

CDE's as Care Managers

AADE

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Ann Larsen RN, CDE

Ginny Burns BSN, MEd, CDE



Overview/Objectives

1. Describe the evolution of Care Management at Intermountain Health Care
2. Define Health Literacy and how we assess patients
3. Evaluate Hartford Grant Outcomes (CDE/CM's—Are they worth it?)



Healthcare is increasingly complex and costly

40 Years Ago


- 1 doctor
- In-patient—Acute
- 650 medications
- 1 Pharmacist
- Avg. Rx cost \$3.25

Today

- Multiple providers
- Out-patient—Chronic
- 24,000 medications
- Chain drug stores
- Avg. Rx cost \$28.74
(\$96.01 brand)



Intermountain Healthcare climate is changing

- Acute Care  Chronic Care
- How we responded:
 - Put Diabetes Educators in Clinics with ADA Recognition
 - Set up Care Management in Primary Care Practice
 - Mental Health Providers in Clinics



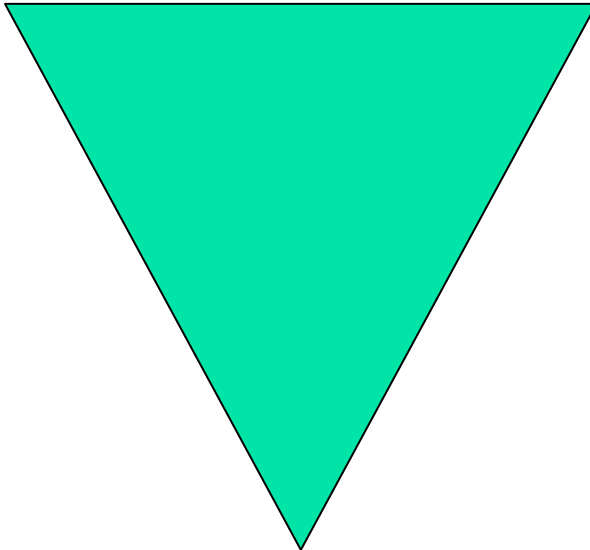
Pilots/Grants

- Hartford Foundation
 - Intermountain HC Established CM Program
 - 2002—06 “Measure impact of CM”
 - Develop tools for Care Managers
- Robert Wood Johnson
 - Mental Health Integration into Primary Care

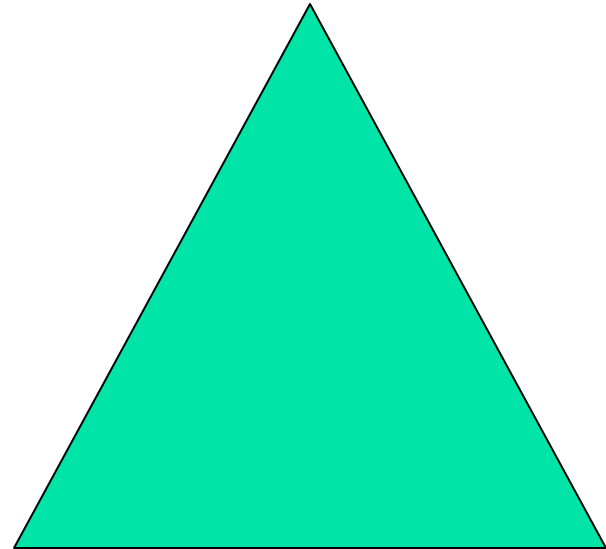


Model Description

CM in one clinic



CM in multiple
clinics





Definition of Traditional Care Management

“A collaborative process between patient, physicians, and care team which assesses, plan, implements, coordinates, monitors, and evaluates options and services to meet an individual’s health needs through communication and available resources to promote quality and cost-effective outcomes”



