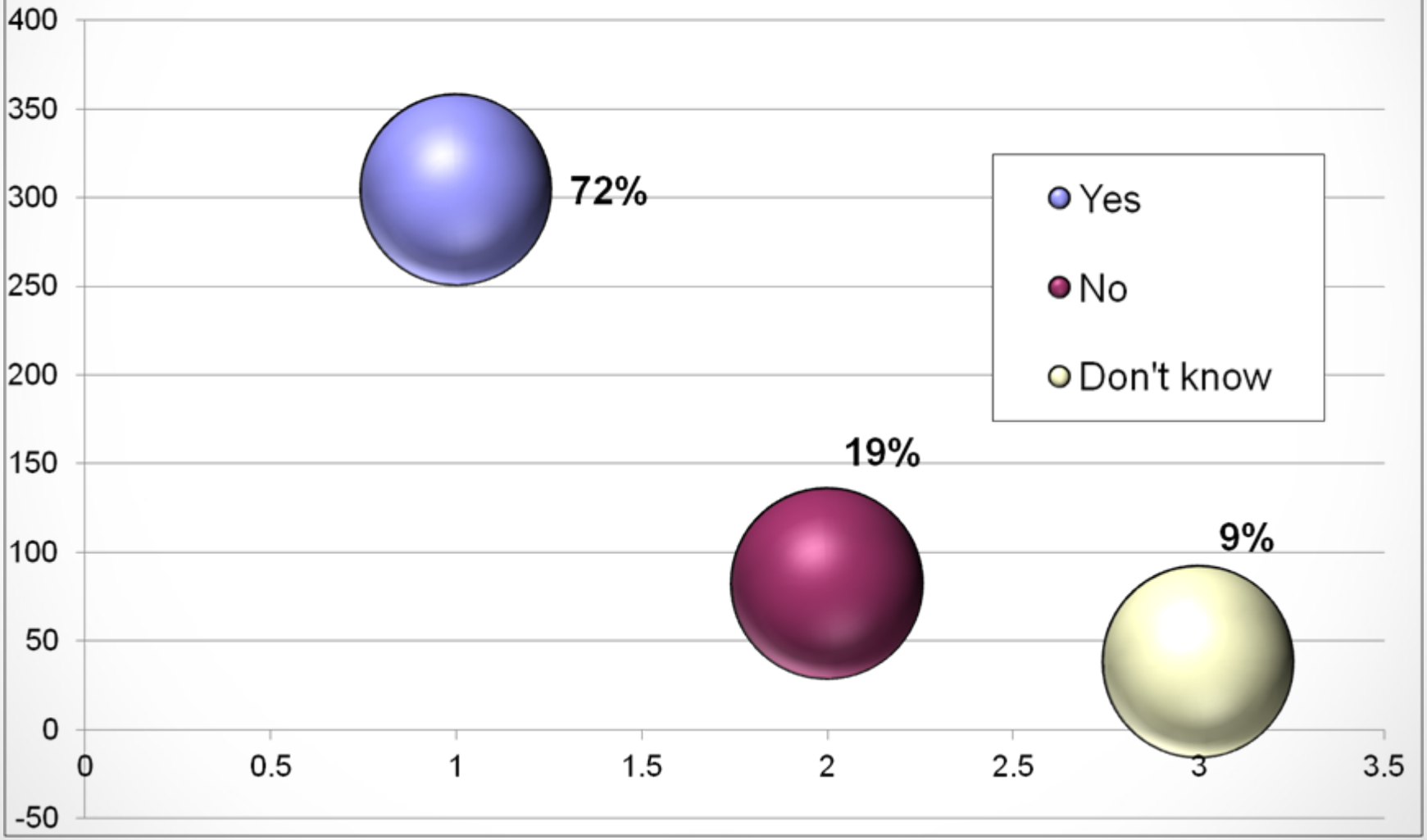


Provider and Patient Satisfaction Survey Results

