Interdisciplinary Team Approach to Acuity-Based Case Management

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Background
The concept of case management (CM) was developed and is currently being utilized. The pilot started on October 8, 2014 and will run through May 2015. As part of a case management transformation, a large health plan client offered Alere an opportunity to develop and implement a pilot program. Historically, only two levels of high intensity—high touch and high cost case management were offered. One level was a high intensity program with 100% of participants receiving an onsite visit by the primary case manager at time of initial assessment. The second level was a moderate high intensity level delivered telephonically by the primary case manager. The care plan and interventions were carried out by primary case managers. The intent of the pilot is to provide case management services to a larger segment of the population with the goal to provide the appropriate level of intervention based on a participant’s acuity. Therefore, an acuity-based model within an interdisciplinary team approach was developed. The pilot design enables the use of the existing case management documentation platform and utilizes standard data feeds from the client to start the case finding/enrollment process.

Objectives
This paper provides a blueprint for case management within a one-day Interdisciplinary Care Team (ICT) and envisions an interdisciplinary team approach to a larger segment of the population who receive case management services.

Design/Methods
This pilot is an acuity-based program. The program is based on the participant’s individualized needs assessment, required contact frequency and interdisciplinary Case Team reviews and recommendations. The participant can move between acuity levels as appropriate to ensure the right level of management at all times. An acuity assessment may be offered for high acuity participants. Each participant is assigned to an ICT. The ICT consists of the following members: participant, primary case manager, case management physician, community assessment specialist, community resource specialist, pharmacist, physician specialist, behavior health specialist, social worker and is selected on the basis of the participant’s needs.

Acuity-based case management within an interdisciplinary team provides CM services to participants at the opportunity time by the appropriate healthcare professional. This provides participants with the tools required to take informed decisions to improve their health outcomes and quality of life. Outcome measures include improved quality measures, reduced healthcare spending, increased patient satisfaction and improved goal achievement.

CONCLUSION
This model was developed as a strategic response to the following issues:

• The need to be able to improve engagement and ensure early intervention with participants.
• The need to reduce the fragmentation that occurs due to organizational silos and provide a continuum of care across multiple care settings and providers.
• The need to be able to expand the participant criteria for case management in order to broaden the population who receive case management services.

ACUITY GUIDELINE

<table>
<thead>
<tr>
<th>Acuity</th>
<th>High</th>
<th>Medium</th>
<th>Low</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case Maturity Target</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Steady State</td>
<td>3-4 months</td>
<td></td>
<td></td>
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<tr>
<td>Initial</td>
<td>3 months</td>
<td></td>
<td></td>
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<tr>
<td>Terminal Care Planning</td>
<td>1-3 months</td>
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</tbody>
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Basic Overview of Interactions
- IMS will make contact, follow-up assessment, may require weekly contact or more often care management, may extend period of treatment plan.
- May offer an at-home visit.
- Issues with care gaps will be addressed in a monthly clinical review with CM physician.
- Bi-weekly contact by RN and/or other members of ICT.
- Issues with care gaps will be addressed in a monthly clinical review with CM physician.
- Only requires monthly outreach by one of the members of the ICT.
- Minimal contact.
- These may be short-term cases, who will see less than one week or a few weeks.

Qualitative (needs) Assessments

• These members do not understand their condition or treatment plan well; they don’t have a good relationship with their providers; very little caregiver or family support; are non-adherent to their medications and/or don’t understand why they are taking them.
• Needs to address at least two or more of these issues.
• Terminal care planning that requires face-to-face conversations.
• May have multiple providers and need education on at least four areas.
• Two hospitalizations in past 3-6 months.
• Acute pain or symptoms not well controlled.
• Significant physical and/or psychological deficit.
• Endocrine dx.
• Respiratory conditions.
• Neurological diseases.
• Acquired brain injury.
• Multiple trauma.
• Severe, very complicated conditions.
• Azalea pain or symptoms at 3 to 4 or a 4-1 scale management.
• Multiple providers of care with poor understanding of plan.
• Repeated hospitalizations/ER with required issues.
• Early stage cancer.
• Non-complicated breast, prostate and skin cancers.
• Patients that require a FDA and have limited gaps or barriers, may require only one additional follow-up call.
• New co-morbid dx.
• Orthopedic surgical patients.
• Chronic pain or acute pain associated with an event such as surgery that can be managed without difficulty.
• New to care, needs support with education, limited # of providers.

Methods

<table>
<thead>
<tr>
<th>Goal Achievement</th>
<th>Total # of Case Maturity Levels</th>
</tr>
</thead>
<tbody>
<tr>
<td>Steady State</td>
<td>Total Maturity Plans</td>
</tr>
<tr>
<td>Initial</td>
<td>4 10 14 19 20 21 27 33 39 49 64 128</td>
</tr>
<tr>
<td>Terminal Care</td>
<td>Planning</td>
</tr>
</tbody>
</table>

CONCLUSIONS

- The need to improve engagement and ensure early intervention with participants.
- Engagement Rate increased significant increase in engagement rate and adherence.

- The need to reduce the fragmentation that occurs due to organizational silos and provide a continuum of care across multiple care settings and providers.
- Average successful contacts
  - Lower 2 successful patient contacts per month
  - Moderate 3 successful patient contacts per month
  - High 4 successful patient contacts per month
- Goal achievement: 92% goal achievement.
- The need to expand the participant criteria in order to broaden the population who receive case management services.
- Expanded eligibility criteria lead to increased enrollment into a case management program.