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Preparing for Medicaid Expansion with High-Powered Care Management

A health system’s innovative practice secures comprehensive care for patients

BY BARBARA HARDING, RN, MPA, CCM, PAHM, AND ARLINE BOHANNON, MD

As states explore and develop their Medicaid expansion plans under the Affordable Care Act (ACA), understanding the care requirements of the population and the challenges that will be faced is necessary. Virginia Commonwealth University Health System (VCUHS) has developed an innovative program to care for this population with the intent of improving access to healthcare for eligible uninsured individuals living in the Greater Richmond Metropolitan and Tri-Cities areas who historically sought care through the emergency department (ED).1

This program, Virginia Coordinated Care for the Uninsured (VCC), is a unique initiative in which 82 percent of the population has an income less than or equal to 100 percent of the federal poverty level (FPL). Established by VCUHS in November 2000 with an inaugural population of 11,000 enrollees, VCC was designed to improve access to primary care for uninsured indigent persons through establishment of a medical home, which includes a primary care physician (PCP) within a network of community providers as well as physicians located at VCUHS.

The effects of the slowing economy in 2008 contributed to growth in the VCC, where enrollment increased to a high of nearly 30,000 unique enrollees by October 2011. The cost of maintaining the structure of this program for this increasingly complex population was not sustainable, as it placed a significant financial burden on the VCUHS. Although a program evaluation had shown a decrease in use and costs precipitated on the establishment of continuous engagement with a primary care provider,2 additional strategies were considered to attain further quality, process improvements, and cost savings. It was determined that a redesign of the program, focusing on a population’s health outcomes and cost containment, would be the best strategy. It was believed that implementation of program changes would not only enhance the quality and cost-efficiency of the VCC program but provide a foundation for additional population management initiatives (PMI) under health reform.

RISK STRATIFICATION OF THE PATIENT POPULATION

The VCC program focused on the identification and management of patients with high-cost and high-use profiles. Many of these enrollees had multiple chronic conditions, resulting in substantial costs to the program. By providing targeted, aggressive care management and care coordination to these enrollees, the VCC PMI would be able to positively impact both the current cost trend as well as ensure better health outcomes for these enrollees.

Risk stratification of the population offered the best opportunity for targeting individuals with health profiles that would benefit from an enhanced care management model. A methodology to identify current and new enrollees was defined and developed, resulting in stratification into three care management Levels:

• Level 3: High risk for significant disease progression with high cost and use.
• Level 2: Stable, with moderate risk of disease progression or stable with risk of advancing to Level 3.
• Level 1: Accesses health “as needed” or episodically; low risk of increased healthcare needs.

Hospital, physician and pharmacy cost and utilization data was examined to initially stratify patients who were currently enrolled in the program; next, in order to identify patients who were in the early stages of their disease progression or were accessing care in an inappropriate setting, a second set of data elements was incorporated which are predictive of high cost and utilization: high frequency of ED visits, multiple unique prescriptions and certain targeted diagnoses (diabetes, COPD, CHF, CAD, bipolar, psychoses). Based upon the combination of costs and clinical indicators, enrollees were stratified into one of the three levels for care management. Those with highest rate of utilization and cost were assigned to the highest care management tier (Level 3).

As new applicants enter the program they complete a health intake screening document, which assists staff in determining the care management level that best matches the individual’s need. Questions include self-reporting of health conditions, usage frequency of the ED or hospital and the number of medications that have been prescribed by a provider. Respondents are also asked to rate their perceived level of health. A review of this information is completed by staff, with further clarification by the respondent if needed.

PLACING PATIENTS IN A MEDICAL HOME

As stratification was implemented, it was hypothesized that those enrollees who were identified as high cost, high risk and having complex chronic disease (Level 3) would benefit from a care delivery model utilizing an interdisciplinary team that is focused not only on the management of chronic disease but is designed to incorporate interventions to address psychological and social issues often impacting the population. The team was designed to include a primary care physician, nurse practitioner, clinical RN, RN case manager, social worker, pharmacist and a clinical psychologist who would provide a comprehensive and integrated approach to management of the enrollee’s complex needs.

