St. Joseph Health
Queen of the Valley

# **C**ase Management
# **A**dvocacy
# **R**esources
# **E**ducation
# **Network**

Dana Codron, Executive Director
Community Outreach

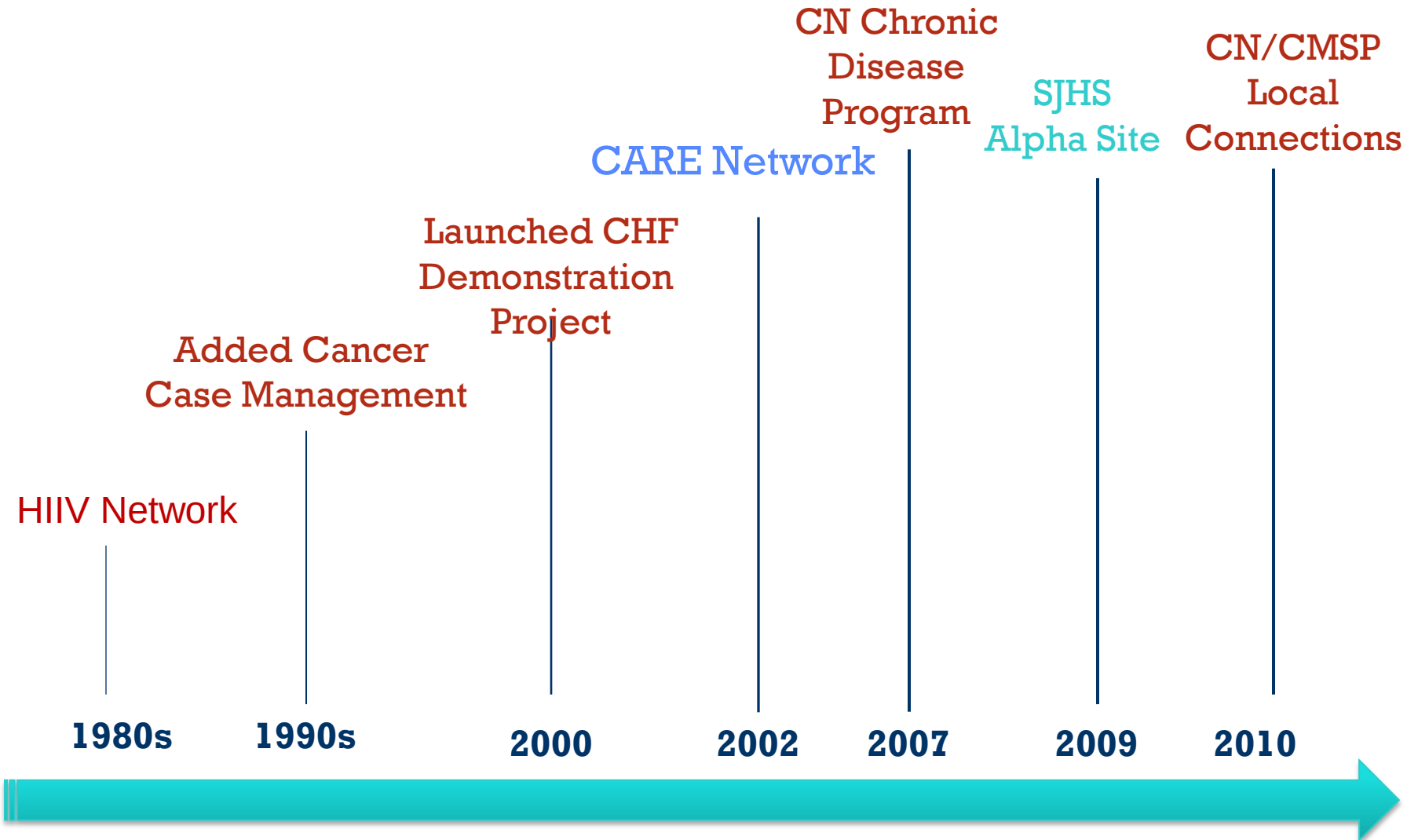
Aura Silva, Coordinator
CARE Network

# The Call to Action

- $30 Billion
- CMS Penalties
- Quality of Life

www.caretransitions.org/definitions.asp

# CARE Network History



# Lessons Learned

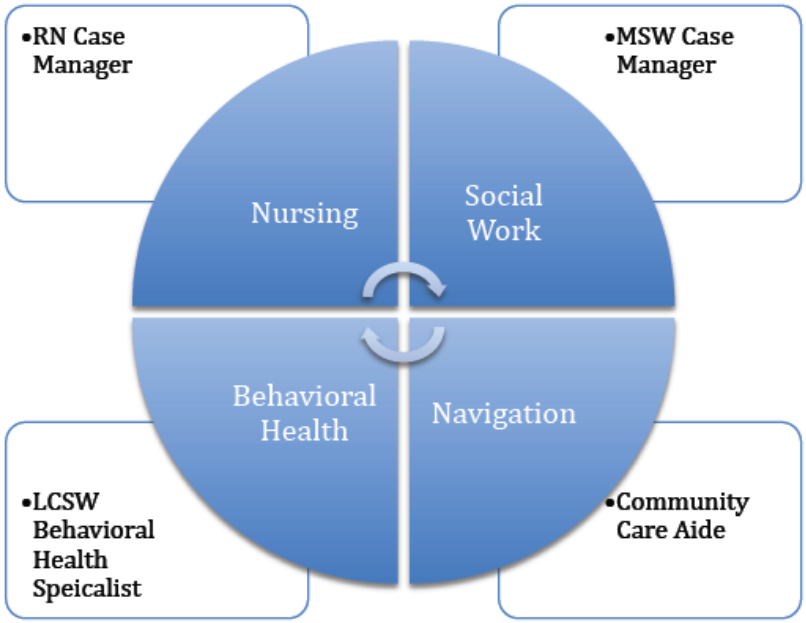
## Adapting Models of Care

- High risk, frequent users require significant support beyond medical care transitions
- Health issues (medications, caregiving, medical home) may be stabilized in 3 months but issues related to poverty, lack of access due to language and education, substance use and mental or cognitive health concerns take longer - 6 months or more.
- Availability of community resources for MediCaid  low-moderate income older adults or uninsured can be a barrier to success (e.g., substance abuse, mental health, caregivers)

A 2011 RWJF survey of 1,000 primary care physicians and pediatricians found that 82% of physicians said patients frequently express health concerns caused by unmet social needs that are beyond their control as physicians. And 74% of doctors report that these unmet needs often prevent them from providing quality medical care.

# Models of Care

## Interdisciplinary Teams
## Keys to Effectiveness




Recent studies by California Endowment and California Healthcare Foundation support the following as keys to reducing disease burden, emergency room use and hospital stays among high risk, complex, frequent users of care:

- Intensive case management (Medical, SW)
- Navigation links to primary care
- Benefits advocacy
- Behavioral health services


Raven et al.: An intervention to improve care and reduce costs for high-risk patients with frequent hospital admissions: a pilot study. BMC Health Services Research 2011 11:270.

Tsai AC, Morton SC, Mangione CM, Keeler EB. A meta-analysis of interventions to improve care for chronic illnesses. *Am J Manag Care.* 2005;11:478-488. ISI | PUBMED

http://www.teamupforhealth.org/

# CARE Network Foundations

- Experience over time working with complex patients in a community-based, primary and acute care linked model
- Standards of Practice for Social Work and Nursing Case Management
- Target services to highest risk for hospitalizations/re-hospitalizations
- Implementation of core components of models shown to be effective with specific and heterogeneous populations – adapted to the community based context and client population (e.g., Chronic Disease Self-Management; Care Transitions)
- Use of evidence based tools to assess needs and track progress

# Client Profile FY12

| Total CN Clients Served/New Enrollees |
|---|
| 383/203 (53%) |

| Ethnicity | Percent |
|---|---|
| White | 61% |
| Latino | 34% |

| Coverage | % of Clients |
|---|---|
| Medi-Cal/CMSP | 71% |
| Medicare/Medi | 13% |
| Medicare | 5% |
| Uninsured | 11% |

| Age | % of Clients |
|---|---|
| 21-40 | 18% |
| 41-60 | 54% |
| 61-70 | 19% |
| 71-90 | 7% |
| 58% Male | 42% Female |

