Interdisciplinary Team Approach to Acuity-Based Case Management

Susan Garcia RN, BSN, CEN; Barbara Kelly Hayward RN, BSN, CCM | Alere Health, Marietta GA

Background

This model of case management (CM) was developed and is currently being piloted. 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 moderately high intensity program 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.

Objective

This poster provides a blueprint for case management within an Interdisciplinary Care Team (ICT). The interdisciplinary team has a great promise to deliver improved participant care and outcomes; however it is not widely implemented in case management. 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.

Design/Methods

This model is an acuity-based program. The program is based on the participant's individualized needs assessment, required contact frequency and Interdisciplinary Care Team reviews and recommendations. The participant can move between acuity levels as appropriate to ensure the right level of management at the right time. An onsite 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, primary care physician, case management assistant and an enrollment specialist. Ancillary healthcare professionals, such as a pharmacist, nutritionist, community resource specialist, community assessment specialist, physician specialist, behavioral health specialist and social worker are added to the team based on the participant's needs.

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

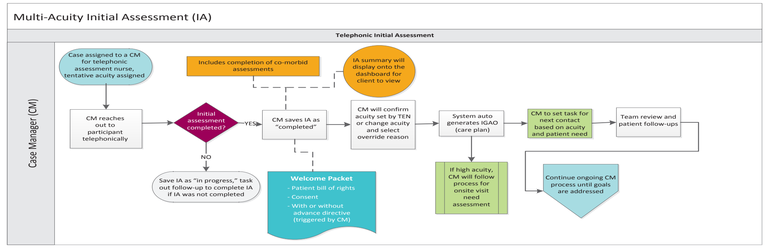
INTERDISCIPLINARY CARE TEAM (ICT)

ICT Members:	Ancillary Healthcare Professionals: *(added to the ICT based on the participant's individualized needs)*
Participant (Patient/Member)	Pharmacist
Primary Case Manager (RN)	Nutritionist
Case Management Physician	Community Resource Specialist
Care Support Manager (RN Supervisor)	Community Assessment Specialist
Primary Care Physician	Physician Specialist
Enrollment Specialist	Behavioral Health Specialist
Case Manager Assistant	Social Worker

ONSITE (HOME) ASSESSMENT CRITERIA

- Participant does not have a stable or appropriate living situation
  - » Participant's location is unsafe or inappropriate for the care level required
- Medication issues
  - » Lack of knowledge, taking multiple meds, unable to reconcile over phone
- Caregiver coping issues
  - » Participant requires caregiver, but capable caregiver is not available
  - » Participant does not have adequate support system
  - » Caregiver is not coping effectively with participant's need
  - » Caregiver issue(s) prevent participant's adherence to treatment plan
- Safety issues
  - » Participant's location is unsafe or inappropriate for the care level required
  - » Functional barrier(s) prevent participant adherence to treatment plan
- Terminal care planning that requires face-to-face conversation
- Non-compliant cycles
- Other
  - » Language/cultural barriers

