



LEVERAGING THE POWER OF CARE MANAGEMENT

Connect the Dots in Community Services

2016 Population Health Colloquium
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Agenda



Leveraging the Power of Care Management to Connect the Dots in Community Services

- Caring for High-Need, High-Cost Patients: What Makes for a Successful Care Management Program?
- The “Foundational” Approach to Community Care Coordination
- Care Managers Engaging with Patients and Families
- Discussion

Care Management Solutions and Complex Patients

Electronic Health Record

Acute and Ambulatory.....what's missing in the EHRs?



The screenshot displays a comprehensive EHR interface for a patient named NextGen EHR, NRC Xterionix, DOB 05/13/1968, AGE 43 years 7 months (Male), PHONE. The interface is divided into several sections:

- Top Bar:** Includes navigation tabs for Patient Record, Clinical Summary, CFS, Charting, Plan of Care (highlighted), Orders, and Visit. It also shows the last reviewed date as 03/20/2013 23:41 and options to Mark Reviewed, View Standards, and Add Plan.
- Problems Section:** Lists active problems for CSA 03/03/2013 17:43 IP. The problems include Infection Risk, Strength Impairment, Ambulatory Impairment, and ROM Impairment, all marked as Active.
- Expected Outcomes Section:** Lists outcomes with target completion dates and charting status. Outcomes include PTR-STG (Patient's AROM/PROM will increase by/to right knee with 5-15 degrees, active), PTR-STG (Patient's motor control will increase by/to 1-2MMT grades RLE), PTR-STG (Patient's pain level will decrease to (# pain score) to improve functional mobility 3-4/10 right knee with ex.), Absence of Falls, Absence of Infection Signs and Symptoms, Control of Acute Pain to Patient Satisfaction, and OTR-STG (To complete ADL's and functional mobility, patient will improve standing balance to good).
- Plan of Care Section:** A detailed view of the patient's plan, including:
 - Diagnosis:** Hypertension, Unspecified (Dx Code 401.9).
 - Lab orders:** CMP, CBC w/diff, Urinalysis, Lipid Panel.
 - Office procedures:** Electrocardiogram, complete (ECG).
 - Diagnostics:** Chest X-ray, AP/Lat (2 views), Abdomen MR Angiogram WITH or WITHOUT Contrast, Extracranial arteries study, compl, ECG, transthoracic, heart, complete, Cardiovascular stress test.
 - Office medications:** (Empty list).
 - Office labs:** Urinalysis, non-automated, w/scope, Lipid profile.
 - Instructions:** Activity counseling provided, Smoking cessation counseling provided, Dietary counseling provided.
 - Follow-up visit/referral:** He is to schedule a follow-up visit today, He will be referred to today, Disposition.

Community Resources

Connecting patients to their neighborhood support services



Health Related Social Needs

- Housing
- Food
- Utility Needs
- Safety
- Transportation



Accountable Health Communities Model

CMS 1/5/2016



“The Centers for Medicare & Medicaid Services (CMS) has announced an Accountable Health Communities (AHC) model to address a critical gap between clinical care and community services in the current delivery system.

The AHC model will test whether increased awareness of and access to services addressing health related social needs will impact total health care costs and improve health and quality of care for Medicare and Medicaid beneficiaries in targeted communities.”

Supporting Health Related Social Needs

- Housing
- Food
- Utility Needs
- Interpersonal Violence
- Transportation needs beyond medical transportation



Source: <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Factsheets/2016Factsheetsitems>

Care Management Solution Requirements



- **Community Shared Care Plan**
 - Incorporate the physician treatment plan via CCDA
 - Evidence Based Content for Assessments and Care Pathways
 - Incorporate the patient and family in goals and intervention planning
 - Accessible by all care team members, as well as the patient and family
 - Multidisciplinary problems, goals and outcomes
 - *Incorporate community resources to support non medical gaps in care*
 - *Manage referrals to community resources*
 - *Contract and Services management*
 - *Longitudinal Care Plan*
 - *Ability to view patterns of ED and Hospital utilization*
- **Strong MPI for patient safety and quality of care**