How is this role different

- Based in Physician office—Patient's Medical Home
- "All about teams"
- Follow patient over a lifetime
- Treat the "whole" patient & family
- Flexibility with types of encounters (time)
 - One on one, MD office visit, class, group, home, phone & texting
- Promote change
- Focus on:
 - Prevention/Wellness/Independence



Goals of CDE's as CM's

- Assist physician (too little time)
- Address medical & emotional needs of chronically ill, complex patients
- Identify barriers
- Facilitate communication between team/providers
- Educate, motivate, coach
- Connect to community resources (bridge the gaps)
- Support care givers
- Promote Self-management—Teach when to call
- Follow Best Practice (CPM, National Clinical Guidelines)
- Improve outcomes



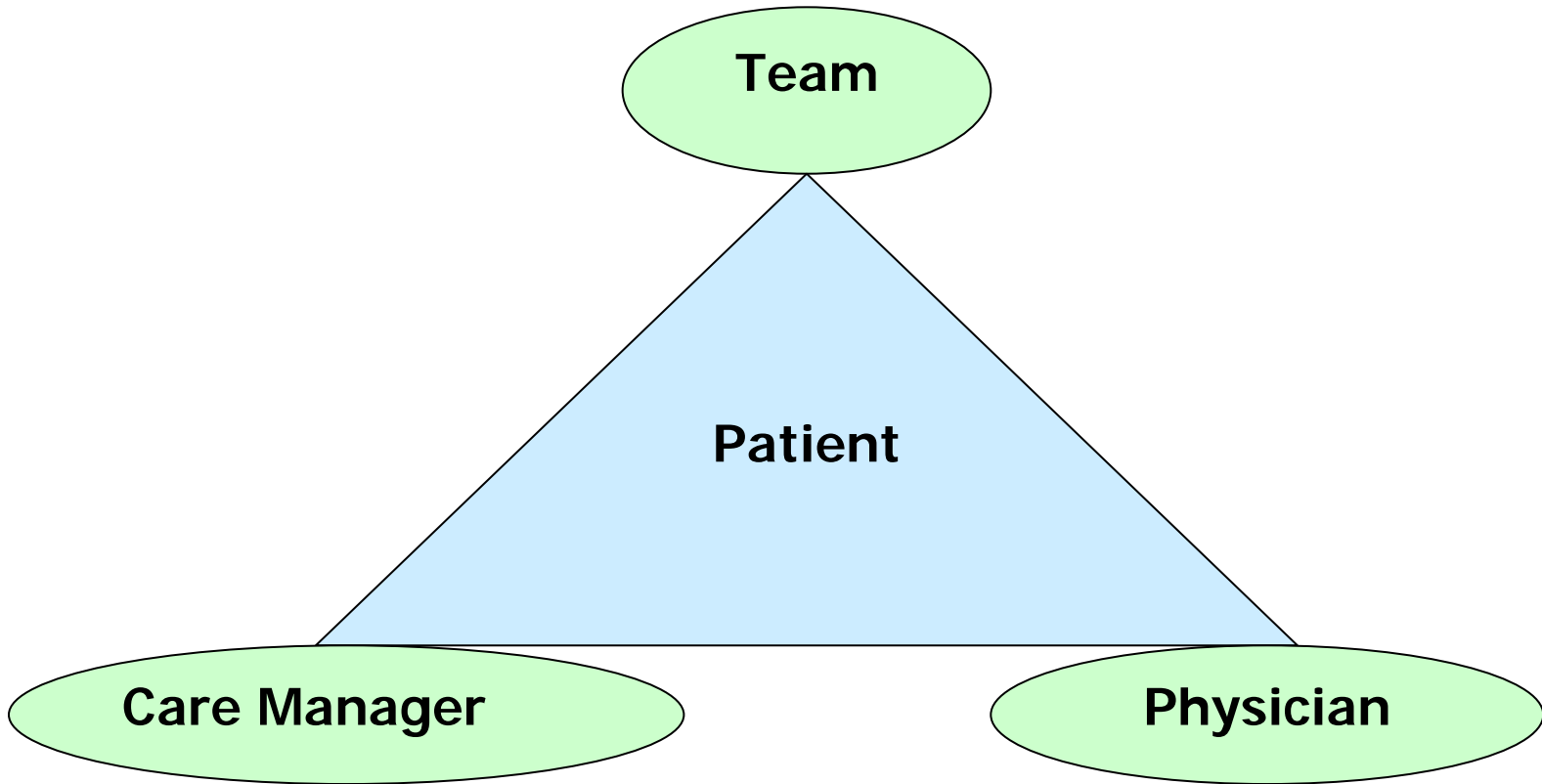
"Do you want to speak to the man
in charge or the nurse who knows
what's going on?"