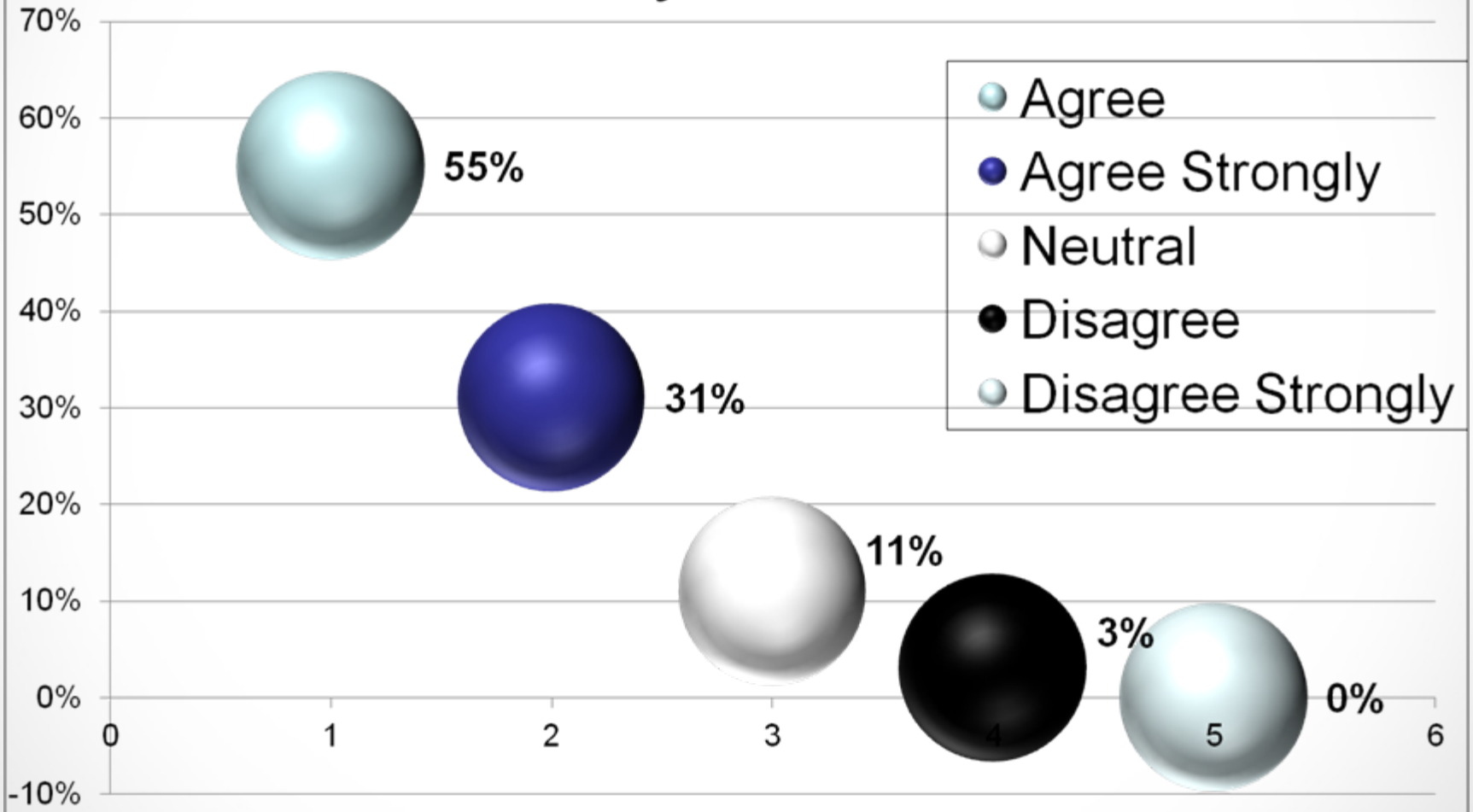
Effectiveness of the CM in working with the patient



