Care Coordination at the University of Illinois Chicago Family Medicine Clinic: Getting Started

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Outline

- Who are we?
- Why did we start a care coordination program?
- The start up
- Challenges
- Recommendations for improvement
- Success stories

Who Are We?

University of Illinois Chicago Health System

- Near West Side, next to Cook County Hospital and Rush Medical Center
- We serve the urban poor
- Only hospital/health system owed by the State of IL
- On the campus of UIC, with 7 health professions schools
- Approximately $1 billion budget

UIC Family Medicine Clinic prior to care coordination program

- 20 faculty, 9 FTE clinical
- 12 family medicine residents
- 9 medical assistants, 5 RNs and front office and billing/referral coordination staff

Why did we start a care coordination program?

Why?

- Not achieving quality incentives from Blue Cross Blue Shield IL HMO-I
- Approximately $250,000 opportunity
- Starting a Medicaid Managed Care Plan
  - (after we started our care coordination program)

The start up

The Start Up

- Hired a nurse, then a second one
- Repurposed an existing faculty member, an occupational therapist trained in motivational interviewing
- Sent them to the ICCC Clinical Health Coach program in Iowa
- Turned them loose!

MPH, OTR/L

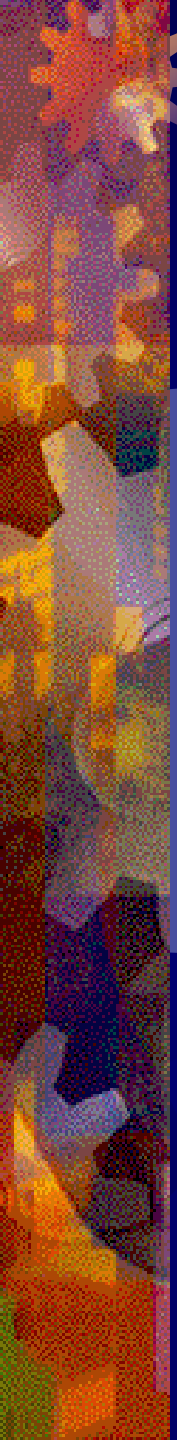
The Care Coordination Team

- Kathy Albecker, RN
- Kim Andrews, RN
- Maureen Gecht, OTR/L, MPH
- Rebecca Stone, PharmD
- Jeff Tiemstra, MD, Medical Director

Initial Focus

- Hitting the quality goals for chronic disease management in diabetes, asthma for Blue Cross Blue Shield IL
- Care management of complex patients
- Hospital discharge transitions

Challenges



Challenges - identity

- "Defining who we are to ourselves and others"
- Differentiation from staff nurses
- Becoming known and trusted
  - Being endorsed by Dept. Head and Medical Director was critical
  - Participating in QI teams
  - Demonstrate enterprise and reliability

Challenges - patients

- Identifying patients, contacting them, having them understand our role
- Monitoring patient compliance
- Patient goals and medical goals are not always aligned
- Some of the patients need a long time to find their voice and actively participate in care

Challenges - systems

- Multiple payers, formularies, networks
- Developing a tracking system/registries
- Identify and working with existing processes
- Communicating regularly and effectively with physicians

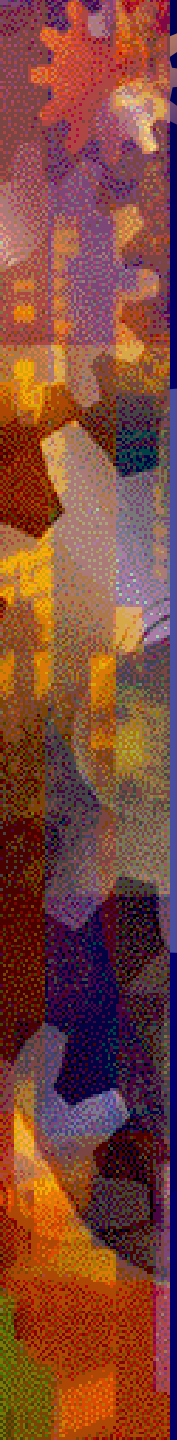
Recommendations for Improvement

Improvement

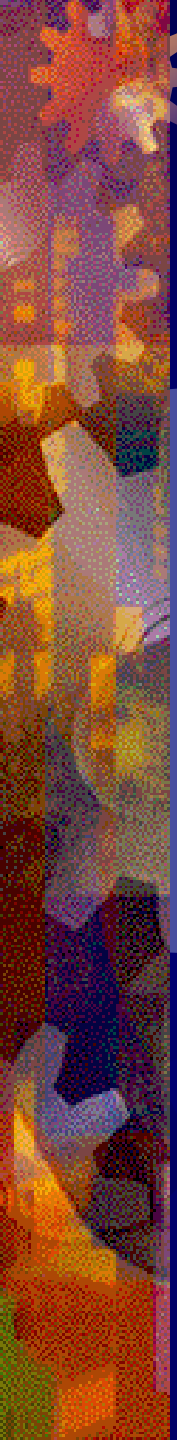
- Introduce care coordinator to patients when they are in for visits
- Provide peer support opportunities and group visits
- Provide training in motivational interviewing for physicians and staff