Primary Care Teams

- Patient
- Care Managers
- Physicians
- Clinical Staff
- Clinic Management
- Support Staff
- **“Its all about the team”**

Patient Centered Care



Based on Relationships and Trust

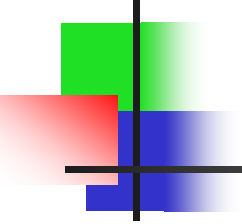


Team Communication

Levels of Building Trust

1. Identify problem
2. Identify and take to team
3. Identify—take to team--w/ solution in mind
4. Identify—collaborate w/ team to solve problem

Key is to determine *how* to interface with the team and physician



Relationships are the Key to Success!!

“INVISIBLE SIGN”



Types of Referrals

- High Risk, high demand
- Chronically Ill
- Medically Complex
- Frail/Elderly
- Disease Management
 - Diabetes
 - Depression/Mental Health
 - Screening all patients
 - “Sad or blue” & “Lost interest”



Assess

- Determine type of visit
- Detective—Salesman--Coach
- Look at the whole picture & beyond
- Adapt to their educational needs & learning style
- Identify barriers
- Get the right resources
- Provide support
- Be Flexible



How to:

- Start with biggest concern “Ask”
- Motivational Interviewing—elicit—provide--elicit
- Family Pattern Profile—“Who do you talk to?”
- Readiness to change/Stages of Transition
- Maintain Clear Boundaries
 - “less is best”
 - “Who’s working harder?”

*** Match the Intervention to the patient ***



“Individualize” the Intervention

- Traditional
 - Make the individual “Fit” our process
- Individualize
 - Focus on individual needs
 - “Customize” the interventions to “Fit” the individual



An Innovative Idea:

“Health Literacy”



Health Literacy Definition

The ability to read, understand, and use health information to make appropriate healthcare decisions and follow instructions for treatment



Why is Health Literacy Important ??

- Have poorer health status
- Use fewer preventive services
- Misunderstand their diagnosis and treatment plans
- Have less knowledge of disease management
- Exhibit poor adherence
- Have higher hospitalization and ER use



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Low health literacy costs the health care industry \$90 billion a year in misdirected or misunderstood health care services.



Problems Identified

26%

did not understand when their
next appointment was
scheduled

(Sources: Williams MV, Parker RM, Baker DW, Parikh NS, Pitkin K, Coates WC, et al. Inadequate functional health literacy among patients at two public hospitals. *JAMA*, 1995;274:1677-1682.)



Problems Identified

42%

did not understand instructions
to "take medications on an empty
stomach"

(Baker DW, Parker RM, Williams MV, Pitkin K, Parkh NS, Coates W, et al. The healthcare experience of patients with low literacy. *Arch Fam Med.* 1996;5:329-334.)