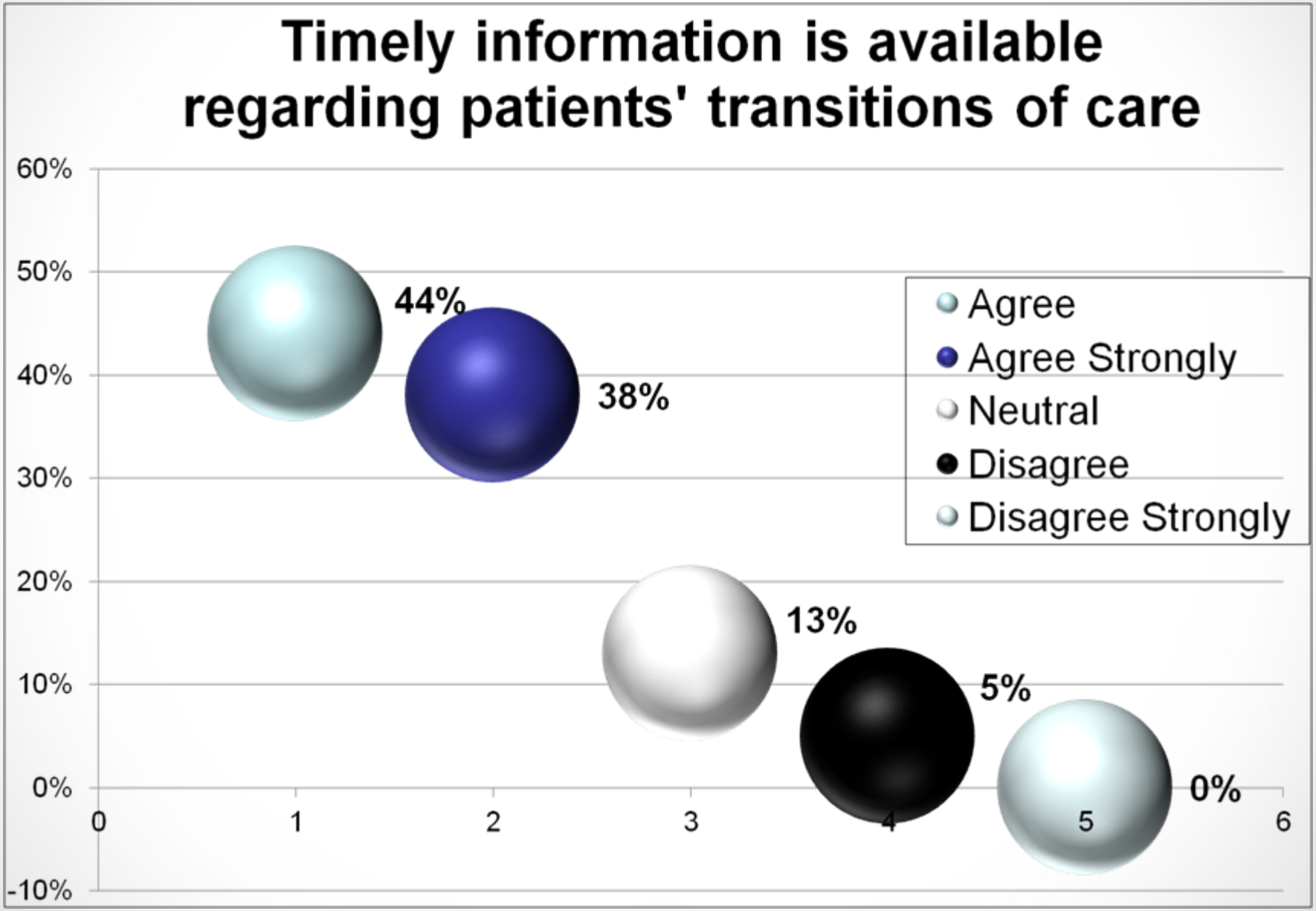
Is quality of care different and better than the past?

