Case Managers in the Primary Care Practice

Tools, Assessments & Workflows for Embedded Care Coordination

Note: This is an authorized excerpt from *Case Managers in the Primary Care Practice.* To download the entire report, go to http://store.hin.com/product.asp?itemid=4268 or call 888-446-3530

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This special report is based on two 2011 Healthcare Intelligence Network (HIN) webinars hosted by Melanie Matthews, HIN executive vice president and chief operating officer.

Speakers

Robert Fortini, PNP, vice president and chief clinical officer at Bon Secours Health System.

Lisa Sasko, MA, MBA, director of clinical transformation at Capital District Physicians Health Plan.

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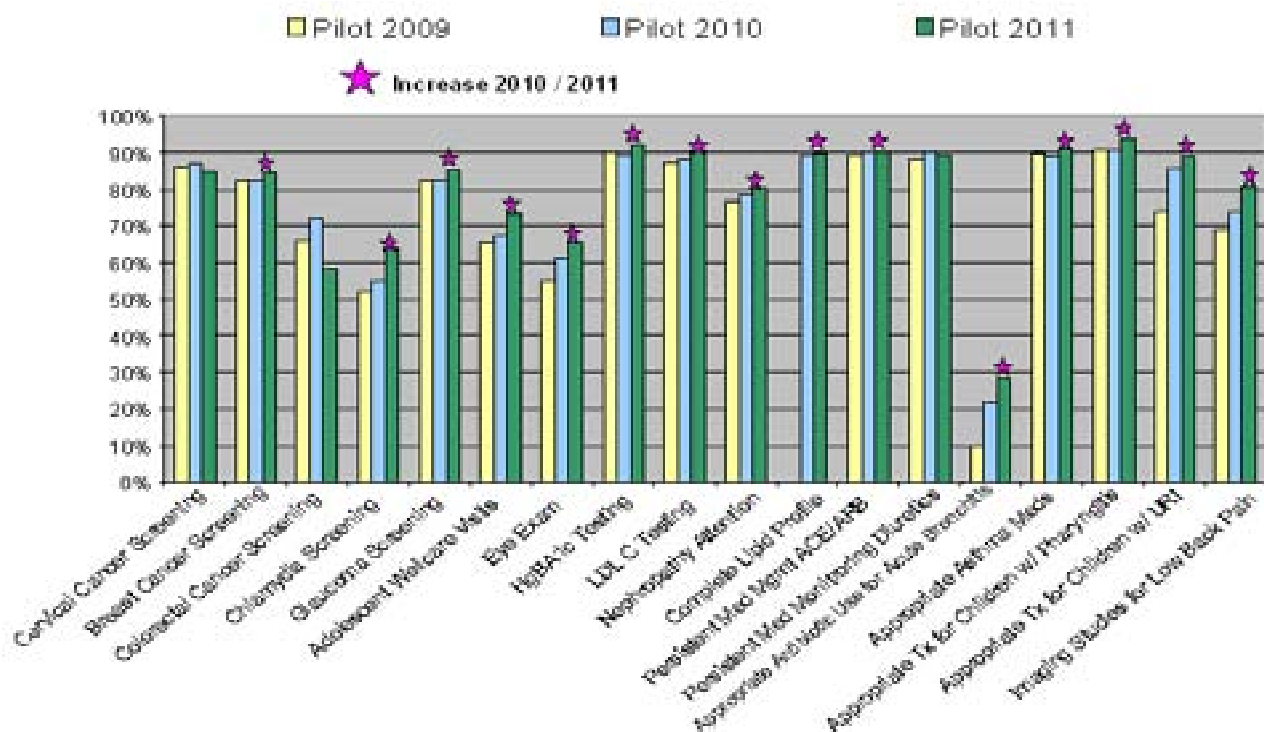
HEDIS Performance Trends



Source: Lisa Sasko, CDPHP

Figure 19

Implementing Embedded Case Management

Charlene Schlude, RN, CCM, is director of case management at CDPHP.

CDPHP's identity has framed the way we started our embedded case management program. As a not-for-profit company, we have a very high number of our members that comprise our Medicaid and Medicare population, and they are vulnerable populations that can benefit from case management. Since we are a physician-directed health plan, we knew we would get good buy-in because when we do work with our physicians, and they are a very important part of our board, we get a significant amount of buy-in. Therefore, we felt comfortable that we had the perfect media for that.