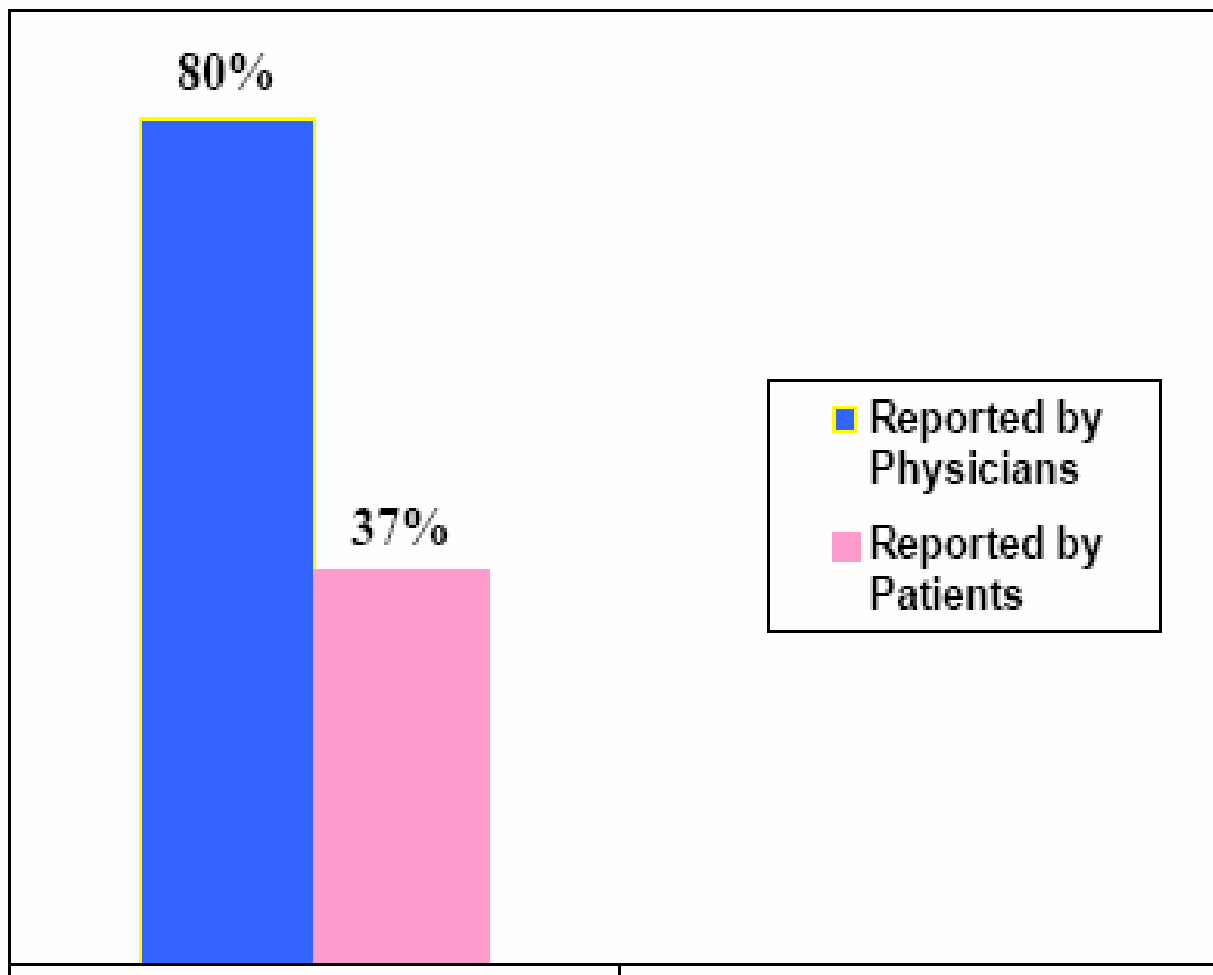
Problems Identified

86%

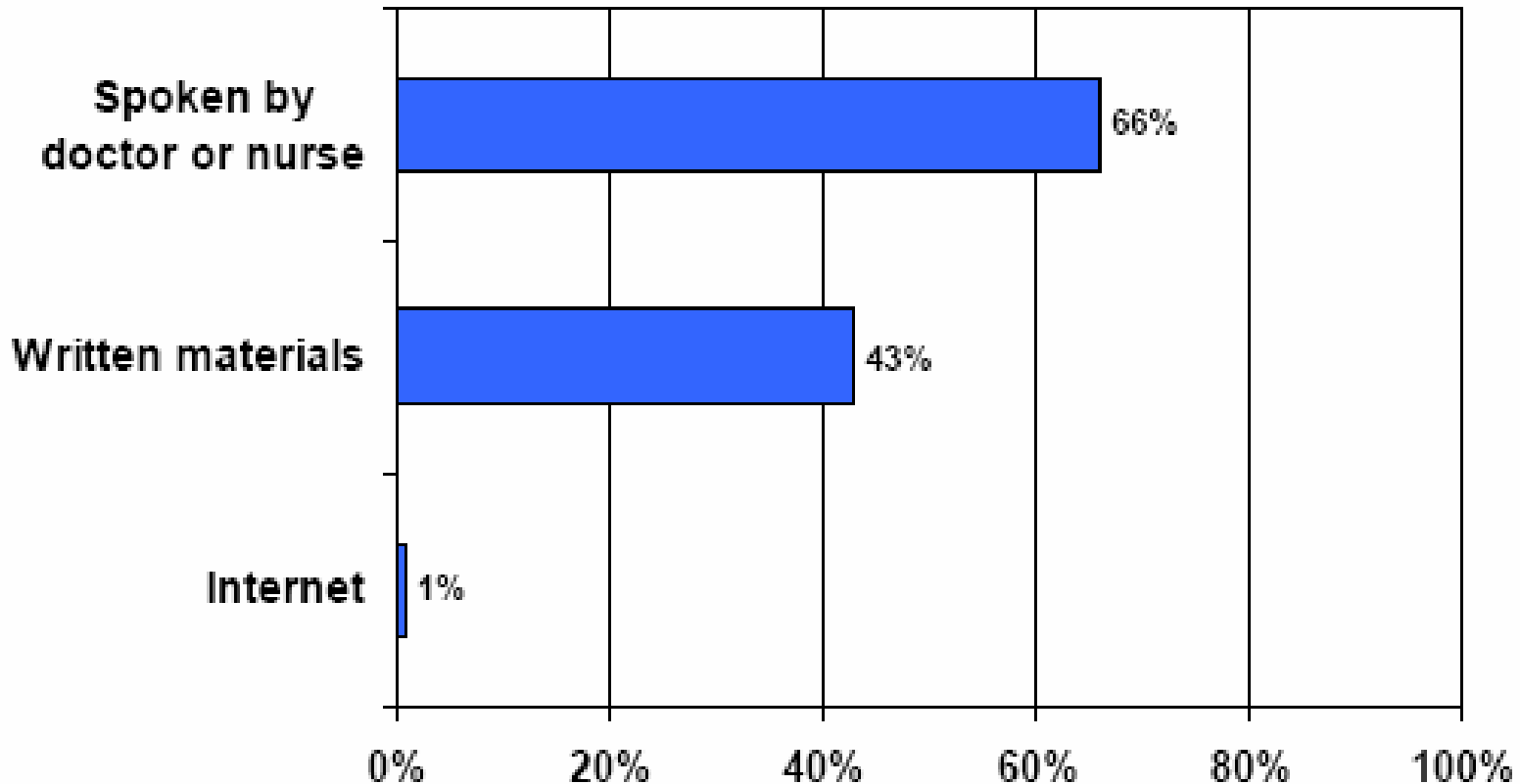
could not understand the
rights and responsibilities
section of a Medicaid
application

(Fact Sheet: Health Literacy and Understanding Medical Information. Lawrenceville, NJ: Center for Health Care Strategies; 2002.)

Patients Leaving the Physician Office With a Good Understanding of What They Are Told



How Would You Prefer to Receive Health Information?



