CPC
Comprehensive Primary Care

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Practice Spotlight 6

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This perspective on care management comes from TriHealth, a Cincinnati-based, not-for-profit health system. Four LLCs operate a total of 32 primary care offices affiliated with TriHealth; 19 of those are CPC practices.

"How would you want your own family cared for?" This is how Care Manager **Anna Bowman, RN**, describes a guiding principle in TriHealth's care management approach in CPC. As the multi-practice system tackled the administrative and clinic logistics of integrating care management into workflow, staffing and other processes, TriHealth's care management staff pulled tenets from best practices to get started. Communication, flexibility and peer-to-peer sharing have carried them through.

Getting Started: Care Management 'Pivots' on Risk Stratification

Building on work done for NCQA Patient Centered Medical Home (PCMH) recognition, TriHealth created two teams in 2012 to start the CPC care management work: while one team was focused on care management processes, the other created TriHealth's risk stratification methodology.

"While care management is the heart of the work, it pivots on risk stratification," said **John Butler, PMP**, senior performance improvement consultant. "We farmed out the best practice materials for our teams to review, and then we came back with recommendations. We wanted our CPC care management plan to be simple and intuitive but also could flex as our patients' needs changed."

The teams created a four-level Care Management Needs (CMN) assessment (see table for detail). As patients are seen, physicians and care managers evaluate them through a series of Care Level screening questions covering clinical needs as well as behavioral health, socio-economic and home life needs (see inset for High CMN screening questions). The result is a well-rounded picture of the patient's general wellness and ability to participate in the care management process.

Care Level Screening Questions

High Care Coordination

- Would you not be surprised if patient is admitted to the hospital within the next six months, or has the patient been admitted into the hospital at least twice in the past year?
- Has the patient presented at the ED three or more times in the past year?
- Would you not be surprised if the patient would pass away in the next year?
- Is the patient in need of end of life care planning?
- Has the patient's chronic disease progressed, become unstable or new conditions and/or significant complications developed?
- Does the patient have extreme situations (e.g., severe head injury, highly complex treatment, dual eligibility, recent MI, progression to ESRD, care by several sub-specialists)?
- Does the patient have significant social needs that require care coordination?
- Does the patient have significant behavioral health needs requiring care coordination?
- Does patient need assistance with ADLs?
- Are there home safety concerns?
- Is the patient a high user of health care resources?

Source: TriHealth

Care Management Needs (CMN) Level	No or Undetermined CMN	Low CMN	Medium	High CMN
Staff	MA	MA	LPN	RN
Percent of Patients	10 to 20%	34 to 45%	40 to 50%	5 to 10%
Goal	Maintain wellness	Wellness	Health and disease management	Complex disease and care management; follows through on care

Care Management and Coordination Services for Patient with High Care Management Needs

Patient Presentation
Advanced complex disease; advancing and need for in-depth intervention; advanced disease; little or no support; in need of End-of-Life planning; frequent ED visit or inpatient discharge; significant change in life or health that requires high-level care coordination

Universal Services

- Work with team to adjust to appropriate care level
- Work with patient and provider to set, communicate and achieve care goals
- Patient education (confirm understanding)
- Pre-visit calls (tests prior to visit; info from other providers)
- Post-visit calls
- Assess needs and identify barriers to care (transportation, affordable meds, psycho-social needs)
- Identify gaps in care
- Screening patient panel for changes in care level

Care Management and Coordination Services

- Coordinate frequent follow up (> once every 3 months) or as outlined by care plan
- Coordinate referrals across multiple providers or care givers
- Provides in-depth education and behavioral reinforcement to patient and/or support point person
- Teach and check home monitoring (BP, HBGM, weight)
- Executes delivery of educational, behavioral or community resources
- Provides End-of-Life Facilitation
- Assure compliance to post hospital D/C plan
- Resolve barriers to care
- Coordinate mental health referral
- Initiate a care management round table/family conference as indicated
- Request and coordinate clinical pharmacy consult with patient on multiple prescriptions
- Know every day how many patients are in house, their names and planned disposition
- Assure team catches the discharge and sets the follow-up appointment
- Delegate to the LPN and MA/PCMH team members
- Call the morning and mid-day huddles
- Refers and coordinates patient's or point person's participation in educational, behavioral or community resources (social worker, pharmacist, dietitian)

Excerpted from TriHealth's four-level Care Management Needs Plan document

"While we had started PCMH at the same time, the CPC care management work was new in the physician practice setting," explained **Robin Thomas, RN**, care manager. "During planning, we sat down with all the providers to define what the work would look like and get their input. We asked them what they wanted managed, and they saw the value."

