The Michigan Primary Care Transformation (MiPCT) Project

Moderate Care Management:
Series 2 / 3

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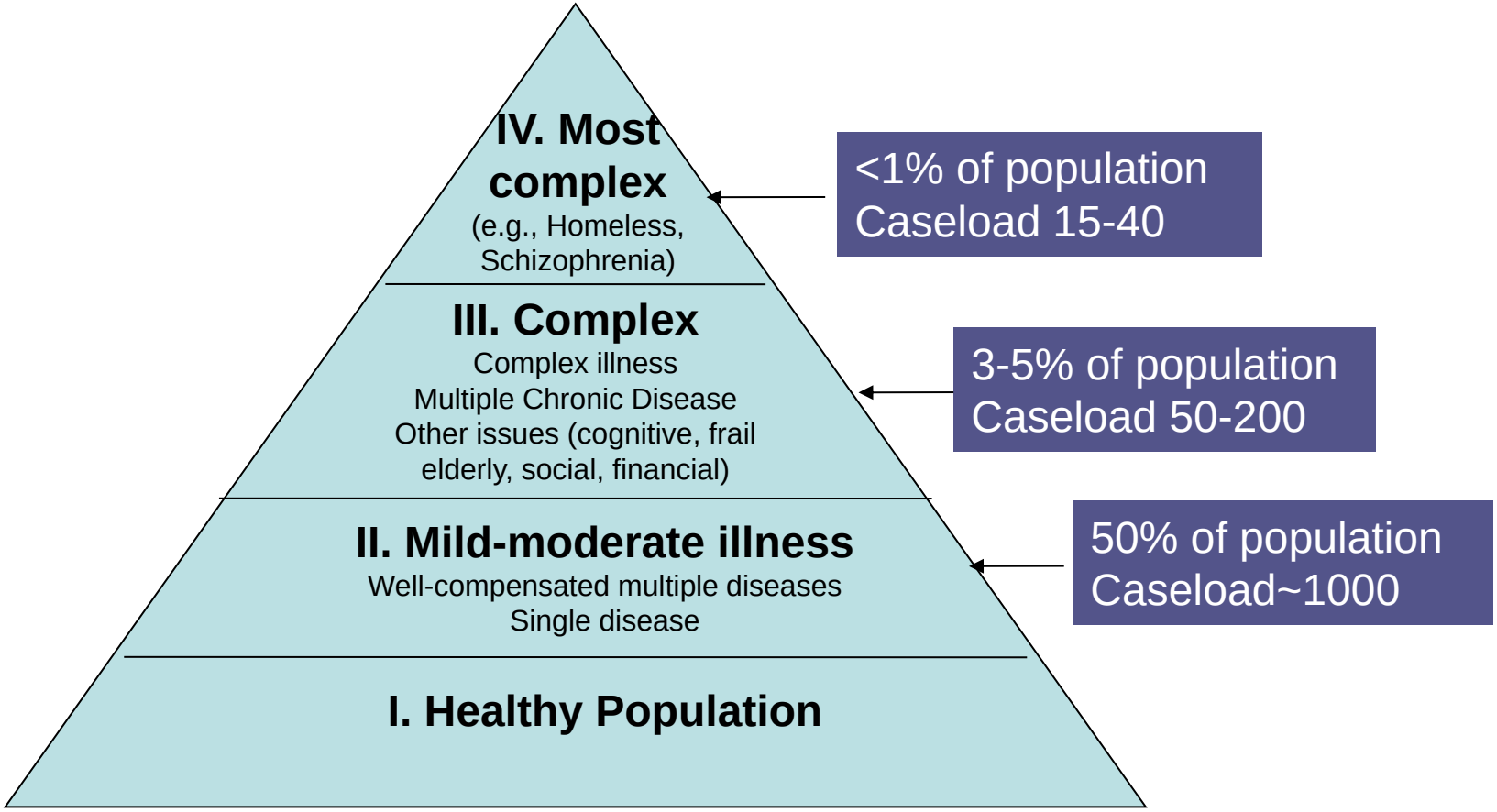
Moderate Care Management Part II Objectives

- Describe the MiPCT Model and population management
- Identify the Care Management 5 step process
- Describe the activities for Moderate Care Management and Case Closure
- Identify and discuss solutions for the Hybrid CM's to provide care management for both complex and moderate patient levels.

