MiPCT Webinar

Care Management of the Underserved Population

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Today's Panelists

- **Ann Shoop MSN,RN, Care Manager**
  - Neighborhood Family Health Center
- **Beth Jurczak LMSW, Care Manager**
  - Neighborhood Family Health Center
- **Jan Pund RN, Care Manager**
  - Ypsilanti Health Center
- **Maureen Koval RN**
  - MIPCT Regional Clinical Lead, Facilitator
- **Lynn Klima MSN, RN**
  - MIPCT Master Trainer

Objectives

- Correlate the Five Step Care Management process to the care of the underserved.
- Identify strategies for successful management in the underserved population.

Five Step Care Management Process

- Referral/Identification
  - Patient triggers for care management
- Screening
  - Determining level of CM service – RN or SW?
  - Establishing the partnership
- Enrollment
  - Comprehensive assessment
  - Patient agreement to case management
  - PCP agreement to case management
  - Documentation of agreement in patient record

Five Step Care Management Process (continued)

- Management
  - Collaboration between SW and RN Care Managers
  - Role of the SW in managing the case
  - Advocacy
  - Care Coordination
  - Transition Care
  - Working with the care tam
  - Working in the medical neighborhood: Assisting with resources, internal and external
- Case Closure

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

Case Study #1: Mr. B

- 39 year old male
- married, 2 children 9 yr. old, and 16 yr. old
- former factory worker
- lives in trailer park
- bilateral above the knee amputee due to lymphedema, osteomyelitis and chronic ulcers
- Stage 3 decubitus on both buttocks and both stumps
- suprapubic catheter, multiple UTI's
- pt. weighs over 300 pounds,
- previous height over six feet tall
- No handicap access to shower in mobile home

Referral/Identification and Screening

- Referral
  - care manager identified the patient as high risk on MiPCT multi-payer list
  - Physician requested care manager work with patient

- Screening
  - Review of drivers (reasons for inclusion into caseload)

Collaboration

- MSW role/responsibilities
  - Access to resources
    - Environmental factors – no shower in the home
  - Support for care giver
    - Response to acute psychosocial challenges
    - Assist with problem solving, relapse prevention
- RN Care Manager role/responsibilities
  - Transition management
    - maintain comprehensive care plan in different settings
  - Advocacy
  - Monitoring and follow up of physical symptoms
  - Referral to additional resources i.e. home care

Care Management Plan

Acute Stage Interventions

Short Term Goal: Healing the decubitus ulcer

Interventions:

- Home visit with homecare wound nurse
- Participate in all office visits
- Coordinate care with wound care center and homecare
- Transition management between providers/agencies
- Improve fluid intake: poor fluid intake, drinks coffee and pop

Care Management Plan

Ongoing Interventions

Assessment/ reassessment:

- wounds now almost healed
- crisis last August-wife unable to care for pt.
- positive c.diff incontinent of stool, uncontrolled diarrhea
- admission to ECF and transport on Friday before Labor Day weekend
- Pt. discharged home early December 2012 then back to facility for UTI's, IV antibiotics through PICC line

Advocacy

- attended care conference at facility
- resource alignment

Care Management Plan

Ongoing Interventions

Care Coordination:

- Identifying external resource support
- Building the network
  formal/informal networking
- Maintaining the relationships
- Ongoing collaboration/coordination
- Advocacy with difficult/challenging client situations

Care Management Plan

Long Term Interventions

Family/Care Giver Support

- If long term placement what will wife do? Currently supported by patient's social security

- Wife confessed to me she is smoking 2 packs of cigarettes a day, provided with office contact on smoking cessation program

Case Closure

- What would need to be present to close this case appropriately?
  - Independent in managing his own care
  - Care giver independent in managing his care
  - Long term placement in a facility

Case Study #2: D

- 54 year old female
- African American
- Asthma/COPD
- Type II Diabetes
- HTN
- Anxiety
- hyperlipidemia
- She is a single mother with one high school age daughter who also suffers from asthma.
- She is on disability income.