Early discussions with physicians led to an initial focus on patients who had difficulty controlling their diabetes and patients with hypertension.

Joan Metze, BSN, RN, care manager, agreed that provider engagement opened doors, "The transition was easy with physician buy in. They were excited about getting assistance to fill that gap of missing services."

As care managers blended into the care teams, they leaned heavily on communication and flexibility. They met regularly with the care teams to set a baseline understanding of roles with the expectation that nothing was permanent, and shifting workflows would be the norm as they worked through processes.

TriHealth's previous PCMH work was an asset; staff had learned to better manage change, especially when a clear benefit was in sight.

What the Work Looks Like

All practice sites follow the same care management processes, but daily work varies among the care managers according to the patient's level of need.

In each CMN level, TriHealth has identified "universal" services that apply to all patients in that level. Those services are augmented by care coordination services that often extend outside the practice walls, across other clinical services (dietitian, for example) and into the patient's home and community. This wrap-around approach helps eliminate the gaps that often lead to barriers to successful disease management and wellness.

Community resources to support patient wellness include the local Goodwill, which sells discounted medical equipment, or a local nonprofit that can help patients pay back rent or a late utility bill. Another community group helps patients pay for medications.

Joan Metze is a care manager for patients with high CMNs. As her physicians meet with these patients, they introduce her, explain her role in their care and describe how she will regularly contact them. The physician introduction of the care manager role increases patient engagement, she said, especially for the high CMN patients who need more services. (See inset for an excerpt of TriHealth's approach for these patients.) She tracks patients through the EMR, and she encourages patients to call her as needed.

"I tell them, 'Call us if you have changes. We're here to prevent those hospital and ED visits,'" Joan said.

Care managers also check daily reports from hospitals and EDs. If a care manager's patient was treated or admitted, the care manager follows up with the patient to assess needs.

In-depth patient education is among a care manager's responsibilities, meaning the necessary skill set expands beyond clinical knowledge. Finding staff with soft skills like empathy and graciousness have helped TriHealth practices put the "right people for the right roles," according to John Butler, performance improvement consultant for TriHealth.

Sharing the Knowledge

Care managers convene for monthly calls, which are a resource rich with valuable information and insight. In this forum, they discuss barriers and solutions as well as success stories. Hospital navigators are frequent visitors to meetings.

"We piggyback on each other's experiences, and we reach out when we have a difficult case," Anna Bowman said. "The hospital navigators are great because they often can point us to new community resources to help us better support our patients. I've learned about a prescription website that can help patients and our council on aging offers a lot of services."

Care managers are also encouraged to network with other care managers outside the TriHealth system through the RN Ambulatory Care Coordinators Association (www.RNACCA.com), which has Cincinnati roots but a national reach.

Care managers and physicians risk stratify patients through a series of Care Level screening questions. TriHealth combed best practice literature to develop its stratification process, looking for universal tenets to apply across the system but also for approaches that allowed flexibility by site.

What's Ahead for 2014

The new primary care strategies in PY 2014 (Milestone 2) offer a new opportunity for TriHealth to deepen its care management work.

"We're looking at a focus on medication management, but it's still under discussion with our lead physician steering committee," said John Butler. Practices have until March 2014 to report a direction.

Regardless of the strategy chosen, the care management team is ready to do the work, which Robin, Anna and Joan agreed is demanding but satisfying.

"Compared with other nursing jobs, this isn't the technical part, but it's rewarding. You start working with high-risk patients and then find solutions for them," said Joan Metze. "You see them grow, and they thank you for caring for them and making their life better."

Is your practice ready for the Spotlight? Please email Belinda McGhee, belinda.mcghee@tmf.org, with your story suggestions.

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