MiPCT Clinical Model: Optimizing Patient Engagement, Improving Population Health

Managing Populations: Stratified approach to patient care and care management



Michigan Primary Care Transformation Project
Advancing Population Management

PCMH Services

Complex Care Management ***Functional Tier 4***	All Tier 1-2-3 services plus: ▪ Home care team ▪ Comprehensive care plan ▪ Palliative and end-of life care
Care Management ***Functional Tier 3***	All Tier 1-2 services plus: ▪ Planned visits to optimize chronic conditions ▪ Self-management support ▪ Patient education ▪ Advance directives
Transition Care ***Functional Tier 2***	All Tier 1 services plus: ▪ Notification of admit/discharge ▪ PCP and/or specialist follow-up ▪ Medication reconciliation
Navigating the Medical Neighborhood ***Functional Tier 1***	▪ Optimize relationships with specialists and hospitals ▪ Coordinate referrals and tests ▪ Link to community resources

Prepared Proactive Healthcare Team
Engaging, Informing and Activating Patients

PCMH Infrastructure

Health IT
- Registry / EHR registry functionality *
- Care management documentation *
- E-prescribing (optional)
- Patient portal (advanced/optional)
- Community portal/HIE (adv/optional)
- Home monitoring (advanced/optional)

Patient Access
- 24/7 access to decision-maker *
- 30% open access slots *
- Extended hours *
- Group visits (advanced/optional)
- Electronic visits (advanced/optional)

Infrastructure Support
- PO/PHO and practice determine optimal balance of shared support
- Patient risk assessment
- Population stratification
- Clinical metrics reporting

*denotes requirement by end of year 1

P O P U L A T I O N M A N A G E M E N T

Nurses as Change Agents:

Staff Nurses Leading Practice Changes

June 7, 2012 - Most nurses have become masters at adapting to change, but what about serving as change agents?
At a time when much change is occurring in health care--some of it driven by regulatory and reimbursement policies--there are staff nurses at a number of hospitals who are leading the way with improvements in patient care processes and procedures.

http://www.nursezone.com/nursing-news-events/more-news/Staff-Nurses-Leading-Practice-Changes_40109.aspx

How it *feels* to be a change agent.

- A change agent lives in the future, not the present
- A change agent is fueled by passion, and inspires passion in others
- A change agent has a strong ability to self-motivate
- A change agent must understand people

http://it.toolbox.com/blogs/original-thinking/what-is-a-change-agent-23764

It takes TEAM work:

Currently existing TEAMS include:

1. PO's and practices with MiPCT
2. Physician, CM and Pt with moderate risk interested in self-management
3. Office staff
4. CM's and the Medical Neighborhood
5. Patients and office staff

Focus of Moderate Care Management

Proactive Population Management:

1. Optimize control of chronic conditions
2. Prevent and/or minimize long term complications

Moderate Care Manager focuses on:

- patients with a newly diagnosed chronic condition
- Poorly controlled chronic condition
- Those patients at a state of readiness to take an active role in self-management
- Patients with Obesity
- Individuals wanting to quit smoking

Common Moderate Care Chronic Conditions

- Diabetes
- Asthma

- Hypertension
- Obesity

http://mipctdemo.files.wordpress.com/2011/09/mipct-clinical-metrics-updated-12-10-12.pdf