Responses combined from 4 clinics

Note: Percentages total more than 100% because multiple responses were allowed



Neighborhood Clinic: Key Findings

- **50%** don't feel very sure they are taking the medication correctly
 - **96%** cannot read or cannot easily understand the instructions – language barriers
 - **58%** missed taking the medication
 - **68%** missed because cannot afford to pay
-



Key Findings: Senior Clinic

- **37%** don't feel very sure they are taking the medication correctly
 - **40%** cannot read or easily understand the instructions
 - **24%** use mail order
 - **41%** missed taking the medication
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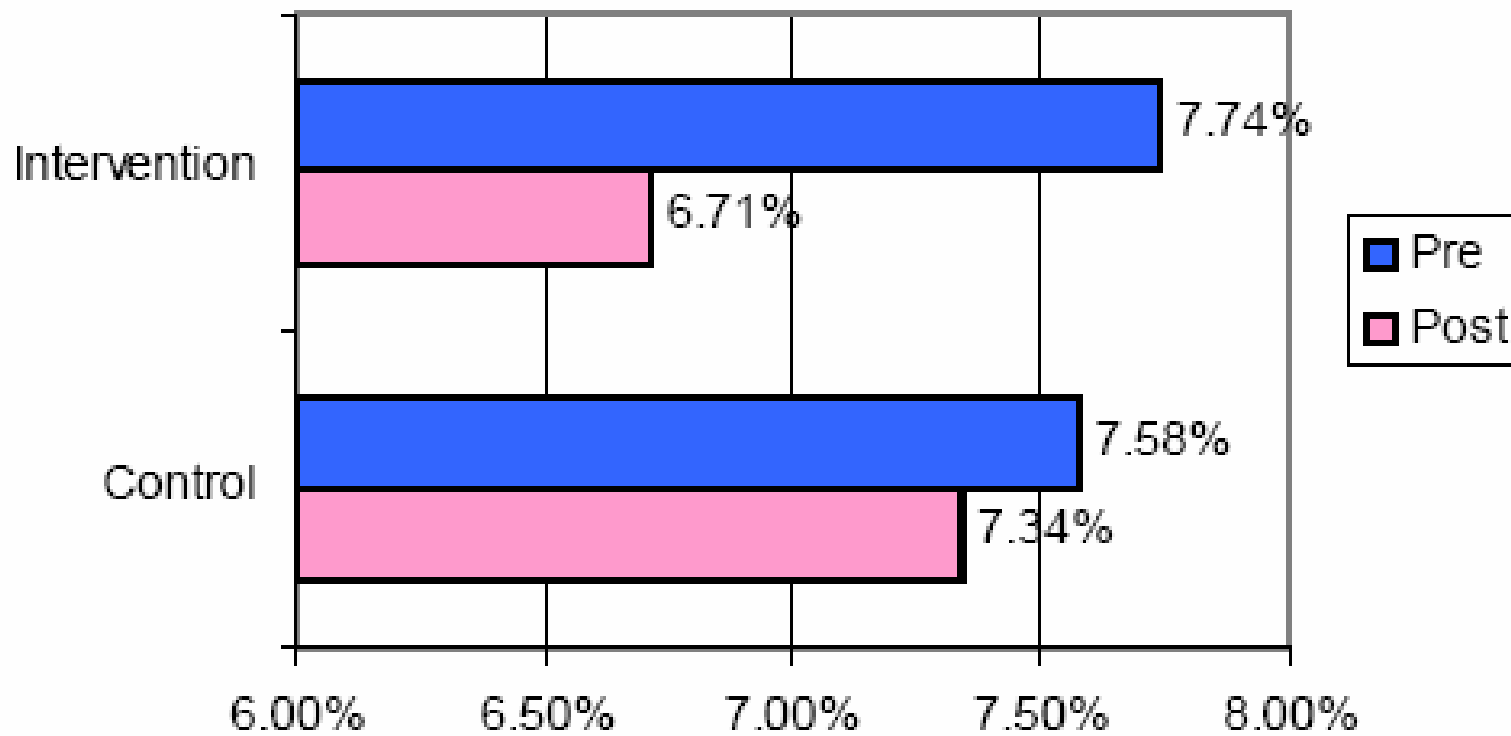


