Care Management Essentials: Practical Approaches to Implementing a Successful Care Management Program

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Care Management is an emerging concept that refers to:

- a set of evidence-based, integrated clinical care activities
- that are tailored to the individual patient
- and that ensure each patient has his or her own coordinated plan of care and services
Goal of Care Management

The goal of care management is to achieve an optimal level of wellness and improve coordination of care while providing cost effective, non-duplicative services.
Clear Definitions and Goals

Care Management means different things to different people, practices, and systems of care.

The goals of a Care Management program may also vary or have additional identified outcomes to achieve.

Defining the population, the specific model, the definition and the goals is a vital first step for developing a program.
Evidence-based Components of Effective Care Management

1. Risk Stratification
2. Use of Care Plans
3. HIT to Support Care Management
4. Team Approach to Care Management
5. Care Managers have Face to Face Contact with Patients
6. Emphasis on Medication Management
7. Use of Evidence Based Clinical Protocols and Standing Orders
8. Recognition of Social Determinants of Health on Care Management Interventions and Care Plans
9. Care Management of the Whole Person-Medical, Behavioral, LTSS Needs, etc.
10. Comprehensive Transitions of Care
11. Cost Containment – Efficient and Effective Processes and Staffing Models for Care Management

Clinical Management: A Review of the Evidence and Policy Recommendation
Jack Meyer, 2014
Risk Stratification

- Identify patient population and levels of risk
- Use health risk assessments to:
  - Assess health status
  - Estimate the level of health risk and care management intervention levels
  - Inform the creation of a care plan and provide feedback to participants to motivate behavior change to reduce health risks
Care Plans

- Informed by Health and Risk Assessment and Continued Assessment

- **Individualized and personalized** for a patient’s treatment and **supports**, formal and informal

- Created with input from every team member but is a patient care plan

- Patients and their families are involved in goal setting and development of plan

- Address whole person—medical, behavioral health, disabilities, environmental, and functional needs within goals
HIT Support of Care Management

- **Registries** for population management and care management tools
- **Care alerts**, notifying care managers when a patient needs to be contacted
- **Facilitate contact** with clinicians, and provides information support to clinicians in real time as they are seeing patients
- **Electronic notification systems with real-time alert** when patient is in ED or admitted
- **Patient accessible** and friendly portals
Care Manager On Team

- Medical
- Behavioral Health
- System Infrastructure (Health Plan or Other)
- Community Based Organizations
- LTSS

Care Manager
Key Components of Team Based Care

- Clear roles and workflows
- Use of evidence-based protocols, standing orders, guides
- Hand-offs and communication processes
- Supportive IT tools
- Care plans
- Huddles/pre-visit/tracking and follow-up
- Training
- Measures/feedback
Care Manager Role in Team Effectiveness

- Promote Communication Among Disciplines
- Focus and Refocus Team on Model of Care
- Advocate for Patient Goals and Outcomes
- Facilitate and Monitor Measurement
- Bring DATA to Team Discussions
Behavioral Health

Treat Behavioral Health in Primary Care Settings

Treat General Medical Conditions in Behavioral Health Settings

Care Management
Social Determinants of Health

Health Risk Assessment

Housing

Transportation

Language

Employment and Education

Food

Safety

Care Plan
Efficient Models and Approach

• Staff working at the top of their training
• Using right staff in the right role on the team
• Efficient and effective workflows and hand-offs
• Staffing ratios appropriate to care level needs
• Financial and other incentives to the whole care team when patient outcomes are achieved
Task Sharing- Example

BHP 1.
Paraprofessional Staff

BHP 2.
Paraprofessional Staff with Advance Training

BHP 3.
Licensed Behavioral Health Provider

Specialty Behavioral Health

BH Screening
Registry Tracking
Health Promotion

Brief Intervention for Situational Stress and Education on Health Changes

Diagnostic Clarification
Brief Intervention
Complex BH Needs
Continual Assessment of Outcomes

- Shared Specific Metrics
- Quantifiable and Measurable
- Evidence Based
Care Transitions

- Discharge Planning Starts at Admission– with Real-time alerts for ED, admit, discharge
- Build Relationships with ED and hospital care transitions/navigator roles
- Follow-up Includes:
  - Comprehensive Discharge Planning
  - Home and PCP follow up to educate patients about early symptom spotting, dietary advice, medications, social services, and self-management
  - Medication Management
  - Patient and Family Engagement
  - Transition Care Support
  - Transition Communication
Measurable Processes and Outcomes

• The team agrees on and implements reliable and timely feedback on successes and failures in both the functioning of the team and achievement of outcomes. These are used to track and improve performance immediately and over time.

“They do say results will vary.”
Where Do You Start?

Three Key Steps

➢ Importance of starting with an assessment and gap analysis
  – Understanding your current systems, processes, and team structure/workforce
  – Understanding your current patient panel and mix of risk levels and needs
  – Identify needed ratio of staff for effective caseloads

➢ Create an action plan from the gap analysis

➢ Focus on Training Teams and Care Managers onsite or at a Care Management training workshop
HMA Can Help

- HMA conducts comprehensive needs assessments and gap analysis and aids in creating a step-by-step action plan for Care Management
- HMA offers Care Management Training – Client Individualized
  - 2 day – first half day can be for the PC team and day and a half is for care managers
  - CM training covers core competencies such as:
    - Basics of Care Management
    - Understanding workflows
    - Care management checklist – what does a CM need to know
    - Using tools and new processes
      - Guides and protocols
      - Risk assessments
      - HRAs
      - Care plans
      - Registries
      - Relapse prevention and maintenance plans