Advocacy: Dealing with Stigma

- **ER VISIT**: D had remained in the ER through the night and admitted to the floor in the AM. She called the PCP office from the hospital in tears because she felt she had been ignored and bullied in the ER for being a Medicaid patient that the resident told her “you don’t belong here”.

- Her diabetes not attended to: they had not checked her blood sugars, nor offered her anything to eat. She had been over 12 hours without anything to eat or drink and was feeling shaky.

- She wanted to go home.

- CM facilitated a same day clinic appointment. A breathing treatment, prednisone order and an antibiotic and we were able to keep her out of the hospital.

Referral/Identification and Screening

- MiPCT list with high utilization
- 3 admissions in 3 months for her asthma which was rapidly progressing to COPD.
- Each time she was on a prednisone taper, and an antibiotic her blood glucoses would subsequently elevate.
- She was getting quite frustrated as she manages her diabetes quite well. Her Hgb A1C's range from 6 to 8 but not usually above 8.5. It was beginning to creep up to 9.0.

CM Intervention:
Transition Management/Enrollment

- Transition call, MiPCT list with high utilization.
- Care manager explained role and how they could work together to keep the patient out of the hospital as much as possible. She was ready and eager to try.
- The patient came in for her post hospital discharge appointment and she asked the care manager to stay in the room during the visit.
- Due to her known history in the clinic and her frequent ER and hospital admissions the care manager suggested to her PCP that we try putting in a standing order for prednisone taper, and possibly an antibiotic.

Care Management Intervention: Transition Management (continued)

- Standing order for the prednisone with the stipulation that she would call the office when she needed to use it to get an appointment.

- Outcome: Since that order, D has had to use the prednisone about 6 times last summer and into the fall. She landed on the discharge list once again in October, but it was for a fractured ankle that needed surgical attention. She did recently get admitted for her COPD and the care manager is following her TOC once again. Her diabetes is back under control. Her most recent Hgb A1C was 6.8.

Care Coordination

- Social Worker for counseling.
- Collaboration with the local Farmer's Market in the summer for fresh fruits and vegetables.
- Patient reports "I have learned to make do with what I have." She knows that her choices aren't always the best ones, as she struggles to put food on the table, but she has learned that she must take care of herself in order to take care of her child.

Effective Management Strategies

- SW and RN Collaboration- capitalize on experience from each discipline
- Advocacy
- Building Trust with the patient/family
- Focusing on effective coping skills and past experiences which were effective
- Build a network of resources used regularly and develop relationships

Effective Management Strategies (Continued)

- Coordinating care across settings
  - Medical Neighborhood
  - Community Resources
- Working with all members on your care team- PharmD, RD, CDE, Practice Nurses, Medical Assistants
- Building and maintaining/ rebuilding relationships with healthcare providers/agencies

Case Closure

- What elements would need to be present for this case to be closed appropriately?
  - Independent with managing her own chronic conditions and psychosocial and financial needs.
  - Care giver independent with managing the patient's chronic conditions and psychosocial and financial needs.
  - Frequency and intensity of contacts vary related to patient's disease progression and circumstances.

Resources/Reference Guide

- Local churches
- County website
- County health department
- Community mental health
- Local hospital or health care clinics- case management or social work department
- State of Michigan: www.michigan.gov
- Department of Human Services: www.michigan.gov/dhs
- State-wide Area Agency on Aging elder care locator: 800-677-1116

Top 10 Tips for Providing the 3 C's
Competent, Compassionate Case Management

- Meet the patient where they are at
- Baby steps
- Don't get frustrated
- Don't assume ANYTHING
- Don't get discouraged by set-backs

Top 10 Tips for Providing the 3 C's
Competent, Compassionate Case Management (continued)

- Respect that the patient has the right to make their own decision
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- Stand by and provide non-judgmental supportive care
- Be creative
- Use any and all contacts you have, and make new ones
- Keep forging ahead until you find your resource or meet your goal. "I don't know" or "no" is not acceptable.

THERE ARE NO FAILURES, JUST FUTURE OPPORTUNITIES

Thank you!

- Questions