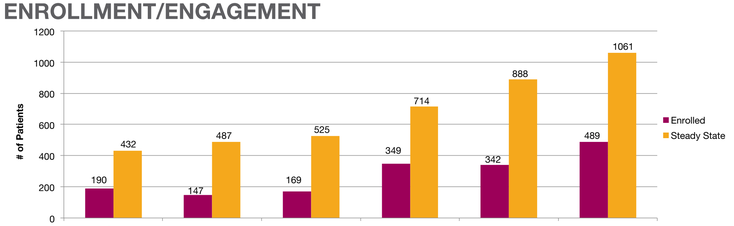
Methods



ACUITY GUIDELINE

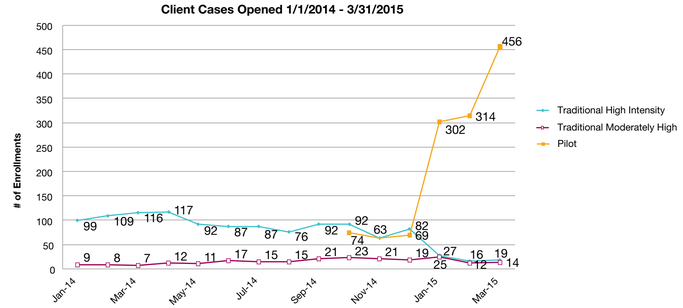
	High	Medium	Low
IA	Telephonic	Telephonic	Telephonic
Case Maturity Target	3-4 months	3 months	1-3 months
Basic Overview of Interactions	• RN will make contact, follow-up assessment, may require weekly contact or more often • May be offered an onsite visit • Issues with care gaps will be addressed in a 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 • Only one required clinical review • These may be short-term cases, okay to be less than one month
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/no caregiver or family support; are non-adherent to their medications and/or don't understand why they're taking them	• Needs between low and high	• These members have needs and qualify for the program, but mostly understand their condition and its progression; they have a fairly good grasp of their treatment plan and good relationship with providers; adequate caregiver and/or family support is in place
Basic Criteria Guideline	• Late stage cancer • Severe burns • Spinal cord injury • Acquired brain injury • Multiple trauma • Neurological diseases with significant defects and psycho/social issues • Severe, very complicated co-morbidities • Acute pain or symptoms at a 3 or 4 on a 1-4 scale management • Multiple providers of care, poor or no understanding of tx plan • Repeated hospitalizations/ER without resolved issues	• Moderate stage cancer • Circulatory (such as severe peripheral vascular disease) • Digestive conditions • Endocrine dx • Respiratory conditions • Neurological diseases • Fewer co-morbidities • Chronic pain w/ moderate control • May have multiple providers and need education on tx plan • Two hospitalizations in past 3-6 months with continued risk for readmission	• Early stage cancer • Non-complicated breast, prostate and skin cancers • Patients that require a PDA and have limited gaps/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 tx, needs support with education, limited # of providers

ENROLLMENT/ENGAGEMENT

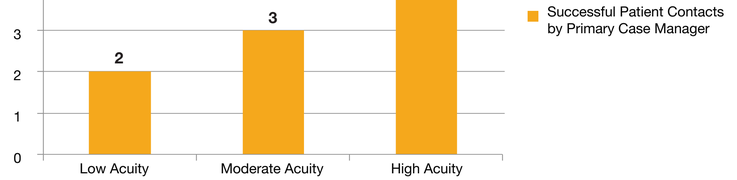


Results

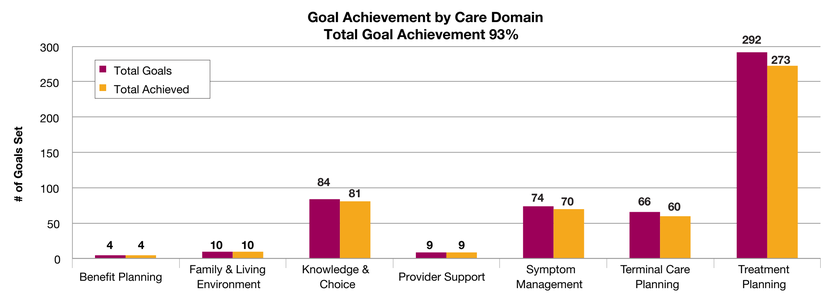
ENROLLMENT COMPARISON



AVERAGE SUCCESSFUL CONTACTS PER MONTH TO PARTICIPANTS



GOAL ACHIEVEMENT



Conclusions

- The need to improve engagement and ensure early intervention with participants.
  - » **Engagement Rate Increased: significant increase in engagement, too early in pilot to determine percentages**
- 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
  - » **Low: 2 successful patient contacts per month**
  - » **Medium: 3 successful patient contacts per month**
  - » **High: 4 successful patient contacts per month**
- Goal Achievement
  - » **93% 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**