COLLABORATIVE CASE MANAGEMENT

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COLLABORATIVE CASE MANAGEMENT

"Case management in hospital and health care systems is a collaborative practice model including patients, nurses, social workers, physicians, other practitioners, caregivers and the community. The case management process encompasses communication and facilitates care along a continuum through effective resource coordination. The goals of case management include the achievement of optimal health, access to care and appropriate utilization of resources, balanced with the patient's right to self-determination."

Approved by ACMA membership, November 2002

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Innovations in Clinically Integrated Care Management Across the Continuum of Care

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This article is based on a poster presented at the 2016 ACMA National Conference. It received the award for Ability to Replicate and Implement.

As health care providers address the need to become more clinically integrated and seek to improve patient care across the continuum, effective communication is critical. The Scottsdale Health Partners Care Management Program bridges the gap in communication, while assisting with disease management and social support for its high-risk patients and aging Medicare population. By enhancing communication through the organization's Health Information Exchange (HIE) and HIPPA-compliant texting system, as well as by placing members of the care management team in its primary care practices, hospitals and post-acute facilities, the organization has been successful in decreasing hospital and emergency department visits, lowering readmission rates and improving quality of care.

LEARNING OBJECTIVES

1. Understand the need for a responsive communication system that connects all team members
2. Describe the role of Transitional Case Management across the continuum of care
3. Describe the role of Comprehensive Care Coordination in the continuum of care

OVERVIEW OF SCOTTSDALE HEALTH PARTNERS

Scottsdale Health Partners (SHP) is an organization strategically positioned to transform health care delivery within the local community as it works to provide comprehensive care. Over the last three years, more than 750 physicians, including more than 170 primary care physicians (PCPs), have joined its clinically integrated physician network. SHP also has contracts with six major insurance companies, including Medicare, and covers more than 40,000 patient lives. In January 2014, SHP was awarded a Medicare Accountable Care Organization (ACO) status. During that first year, SHP successfully obtained shared savings of nearly $4 million through the Medicare Shared Savings Program.

Given the fragmented nature of the current health care system in the United States, patients sometimes do not receive post-acute services or return home unprepared to maintain the level of care required for a successful recovery. This can lead to an avoidable hospital readmission. Lack of communication among the various service providers is often the root cause of the problem. SHP sought to address this issue through its care management program. The program was modeled after an Intensive Outpatient Care Program (IOCP) implemented by the Pacific Business Group on Health (PBGH) through a grant with the Centers for Medicare and Medicaid Service and Centers for Medicare Innovation (Grant Number: 1C1CMS331047 from the Dept of Health and Human Services, CMMS). The program places a strong emphasis on the role of interconnected communication.

A FOUNDATION OF COMMUNICATION

SHP's emphasis on communication began when the organization realized that PCPs were often unaware of the treatments their patients had received, which contributed to fragmented care delivery. Understanding the need to keep their PCPs informed, SHP decided to invest in more robust communications.

Before rolling out its innovative care management program, SHP spent time building its communication infrastructure. SHP contracted with a provider of a secure, real-time, HIPPA-compliant texting system. This service gave SHP the capacity to link the care management team, physicians, specialists and post-acute providers participating in the patient's care. Being linked by one secure and easily accessible

information-exchange platform allowed the entire team to share information. This information exchange provided better outcomes for patients, including treatment progress, discharge planning and more community resource options.

In collaboration with a health care information technology company, SHP developed a Health Information Exchange (HIE) platform in which data from the partnering health system, local laboratories, radiology departments, and some physician practices were integrated into an online, easily accessible tool. The tool is available for physicians and staff to utilize in order to provide the best possible care for their patients. SHP utilized physician input to determine what key clinical information of value to them should be placed in the HIE. This physician input created strong physician satisfaction with the HIE end product. SHP recognized the need for not only the HIE, but also a good documentation system integrated with the HIE, in order to expand communication within the patient's circle of care providers (care coordinators, specialists, primary care, transitional care coordinators, etc.).

CARE MANAGEMENT PROGRAM

In addition to the improved communication system, SHP recognized that they needed an infrastructure of people designated to follow patients across the continuum of care. They developed two integrated components to their care management program: Transitional Care Management and Comprehensive Care Coordination. These two innovative programs serve SHP patients and physicians with highly collaborative, effective and evidence-based service coordination designed to improve patient outcomes and make the health care experience less complex and more satisfying for patients.

TRANSITIONAL CARE MANAGEMENT (TCM)

This service is provided to hospitalized patients or those recently discharged from the hospital. The program is designed to assist with the needs of patients and to ensure a smooth transition from an SHP network hospital, emergency room, or partnered post-acute facility to home or another facility. The focus is on maintaining clear communications among patients and family members, PCPs, specialist physicians and post-acute facilities about treatment plans during and post hospitalization. The transitional care managers handle an average of 20 patients each day.

THE ROLE OF THE TRANSITIONAL CARE MANAGER IN THE HOSPITAL, EMERGENCY DEPARTMENT (ED) AND POST-ACUTE FACILITIES

- Messages the PCP and care coordinator with patient admission information, diagnosis and plan of care
- Tiers the patients to determine those at high risk of readmission and potential high utilizers of medical services
- Exchanges information with the hospital case manager to ensure a successful discharge
- Meets with patients to establish a relationship and provide them with contact information in the event of questions or issues after discharge
- Updates the PCP and care coordinator about discharge dates, details and the hospital's recommendations for disposition, medications, and follow-up appointments and tests
- Communicates handoffs to the care coordinator in PCP's office with details about the discharge plan, social issues and risk factors that need to be addressed
- Completes follow-up phone calls to the patient within 24-48 hours after discharge to ensure that the patient understands instructions, medications and that follow-up appointments have been scheduled
- Intervenes as needed to prevent readmission by facilitating home health care, SNF admission, caregiver assistance or placement resources

COMPREHENSIVE CARE COORDINATION

SHP also offers an intensive outpatient care coordination program that utilizes a specially-trained care coordinator assigned to work with a PCP. The role of the care coordinator is to create close relationships with medically complex patients and deliver highly individualized and accessible primary care. The aim is to develop a patient-centered, goal-oriented treatment plan and to maintain close communication with patients, supporting their efforts as they move to a more advanced state of emotional or physical wellness.