Case management is about knowing that if you impact someone and help them to reach their optimum health goals and if you work with them and get them to their best functional capabilities, everyone in the system is going to benefit. We wanted to align with the goals of the patient at our medical homes or their enhanced primary care. The patients have improved quality of life and much higher member satisfaction with this. Their caregivers and support systems benefit from this program as well because many people are struggling with being the caregiver for someone with a chronic illness. The healthcare delivery system is improved because we know our PCPs are challenged with the complex nature of these chronic populations, and the time they have to see them is so limited. Therefore, we want to be able to support and help that. In addition, payors like ourselves are happy to have this program because we know that we can keep our premium dollar at its best and offer the best quality healthcare.

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PPACA Influence on CDPHP Program Design

- ✔ The Triple Aim initiative seeks to help healthcare organizations achieve three objectives: improve the health of patients, enhance their experiences of care, (including access to care and the quality delivered), and reduce the cost of care.
- ✔ The Affordable Care Act proposes changes targeted toward improved access to care and improved quality of care, with a strong emphasis on preventive care.
- ✔ Embedded case management programs play a key role in helping patients to achieve quality outcomes. Case managers will need to use innovative approaches to create health value.

Source: Charlene Schlude, CDPHP

Figure 20

Incorporating the Triple Aim Initiative

The Affordable Care Act and the information that we have been receiving about the national direction are having an impact on what we wanted to do with our program. We made the Triple Aim initiative the center of how we developed our care management program for embedded case management because it's about improving the quality of the care, which is a very big focus for our medical homes. (See Figure 20.) It is about delivering care at a reduced and effective cost, and working on those efficiency metrics. Right in the center of it, we want to look at enhancing the experience of care. As a health plan, we know that if you don't have members, you don't have anything, and that is what is important to us. In the future, we are improving their experience of care along the way. We know that the Affordable Care Act talks a great deal of targeting improvements on quality of care and puts a strong emphasis on that care coordination and preventive care. That is at the center of our embedded case manager program. We know that case managers are going to be a big part of that process.

We started it in 2010 in a very small way, as shown in Figure 21. The statistical performance of the program was good, so we decided to extend it in 2011. We now have six registered nurses that are embedded in 12 practices. A nurse has two practice sites; she goes to each practice two days a week and then has an office day. She can work at the other practices if she has a call, a follow-up or a concern that she needs to address, and that was our original model. We are modifying that as we see the value of being in the practices more frequently.

Number of Practices With Embedded Case Management

- ✔ Six RN case managers staffed in 12 practices.
- ✔ Plans for expansion to an additional five practices for 2012.
- ✔ Expansion of time spent in practices to four days per week.
- ✔ Behavioral health case management in one practice 2011.
- ✔ Plans for an additional behavioral health case manager in Quarter 4, 2011.

Source: Charlene Schlude, CDPHP

Figure 21

Expanding Programs and Practices

We have a plan to expand in 2012. We are budgeting for five additional practices, and our goal is that the patient and practice relationships with the nurse are improved by being there more frequently. Our plan is to have the five new nurses

Training Process for Case Managers

Question: How do you introduce the first nurse case managers to the practice? How do you prepare physicians and staff and train the individual care manager?

Response: (Robert Fortini) Broadband communication — being very clear in managing expectations. I'm very careful when I introduce the concept to the physicians in our first meeting. I need their engagement; I need them to take ownership of the project. I give a full description of what is coming down the pike. If they don't have ownership, and if they're not engaged, I say, 'Do not waste my time. I will go to the next practice in line.'

With that engagement comes a certain sense of empowerment. We carefully acquire their input into the development of the protocols and the roles and responsibilities and expectations of performance. We try to be as sensitive as possible to what they need and expect. Again, communication and number of different meetings — weekly sessions initially and then one-on-one sessions as needed through the first few months of implementation are all important.

Response: (Irene Zolotorofe) It takes about four to six weeks to get a nurse navigator up and running. We have an expectation by the time they come out of orientation of how many calls they should be making per week, per day. Once the nurse navigators feel comfortable, they work side by side with a seasoned nurse navigator. Then they start picking up their case load of their site toward the end of the time frame that they are with their preceptor. That is usually about two weeks into the process.

They are on site with someone as they are picking up their case loads. It is an intensive training program because if they're not live on the ConnectCare EHR, if they don't know the medical record, first we have to get them trained on ConnectCare and the other tools. (See "For More Information.")