Care Management
5 Step Process

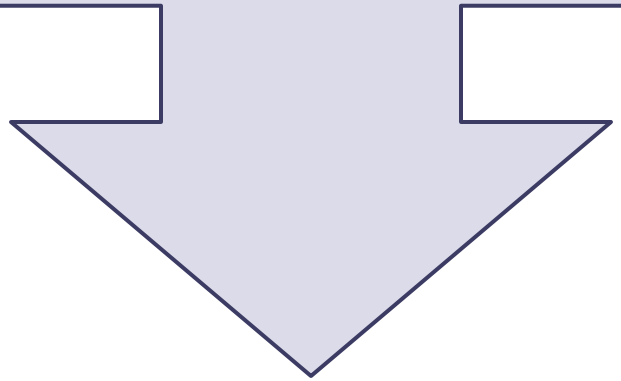
1. Identification
   - Referral
   - MiPCT patient lists
   - Self referral
   - Discharge/admission/ER list (Transitions of care)
   - Gaps reports from practice
2. Screening
   - Criteria that indicate a patient is appropriate for care management
3. Enrollment
4. Management
5. Case Closure

Moderate Care Management:

Steps 4 & 5:
Management and Case Closure

4. Management

- Medication Reconciliation
- Assessment/Reassessment
- Behavioral Activation
  - Motivational Interviewing/Self-management Support
- Follow evidence based guidelines when setting goals
- Assess barriers to success
- Provide disease management education at literacy level
- Refer to ancillary services and agencies as appropriate
- Link to community resources
- Provide information on support groups
- Ongoing management until goals met



Medication Reconciliation

- Medication reconciliation is the process of comparing a patient's medication list to all of the medications that the patient is actually taking.
- According to the Institute for Healthcare Improvement (IHI), medication reconciliation is a three step process:
  - **Verification** – collecting an accurate medication history
  - **Clarification** – ensuring that the medications and doses are appropriate
  - **Reconciliation** – documenting every single change and making sure it 'squares' with all the medication history

Reconciliation challenges:

- Multiple providers
- Stock piles of medications
- Inability to understand name of medication
- Depending on the contract the pharmacy has with the pharmaceutical providers for generic medications, the shapes and colors of the same medication may change from one refill to the other
- Verifying dosage and frequency of medications
- Financial challenges – take only 1/d vs. 2/d as prescribed to make them “last longer”
- Medication changes upon d/c from hospital
- Unaware of the ingredients in medications: ex: Acetaminophen is in Vicodin

Medication Reconciliation:

Provide written copy of reconciled list to:

- ✓ Patient
- ✓ PCP
- ✓ Caregiver / Custodial parent
- ✓ Specialist
- ✓ Hospital
- ✓ SNF
- ✓ LTACH
- ✓ Rehab – Inpatient or Outpatient
- ✓ Home Care Agency
- ✓ School (with parental consent)