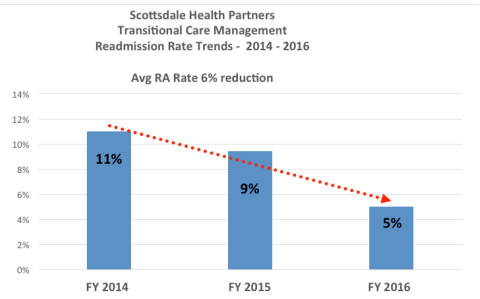
The care coordinator focuses on several critical elements when working with patients, including behavioral modification interviewing, conducting a "Supervisit" (an in-depth information gathering process), facilitating medication management and obtaining three different patient assessments: Patient Activation Measure (PAM), PHQ-9, and Veteran's RAND 12.

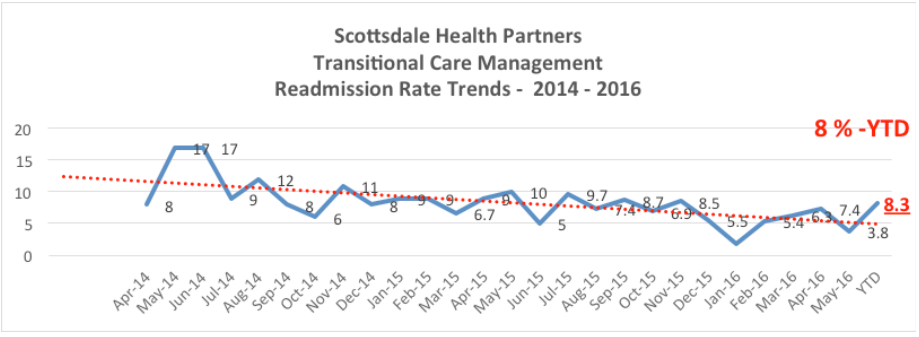
IMPACT OF INTEGRATED CARE MANAGEMENT

The integrated care management services were introduced to patients in early 2014. To measure the impact of these services, SHP used the PAM, PHQ-9 and VR-12 patient assessments. The assessments were conducted upon entry to the program and then again in six months' time.

PAM: PATIENT ACTIVATION MEASURE

The Patient Activation Measure is a tool that measures the patient's confidence in self-management and understanding of health





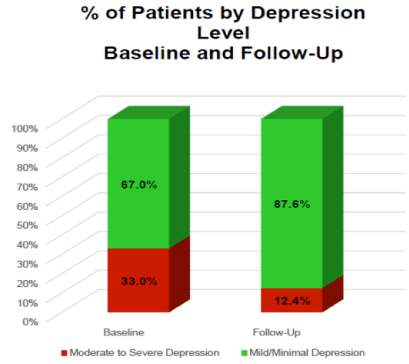
conditions. The PAM involves four levels of patient activation:

1. Disengaged and overwhelmed
2. Becoming aware but still struggling
3. Taking action
4. Maintaining behaviors and pushing further

Since 2014, patients in the SHP Care Management Program have demonstrated a 5.6-point positive change in their activation levels. The baseline average score has been 59.1. In the six-month follow-up assessment, the average score was 64.7. It is notable that a single point change in the PAM score has shown to have a potential in medical cost savings: $110 savings in total medical cost, $43 savings in non-inpatient medical cost, $65 savings in inpatient medical costs and $123 savings in hospital costs.

PHQ-9: DEPRESSION SCREENING

The PHQ-9 assessment is a depression screening tool. In the initial screening, 32.97% of patients had moderate to severe depression. Follow-ups after six months indicated that only 12.43% of patients tested as having moderate to severe depression. This was a 62% reduction in the number of patients with moderate to severe depression.



VR-12: VETERAN'S RAND 12

The Veterans RAND 12 Item Health Survey (VR-12) is a generic, multi-use, self-administered health survey comprised of 12 items. The instrument is primarily used to measure health-related quality of life, to estimate disease burden and to evaluate disease-specific benchmarks with other populations. It has both a mental score and a physical score.

SHP demonstrated an improved mental score for their patient population by over six points and an improved mean physical score by two points. As a comparative benchmark for this improved results we used the national Medicare mean. The mean mental score for SHP was almost two points below the 2014 Medicare national mean and the mean physical score was almost seven points above the 2014 Medicare national mean.

CONCLUSION

Scottsdale Health Partners has successfully increased communication via the implementation of its care management program, utilizing a proprietary HIE and HIPAA-compliant texting system, to reduce readmissions, decrease ED visits, improve the overall quality of care and for the patients it serves, as well as improve patient and physician engagement and satisfaction. The program has created an enhanced collaborative environment between all providers of care and a better understanding of overall patient needs.

SHP's ACO obtained nearly $4 million in shared savings through the Medicare Shared Savings Program in 2014. The goal is to achieve the same outcome for 2015. SHP also hopes to continue to decrease readmission rates from 8%, see additional cost-saving benefits of the care management model and see continued improvement in patient outcomes.

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THESE AUTHORS HAVE NO FINANCIAL RELATIONSHIPS WITH COMMERCIAL INTERESTS TO DISCLOSE

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