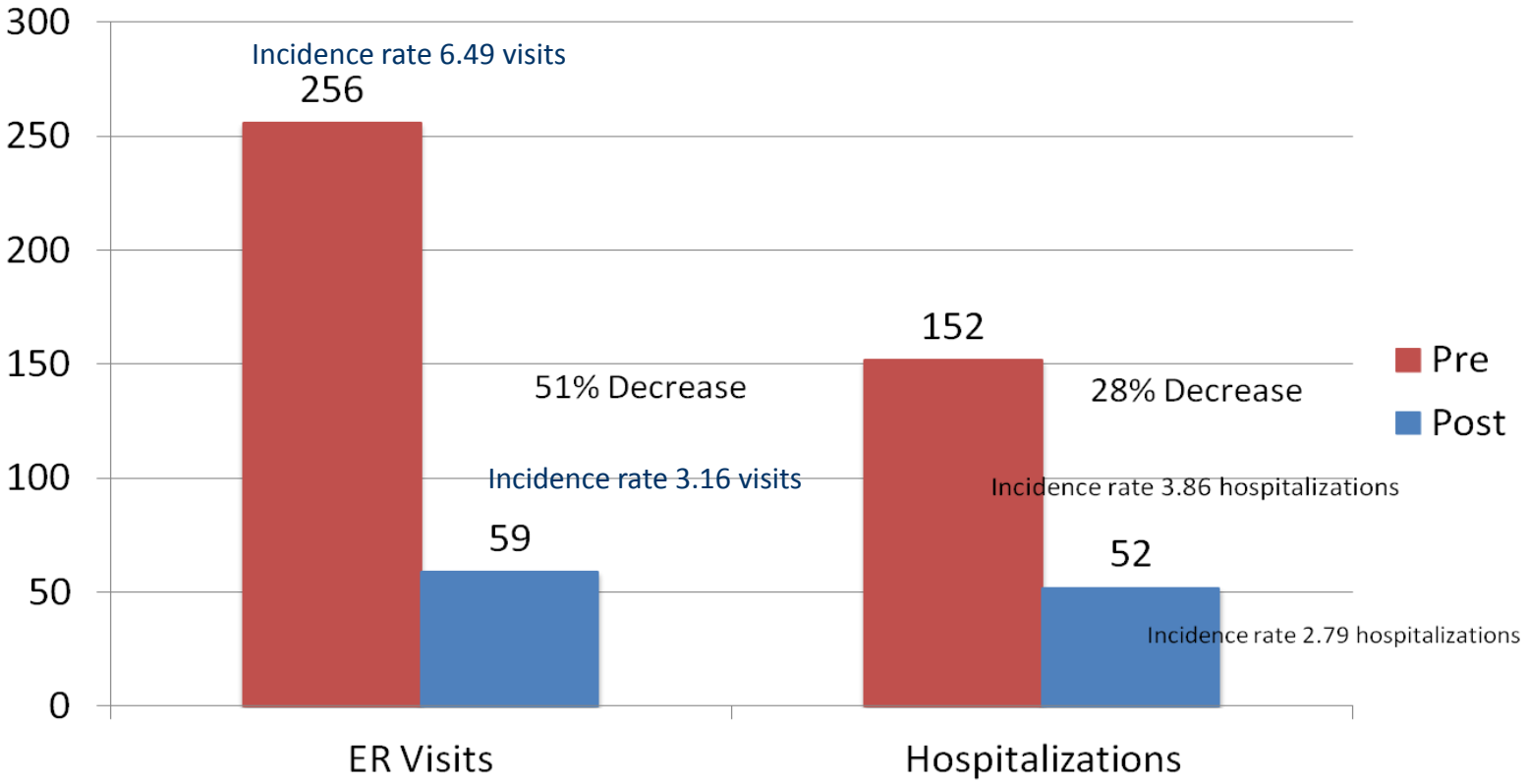
Primary Presenting Issues

- **Medical: Diabetes, Heart Disease, HF, Cancer, Liver Disease, COPD, HIV, ESRD**
- **Socio-economic: Benefits, Food, Housing, Caregiver needs, Medications**
- **Psychosocial: Substance Abuse, Mental Health**