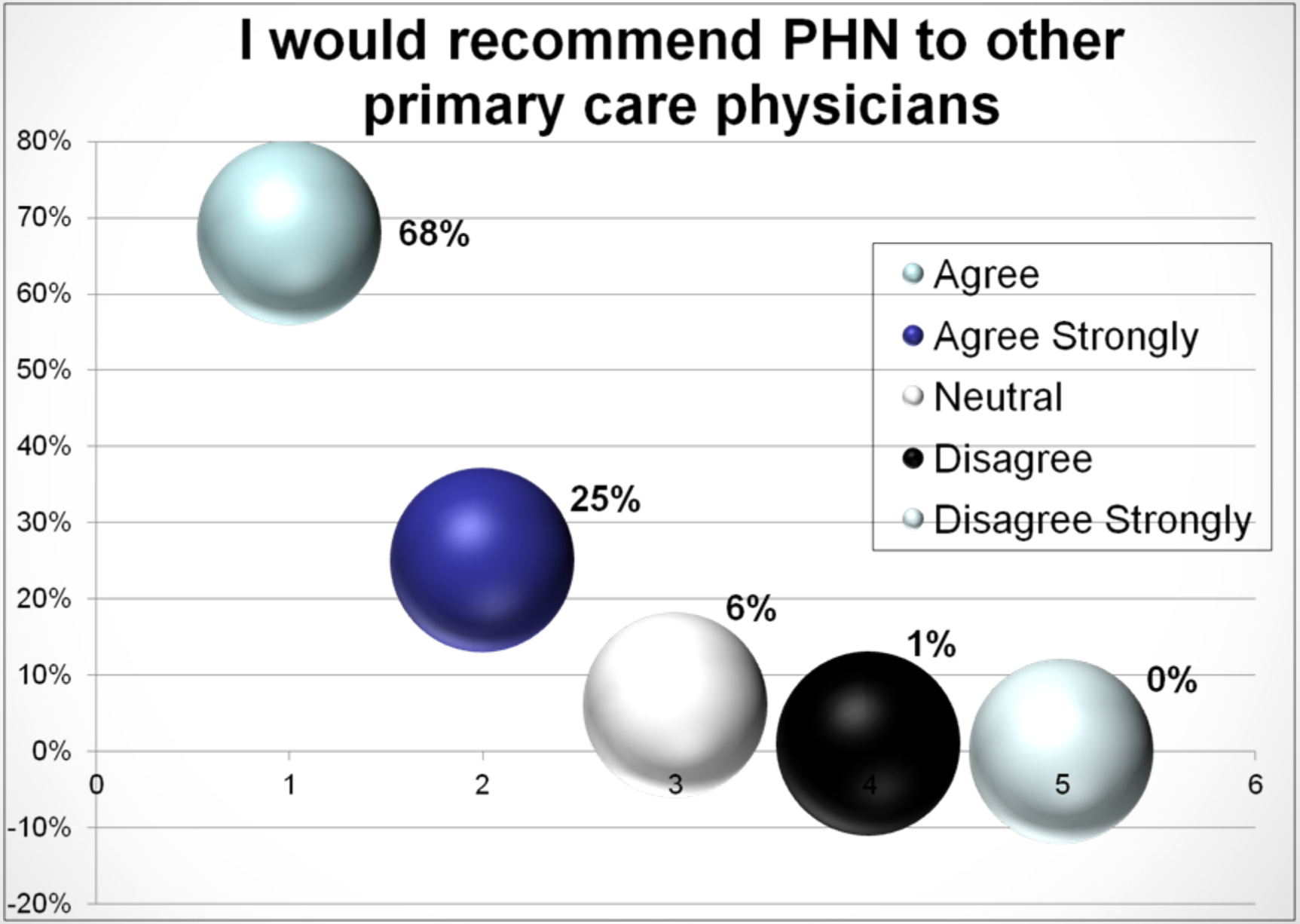


PHN has allowed you to provide more comprehensive care than the previous system



Timely information is available regarding patients' transitions of care





Questions