Improvement

- Follow evidenced based guidelines
- Ensuring patients are aware our services are available to them
- Engage patients to assess their learning preference
- use teach-back method to assess understanding (health literacy is an issue for many)



“I’d like to integrate the staff nurses more into the program. Some of the nurses are providing care coordination to many patients already. I think we need to share our knowledge and resources with each other.”



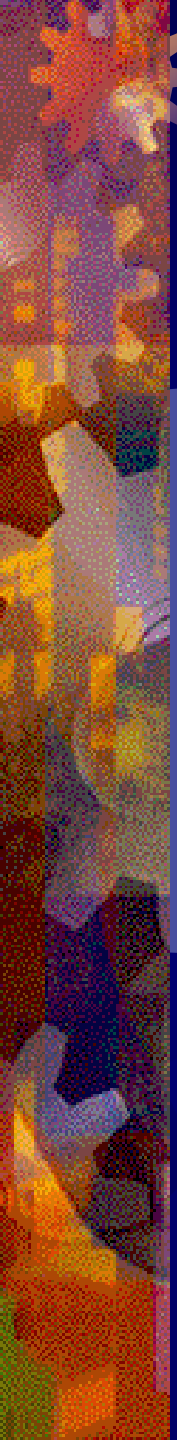
“Barriers to achieving adherence are most often multifactorial. It’s important to know our customers, so plans must be specific for each customer/patient. One size does not fit all; we must take into account the culture and values of our customers/patients when developing our plans of care.”

Success Stories

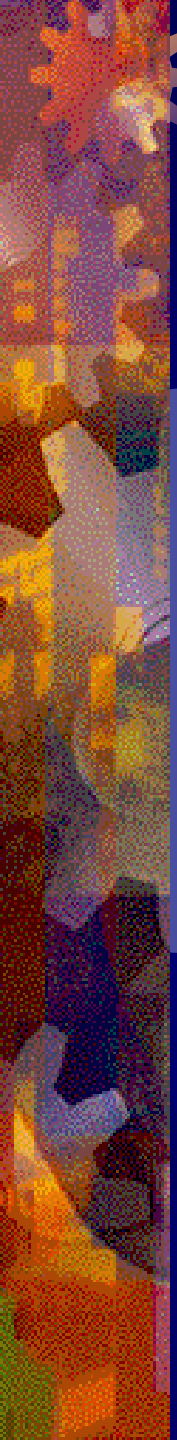
Success Stories

- Patient with long history of DM, HTN, Goiter that had increased in size. Patient had 2 visits with PCP in 2013 (which were sick visits), no visits in 2014, thus far has had 6 visits in 2015.

Patient with HBAIC > 10 has difficult home situation. Both patient and I work closely with MD. Patient now more interested in watching her diet and blood sugars are down. I noticed a big change after I listened a long time to her discuss her lack of support and frustration about no time for herself. I felt like I hadn't done enough to help, just listened and reflected the meaning of what she said. The next time I saw her she was smiling. She told me she reorganized her day so that she has an hour to relax and watch shows when she comes home from work. I asked her about needs for more support and she feels sufficient support at this time from PCP and care coordinator. She reports motivation to improve her health.



Very challenging patient, very anxious, not attending specialist appointments. At initial visits he became very frustrating and angry at times. Now 6-9 months later, he calls often, he goes to appointments most of the time. He follows up with his PCP. He knows we will help him get forms filled out. He talks about strategies to manage his anger. That said, his circumstances remain complicated, his illness remains severe, he needs to work yet not well enough to do so and there are many more issues outstanding.



A 49 woman, a school teacher, came in for a routine appt and announced to her doctor, that she wanted to get into an alcohol rehab program ASAP. The patient had elevated LFT's and other alcohol related manifestations. She was drinking at work. The resident and supervising physician sought out my help. They knew how important it was to facilitate this request as efficiently as possible to capitalize on the patient's momentum to take this step. They also knew that it required discreet handling so that the patient's privacy would be protected and for her emotional needs. I coordinated with the insurance company to ensure use of in network rehab services. She called me on the day of the proposed admission. I coordinated with the admission nurse and helped the pt know what to expect. When I met her in the office after her detox and 6 week residential rehab, she gave me a bouquet of flowers and a thank you card. She is back to work and sober for 6 months.

“We’ve Only Just Begun”

John Hickner

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