# FY 2012

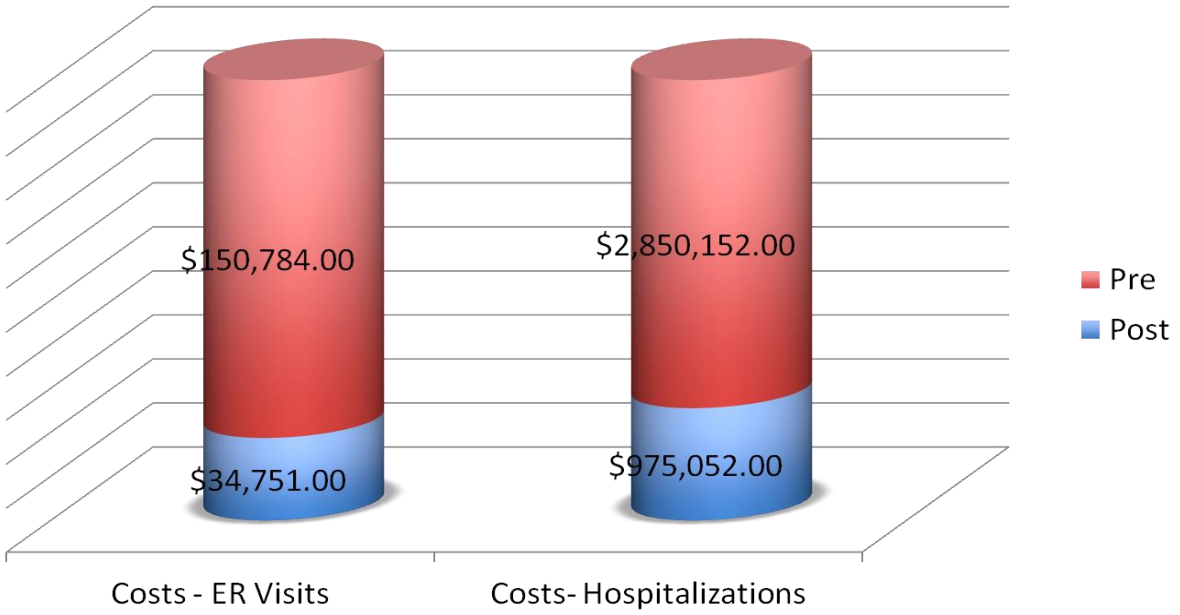
- 383 Clients Served
- 60% reduction in ED visits
- 53% reduction in hospitalizations

# Incidence Rate to Validate Reduced ED/Hospital Visits




N = sample of 108 Patients Served FY11

# Cost of Care Reduction




N=108 Patients Served FY11

**C**ase Management

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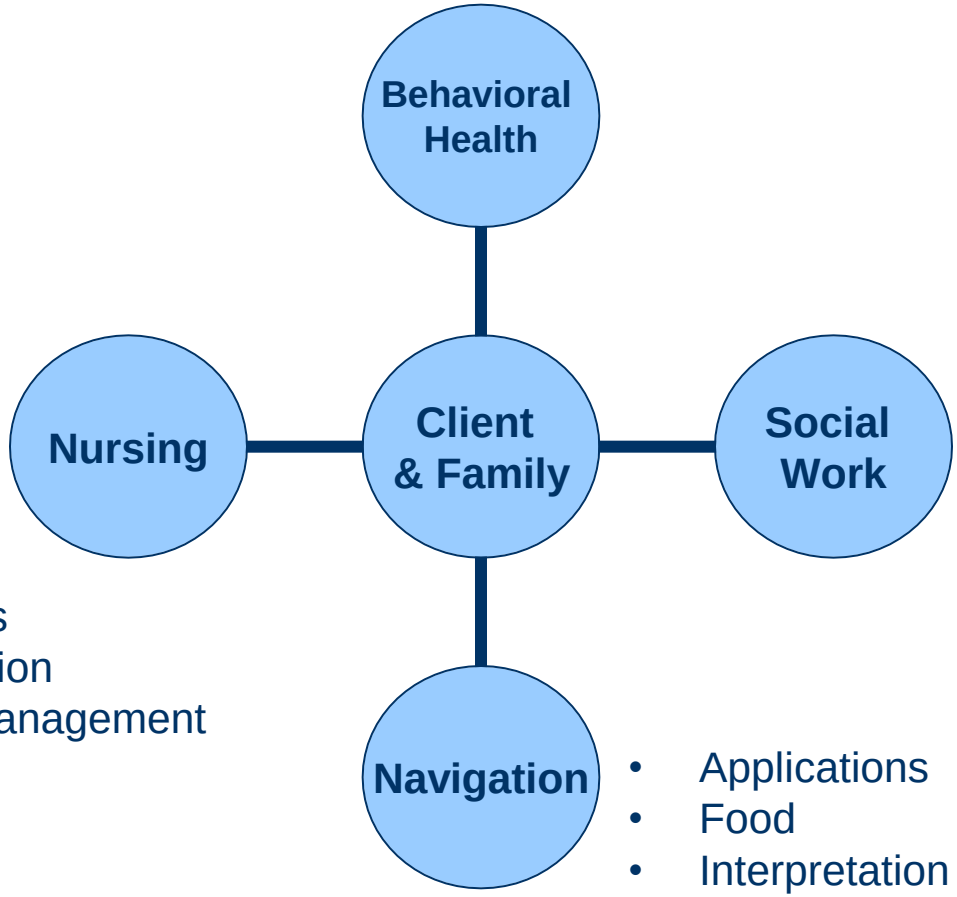
- Brief Counseling (CBT, EMDR, EFT,TRIM)
- Talk Therapy
- Spiritual Care