Case Manager Productivity Benchmarks

Question: What are some productivity benchmarks for the embedded case managers?

Response: (Robert Fortini) Readmission rate and the number of calls that they have made is an indicator of their success. There were 926 visits scheduled by the two of them over a six-month period. Whether or not those visits would have occurred I don't know, but we captured them and we have taken control over their capture, and that is a significant number.

For More Information

This section provides more detail on resources mentioned in this report. A listing here does not constitute an endorsement by the Healthcare Intelligence Network of a company, product or organization.

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The Medical Home Case Manager: Profiting from Patient-Centered Care Coordination provides an inside look at the selection, training, skill set, processes and benefits of the Geisinger Health Plan case managers embedded within the payor's medical home practices. For more information, please visit: **http://store.hin.com/product.asp?itemid=3998**

Best Practices in Contemporary Case Management examines three separate case management initiatives that generated positive results, detailing the impact of case management programs on health outcomes, care delivery and resource utilization. For more information, please visit: **http://store.hin.com/product.asp?itemid=4148**

Bon Secours ConnectCare

http://bshsi.com/clinical-transformation-connectcare.html

ConnectCare is an electronic health record information system. All of the Clinical Transformation work is supported and enhanced by the ConnectCare process to drive evidence-based practice and make it easier for clinicians to do the right things at the bedside. It provides a comprehensive record of care, enabling clinicians and staff to leverage critical clinical information to transform the way we deliver care.

EPIC System®

http://epicsyst.com/trendcompass/index.aspx

EPIC Systems is an independent information technology services company that provides innovative IT business and technology solutions to clients around the world. EPIC Systems provides technologies in the world to present solutions for many fields such as business, education, industry, communication and more.

Fresenius Medical Care

http://www.fmcna.com

Fresenius Medical Care is devoted to patient-oriented renal therapy. Through over 2,700 kidney dialysis clinics in North America, Europe, Latin America, Asia-Pacific and Africa, it provides 32 million life-saving dialysis treatments to more than 215,000 patients worldwide. It also provides dialysis products such as hemodialysis machines, dialyzers and related disposable products. Chronic kidney failure is a condition that affects about 2 million individuals worldwide.

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About the Speakers

Robert Fortini*, PNP, is the vice president and chief clinical officer for Bon Secours Medical Group in Richmond, Va. He is responsible for facilitating provider adoption of EMRs, coordinating clinical transformation to a patient-centered medical home care delivery model, and facilitating participation in available pay for performance initiatives as well as physician advocacy and affairs.*

Fortini has extensive experience in operations and clinical policy development, and experience in workflow re-engineering and CQI in ambulatory care. Before coming to BSMG, Fortini served as the chief medical affairs officer at Queens Long Island Medical Group engaged in quality and HIT adoption. He successfully applied for the first Level 3 NCQA-recognized PCMH in New York.

Prior to that, at Community Care Physicians Medical Group, Fortini participated in the successful launch of the Bridges to Excellence Collaborative in upstate New York.

Fortini has 30 years of experience in healthcare. He is a graduate of Fordham University and the State University of New York College of Health Professions at Upstate Medical Center in Syracuse, N.Y.

Lisa Sasko*, MA, MBA, is the director of clinical transformation at CDPHP. Sasko oversees the development of the CDPHP EPC initiative and its deployment to the plan's broader delivery system.*

Sasko also works collaboratively with all aspects of the plan's medical affairs division promoting the transformation of physicians' medical practices in support of the CDPHP health value strategy.

Sasko holds an MBA from Northeastern University, an MA in clinical behavioral psychology from the University of Massachusetts, and a bachelor's of science from the University of Michigan.

Charlene Schlude*, RN, CCM, is the director of care management at CDPHP, with responsibility for the business planning and operations of the disease and case management programs. Schlude is the business lead for CDPHP's embedded case management program offered in selected Enhanced Primary Care sites.*

Prior to joining CDPHP, Schlude worked as an RN at Albany Medical Center for 14 years. She is also the current board chair of The Healthy Capital District Initiative, a not-for-profit board focused on improving public health and access to affordable healthcare coverage for uninsured Capital District residents. In addition, she serves as the vice president of the New York Capital Region Chapter of CMSA.

Schlude is an RN and holds a certification in case management from the Commission for Case Manager Certification (CCM). Schlude was licensed as an RN at Maria College, Albany, N.Y., and is working toward a bachelor's of science in nursing at Anna Maria College, Worcester, Mass.

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