The goal of the team is to provide the level of care management required...
to ensure appropriate use of services and to positively impact patient satisfaction and compliance. These interventions were designed to ultimately reduce the current cost trend as well as ensure better health outcomes. "Care coordination delivers health benefits to those with multiple needs, while improving their experience of the care system and driving down overall healthcare (and societal) costs.""

The VCC Complex Care Clinic was established on November 1, 2011. Prior to assignment to the clinic, patients are informed of the clinic services and consent is obtained to designate this site as their medical home. As a member of the team, patients are actively engaged in problem identification and prioritization to promote engagement in the process and management of care. The interdisciplinary team works in concert with the patient to identify interventions that are needed to improve their health and well-being.

All team members’ skills are utilized to develop treatment plans, education and support. For example, if a patient who has diabetes is having difficulty managing their disease, the team works with the individual to identify all factors impacting their ability to manage their condition and achieve optimal health. The inability to be compliant with the treatment plan may be caused by low health literacy, unemployment or anxiety due to financial instability. The team works with the patient to understand their condition, promote compliance with the treatment plan and address other factors that are impacting their chronic disease status.

An example of the support provided for this patient would include the social worker assisting the enrollee in developing job-seeking skills and the psychologist actively teaching stress management skills to reduce anxiety. The RN case manager follows up with the patient on an agreed-upon schedule assessing their compliance with the treatment plan and actively assisting in solving problems and challenges that they face, between clinic visits. Clinic visits are typically weekly until it is determined that the enrollee is engaged in the plan and their condition is stabilized.

**LESSONS LEARNED**

Since the implementation of the VCC Complex Care Clinic, more than 400 patients have received care utilizing this innovative model of care delivery. The ability to monitor utilization trends and health outcomes to assess the impact of interventions is critical. This assessment assists in implementing modifications on a timely basis and identifying opportunities for additional quality improvements and cost savings, which has helped to determine the effectiveness of the program. Analysis of data comparing the cost of care before and after enrollment in the clinic showed a 49 percent reduction in hospital costs from November 1, 2011, to October 31, 2012. Upon further examination, inpatient costs dropped 66 percent and emergency department costs fell 36 percent. Patients report high satisfaction with the model of care.

The VCC program is applying additional quality and process improvement interventions to implement best practices in population health management. This includes engaging the community PCP network in two quality improvement initiatives. The first is a focus on reduction of hospital readmissions. Evidence suggests that enhanced care coordination where providers see their patients within 14 days of discharge helps to reduce 30-day hospital readmissions. According to one research study: "Although patients may receive discharge plans from a nurse or social worker, they may not fully understand follow-up care instructions or have the ability to appropriately self-manage their care. Oftentimes, patients do not receive physician or nurse follow-up calls or do not visit their PCPs in a timely manner following discharge."46

The second quality measure focuses on improved management of care of the diabetic population through a multipronged approach incorporating PCP engagement; RN case management-focused interventions and a partnership with the local YMCAs in the provision of health and exercise classes for the targeted population.

The development and implementation of health insurance exchanges and Medicaid expansion requires rapid action plans to address the needs of this challenging, soon-to-be-insured population. Careful consideration must be taken when developing systems of care for individuals who previously were un- or underinsured and rarely experienced chronic care management. Program design must include the inclusion of resources to address the impact of psychological and social issues. The introduction of access to preventive healthcare and consistent management of chronic disease enhances the delivery model for the most vulnerable populations that will have access to Medicaid in the future. In addition, modifying the traditional models to include care management supports a population that requires a targeted approach to care in order to manage the available resources and accomplish the goals that are intended by the implementation of the ACA.

**REFERENCES**


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