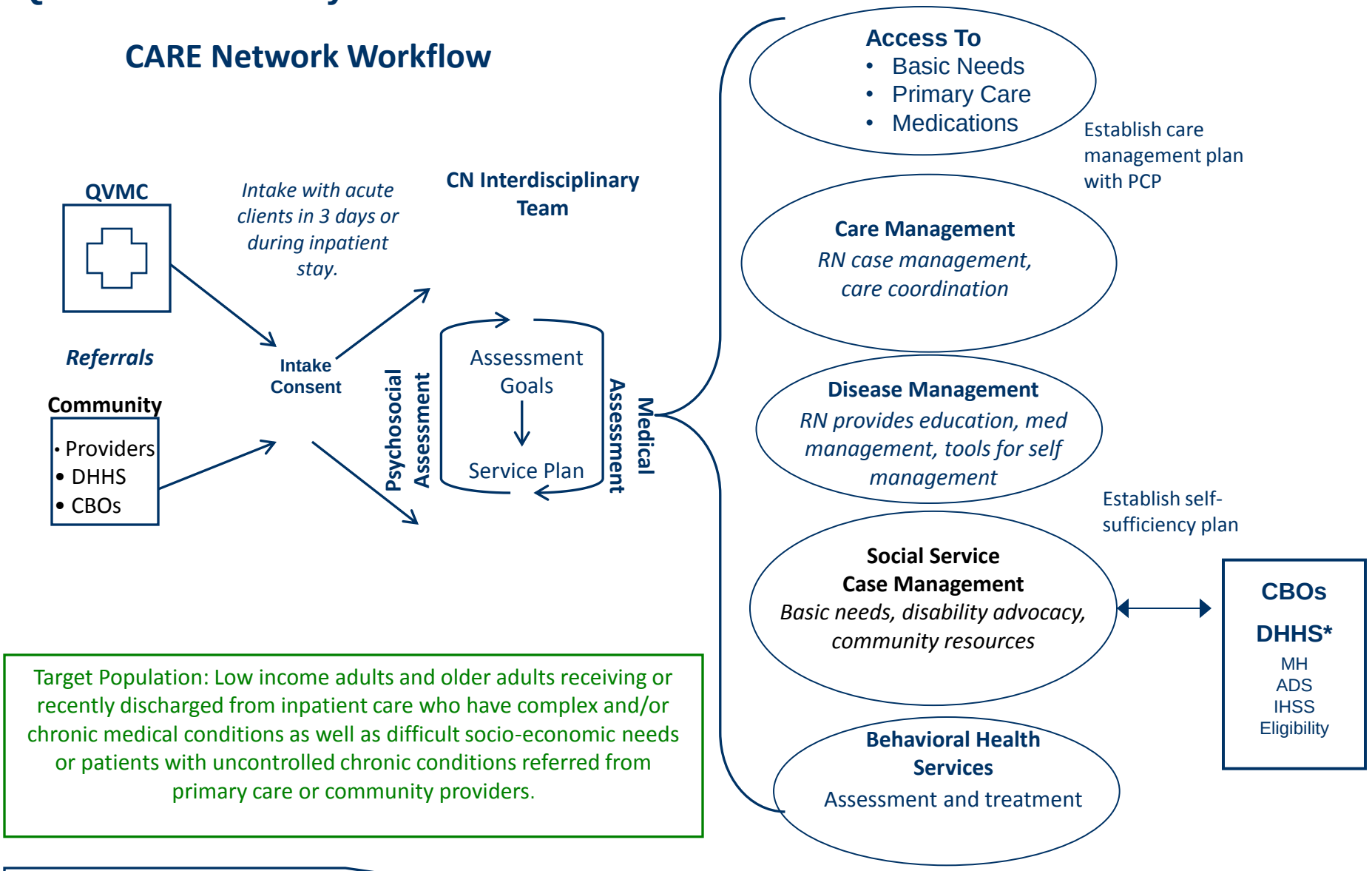

- Basic Needs
- Access to Benefits
- Support System
- Community Resources

- Access to PCP
- Access to Meds
- Care Coordination
- Disease Self Management

- Applications
- Food
- Interpretation
- Social Support

# Queen of the Valley Medical Center

## CARE Network Workflow




Target Population: Low income adults and older adults receiving or recently discharged from inpatient care who have complex and/or chronic medical conditions as well as difficult socio-economic needs or patients with uncontrolled chronic conditions referred from primary care or community providers.