The “Foundational” Approach to Community Care Coordination

It takes a team centered approach

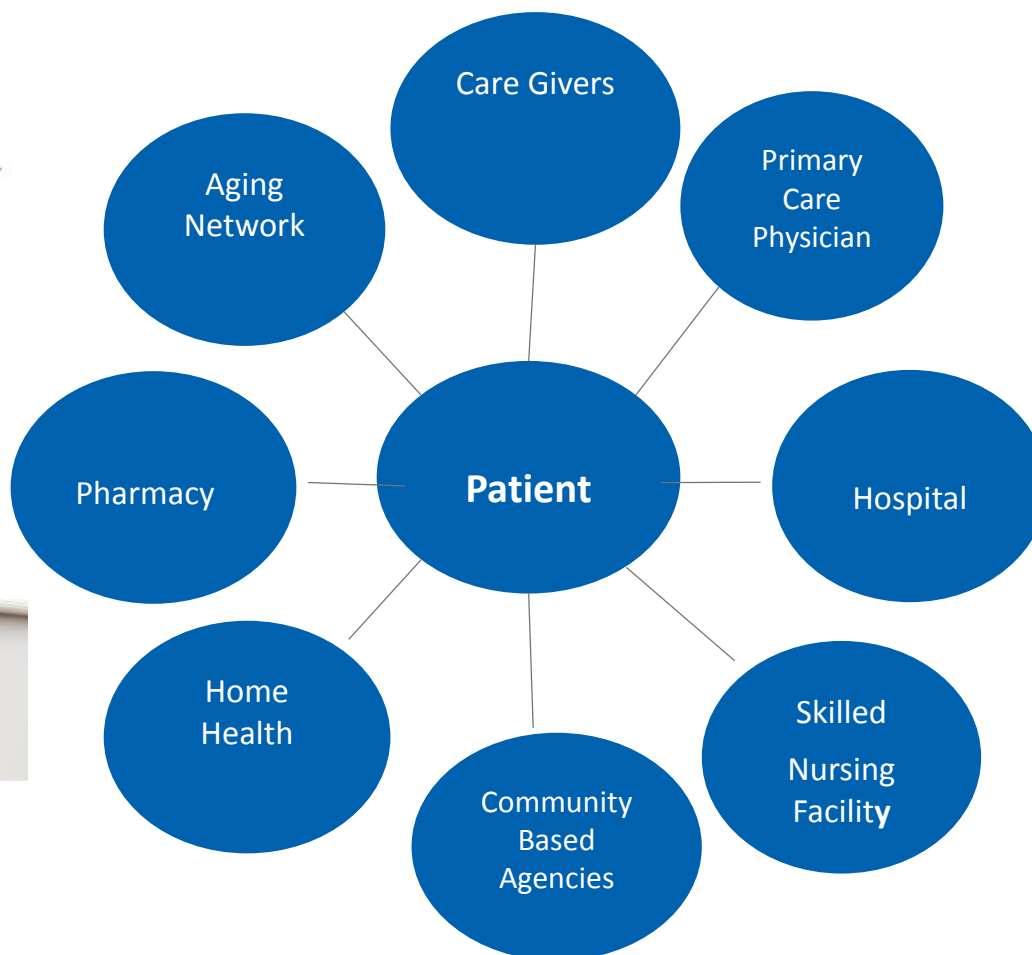


Care Team

**Patient and
Family**

**Community
Services**

Stakeholders Community Shared Care Plan



Community Foundation

FOR SOUTHEAST MICHIGAN



HAWAI'I COMMUNITY FOUNDATION
Amplify the Power of Giving



Community Aging
in Place
Advancing Better
Living for Elders



Care Managers Engaging with Patients and Families

Roles of the Patient Centered Medical Team



Sample of roles and responsibilities

- **Primary Care Manager (RN/BSW)** - Lead the Care Management Team
 - Initial engagement with the patient
 - Face to Face encounters
 - Conduct home visits and complete/update CHA and complete screenings
 - Establish appropriate interventions and set patient centered goals
 - Responsible to other members of the team for establishing individualized plans of care and implementation
- **Care Coordinator (SW)** - Co-lead on the team
 - Responsible for completing social, behavioral, and emotional at-risk assessment
 - Link patients to community resources
 - Support RN Care Manager and collaborate with other members of the Care Management Team.
- **Clinical Care Coordinator (LPN)**: Provide support to the RN Care Manager in the holistic multi-disciplinary team approach, which includes social and emotional assessment, planning, facilitating, education and advocacy for the patient protocol.

Source: <http://www.p4communitycare.org/programs-initiatives/care-management>

Community Health Worker

- A frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served
- This trusting relationship enables the worker to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and **cultural competence of service delivery**