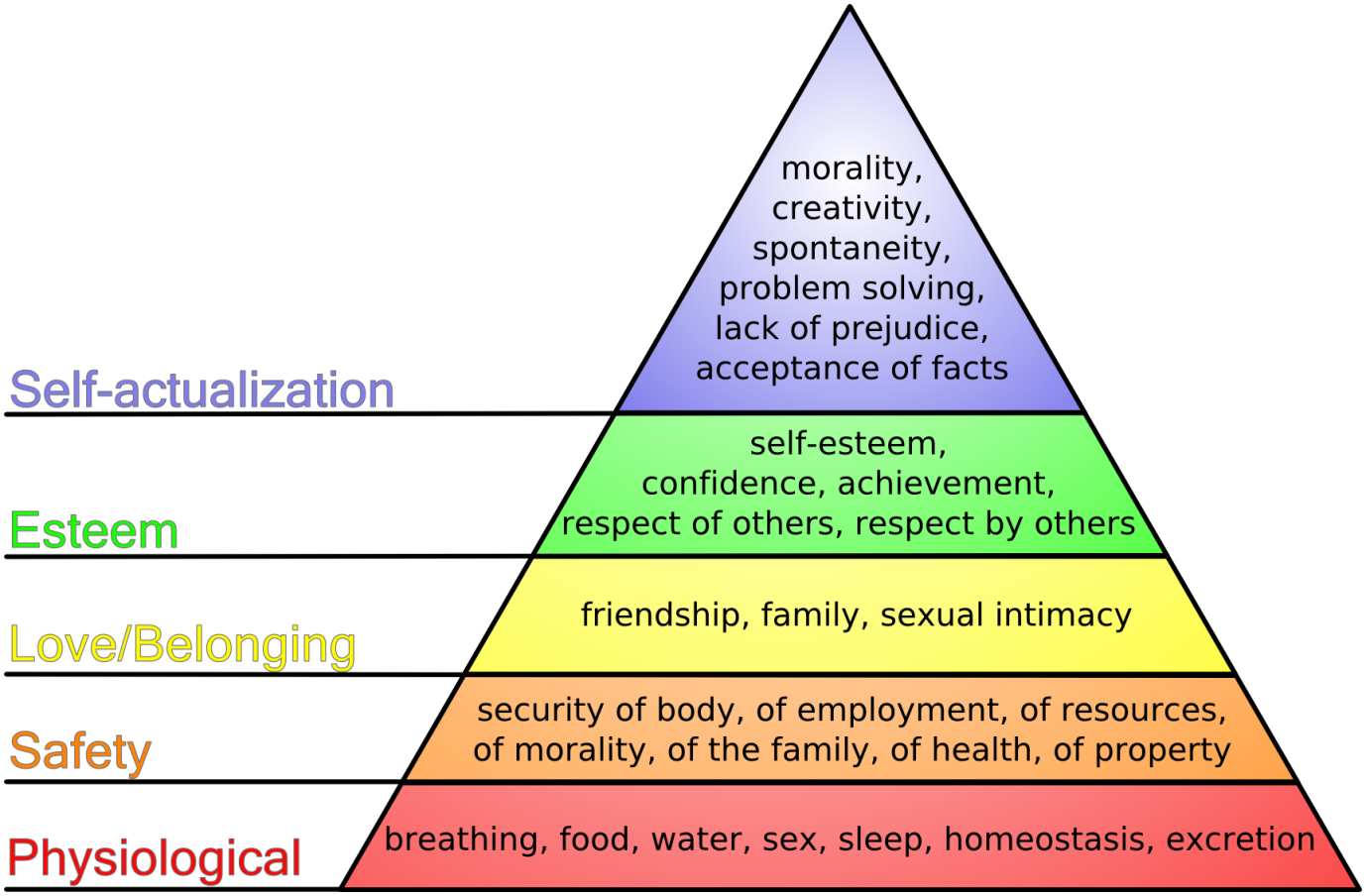
Patient Assessment

- Focused assessment
  - Chronic condition being managed
    - Newly diagnosed
    - Uncontrolled
  - Meets the requirements for billing G9001

Patient Assessment

- Beyond the appropriate assessment specific to the patient, the following elements are imperative:
  - Understanding of disease condition
  - What is important to the patient?
  - Literacy level
  - Language barriers

Assess Barriers:



http://www.simplypsychology.org/maslow.html

Assess Support system:

- Support system/resources
- Functional status
- Safety

Behavioral Activation

- Motivational Interviewing
  - Use of OARS
    - O open-ended questions
    - A affirmations
    - R reflective listening
    - S summaries

Behavioral Activation:

- Self-Management
  - Setting self-management goals
  - Identification of resistance and barriers
  - Overcoming resistance and barriers
  - Confidence level
  - Ongoing follow up (reinforce techniques, problem solving)
  - Re-evaluation of goal

Setting Goals: **What will happen? When?**

Short term and Long term :

- Patient states interest in achieving
- Attainable (barriers addressed)
- Gives a confidence level of 7 or greater
- Clear, concise, concrete
- Measureable
- Evidence-based driven - toward disease management goals

Time frames:

- Short term: Within the next two weeks
- Long term: To be reached in one month or more
- Use your clinical judgment