**Initiated within 1 day -1 week**

**CM 90 -180 Days**

# Service Plan Development Process

- Each client receives a comprehensive Nursing and Psychosocial Assessment. Service Plans focus on improving client ability to function in daily life and self manage their health conditions.
- Multi-disciplinary team approach: nurse case manager and social worker assigned to each client
  - Conduct assessments using evidence-based tools
  - Determine Acuity Level
    - Medical
    - Psychosocial
  - Develop Service Plan

# Service Plan Goals

## MEDICAL

- Knowledge of Illness
- Pain Management
- Medication Management
- Access to Care
- Activities of Daily Living

## PSYCHOSOCIAL

- Basic Needs/Financial Stability
- Access to Community Resources
- Mental and Cognitive Health Status
- Stress Management & Coping with Change
- Support System
- Communication

# CARE Network Acuity Levels

| Acuity | Acuity Level 4 | Acuity Level 3 | Acuity Level 2 | Acuity Level 1 |
|---|---|---|---|---|
| HEALTH STATUS | **High risk** for ER/ Hospitalization Medically Frail | **Stabilization & Education** Medication Medical Home Medical Resources | **Increasing Independence** Discharge Planning or Referral to Other Supports | **Limited Services** or Independent Access to Service |
| SELF SUFFICIENCY QUALITY OF LIFE | Critical complex psychosocial and economic needs | Addressing needs: benefits, housing behavioral health, resources | Highest level of self management and self sufficiency possible | Remains open to allow access to other services |
| INTENSITY OF SERVICES | 3-1 X/week | 4-2 X/Month | 2-1 X/Month Discharge Planning | Quarterly contacts |
| SERVICE PLAN REVIEW | Every 60 days w/case conference | Every 60 days w/case conference | Every 6 months | 6 month updates |

# Self Management Adherence Guidelines

- Client Assessment: Evaluates client knowledge and motivation
- The Readiness Ruler


- Planning based on assessment and readiness factors
- Guidelines can be used with clients at all levels of motivation and knowledge.
- Use of Motivational Interviewing to improve ability to self-manage and build client buy-in.
- Pilot Patient Activation Measure (PAM)

# Evaluation Metrics

| Goal | Metrics | Tools |
|---|---|---|
| Improve Health Outcomes | Percent enrolled clients with acuity level reduction to Level 1 at 90 days and 6 months | Acuity Scale |
| | Percent change in client self reports of self disease management; disease knowledge | Avatar<br>SF-12 |
| | Percent clients with change score of 5 or more on SF quality of life measures | SF-12 |
| Reduce Costs of Care | Percent of clients with improved score on PHQ9 & GAF of clients referred for brief behavioral health interventions at 90 days or discharge | PHQ9<br><br>GAF |
| | Percent eligible clients successfully enrolled in insurance and disability benefit programs as appropriate | Benefits<br><br>Tracking |
| | Percent of clients reporting satisfaction with services | Avatar |
| | Percent change in ED visits post enrollment when compared to 1 year prior | Medi-Tech |
| | Percent change in hospitalizations post enrollment when compared to 1 year prior | Medi-Tech |

# Client Health/Quality of Life Outcomes FY 12

- 63% of clients had improved Quality of Life as measured by the SF12
- 90% of clients were satisfied with the program based on (Avatar Survey)
- 90% of respondents reported increased ability for disease self management (Avatar Survey)
- 54% reduced Acuity Level at 6 months
- 58% improved in Self Management Scores
- 89% of behavioral health clients showed improvement as measured on the Global Assessment of Functioning
- 85% of behavioral health clients showed improvement as measured by PHQ9

# Tracking Progress

## Case Management and Outcomes

- Client demographics, progress toward goals, and outcomes are tracked thorough a case management SQL server database specifically designed for CARE Network.
- Clients are provided discrete identifiers. HIPPA consent to share information forms are completed upon client intake. Client identity is protected in reports.
- Client services, assessment findings and care plan progress and results are tracked for each client.

# Client Story

QVMC CARE Network

# Questions?

Dana Codron, Executive Director
Dana.Codron@stjoe.org
(707) 251-2003

Aura Silva, Coordinator CARE Network
Aura.Silva@stjoe.org
(707) 251-2022

www.thequeen.org