Sample Short term Goals

- I will fill my prescriptions today
- I will take my medications as prescribed (twice daily vs. the once a day to “make them last longer”)
- I will keep my f/u appt this week
- I will decrease number of sodas per day from 6 to 5 (baby steps)
- I will decrease number of cigarettes from 18 to 14 per day this week
- I will use Mrs. Dash seasonings vs. table salt
- I will keep a log of my peak flows daily for the next 2 weeks. If I experience an exacerbation, I will follow my Asthma Action Plan
- I will contact my PCP for additional medical management if Asthma Action Plan is not working for the next 4 weeks prior to going to the ED

Sample Long term Goals

- I will lower my A1c from 10 to 9 in the next 3 months.
  - I will walk 2 miles three times weekly
- I will follow my Asthma action plan consistently for the next 6 months
- I will complete my smoking cessation program in 6 months
- I will contact the CM with problems getting my medications before changing how I take them for the next 4 months
- I will continue to participate in Bereavement support group for the next 4 months weekly
- I will do my physical therapy exercises 3X/week for the next month.
- I will lose 16 pounds by August 30th
- Within the next 3 months I will obtain a micro albuminuria and dilated eye exam
- I will attend Weight Watchers weekly for the next 6 months
- I will not have an ED visit for uncontrolled Asthma in the next 6 months

Patient Education

Provide educational materials from credible sources:

- American Diabetes Association
- American Lung Association
- National Asthma Coalition
- www.michigan.gov/primarycare

Referrals to include Medical Neighborhood expertise

- Diabetic education
- Asthma educator
- Registered Dietician
- Specialists: Endocrinologist, Pulmonologist, Allergist

CM Community Referral Sources

- Area Agency for the Aging
- Transportation options in community or through pts. insurance
- Durable Medical Equipment companies (DME)
- Home Health Agencies
- Respite, Palliative, and Hospice Care
- Bereavement support groups
- Community Mental Health (CMH)
- Headstart or Early-On programs for children
- Substance Abuse programs

Community Resources for Patients

- DHS for financial assistance
  - 211
- Needymeds.com for prescription assistance
- Local educational opportunities
  - Local Health Department
  - Schools
  - Colleges
  - Personal Action Toward Health (PATH)
- Area Agency on Aging
- Transportation options in the community
- Food: Food Co-ops, Meals on Wheels, Church offerings

Support Groups

- Disease specific support groups
- Camps
- Bereavement support groups
- Care giver support groups, websites, chat sites
- Parent support groups

Ongoing Management

- Follow-up
- Monitoring
  - Progress/response toward goals
  - Adjust interventions, time frames, goals as indicated
- Reassessment
  - Screening tools
  - Identify barriers

Case Closure

- Evidence based goals met
- Maintained goal for a period of time
- Patient becomes disengaged
  - Ceases to answer calls or attempt to move forward
- Patient is referred to complex care management
- Patient moves out of the area
- Switches to a new physician – not with MiPCT
- PCP informed and in agreement

Summary

- The goal of the 5-Step process is to engage patients in evidence-based management of their chronic disease
- Management is where the “rubber meets the road”
- Case Closure occurs for a variety of reasons

Next Steps- Hybrid CM case mix

- Hybrid care managers began working primarily with transitions of care patients
- Current state:
  - Much of the day is now spent on TOC activities
  - It is a challenge to include moderate care management patients into the current case load
- Solutions to consider:
  - Use of LACE tool
  - Focus transition of care calls on patients with the two most prevalent chronic conditions in the practice
  - Develop processes that involve other members of the care team

Next steps- Hybrid CM case mix

- Patients with high risk/high utilizers are very vulnerable
- Current state:
  - Case managers have shared it is hard to justify not calling a TOC or complex care management patient to call a moderate risk patient
- Thoughts to consider
  - Each patient is experiencing a life event
  - Each patient needs support
  - Intervening with moderate patients early in their disease may prevent them from becoming complex patients

Additional Thoughts to Consider

- The demonstration project is expected to show improved outcomes with patients from each of the four participating payers in the MiPCT project
- Hybrid Care managers are to provide services to both complex and moderate care management patients
- Incorporating population care management helps the project have a greater impact on the most patients

Questions ?

Discussion ?