Outcomes

A1c levels:

- In the neighborhood clinic, A1c levels decreased more for the intervention group (from 7.7% to 6.7%) than for the control group (from 7.6% to 7.3%), although the difference in changes was not statistically significant due to the relatively small sample size.
 - A1c levels were not assessed in the senior clinic
-

Comparison A1c level

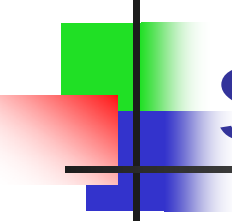




Tips for Educators

- Create a shame-free environment
- Communicate clearly and simply
- “ASK—how do you like to learn”
- Teach in ways the patient learns best
- Verify Understanding (confidence rating)

“One on one” is the most effective !



What gets in the way of self care?????

- Life
- Mental Health
- Other chronic conditions

Literacy skills often affect a person's health literacy BUT NOT ALWAYS



"Tale of Two Men"



Hartford Grant Outcomes

- Improved Diabetes Control
- Decreased Mortality
- Decreased Hospitalization
- Improved Satisfaction
- Increased Physician Efficiency

("Dorr and Brunker, caremanagementplus.org ")

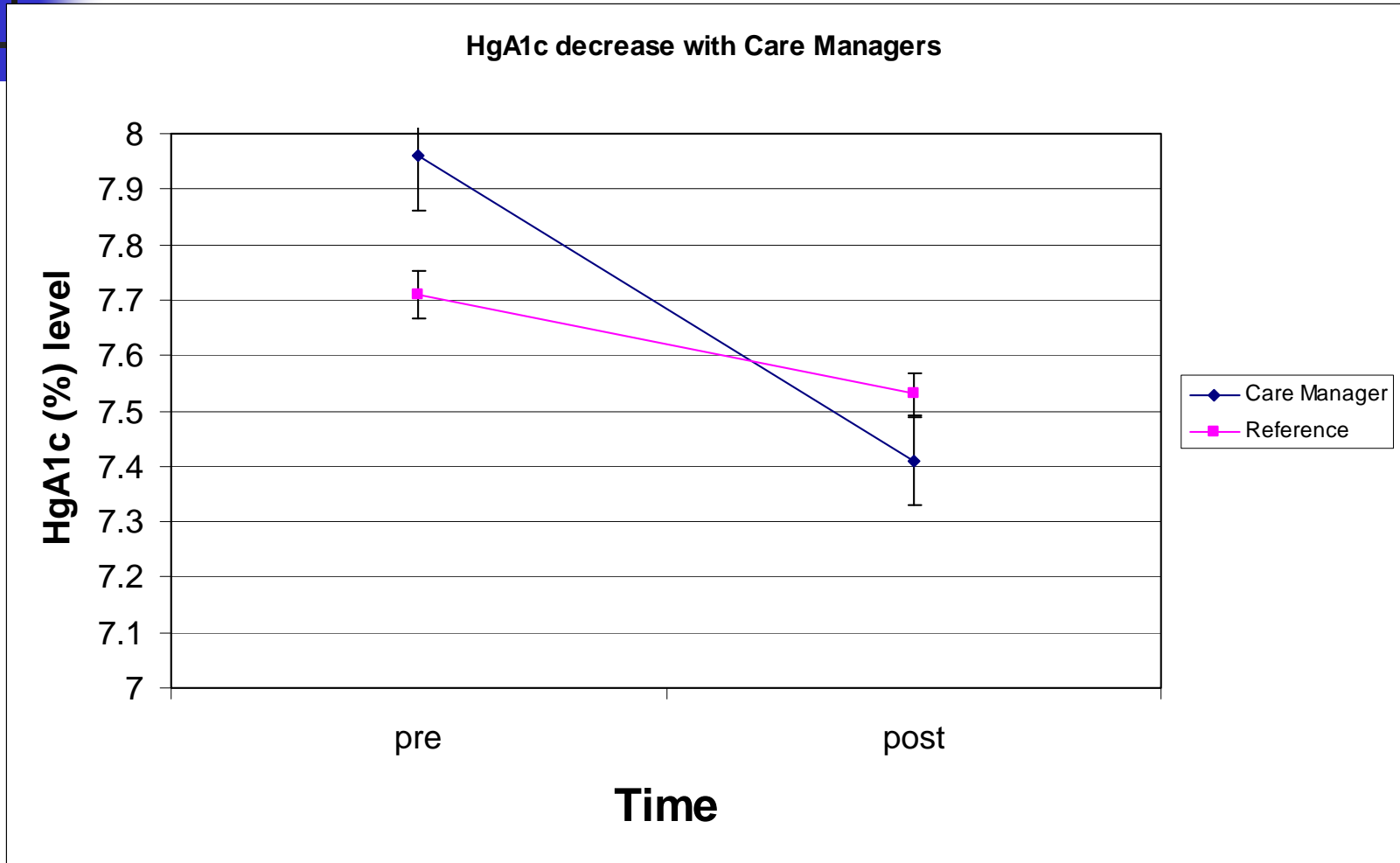


Diabetes

- Patients were more likely to get their HbA1C level tested, and more likely to get tested on time (OR= .79, $p < .01$)
- Patients sent to care managers had worse HbA1C control (average 7.97%) than other patients before being sent, and better control after care management (OR = 1.31, $p < .01$)

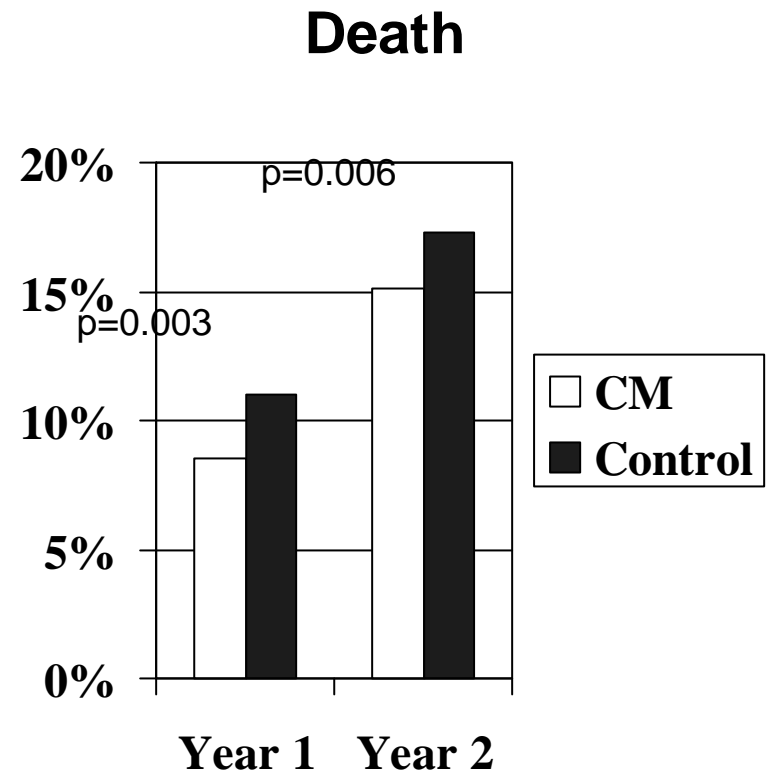
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Diabetes Outcomes



Diabetes Outcomes

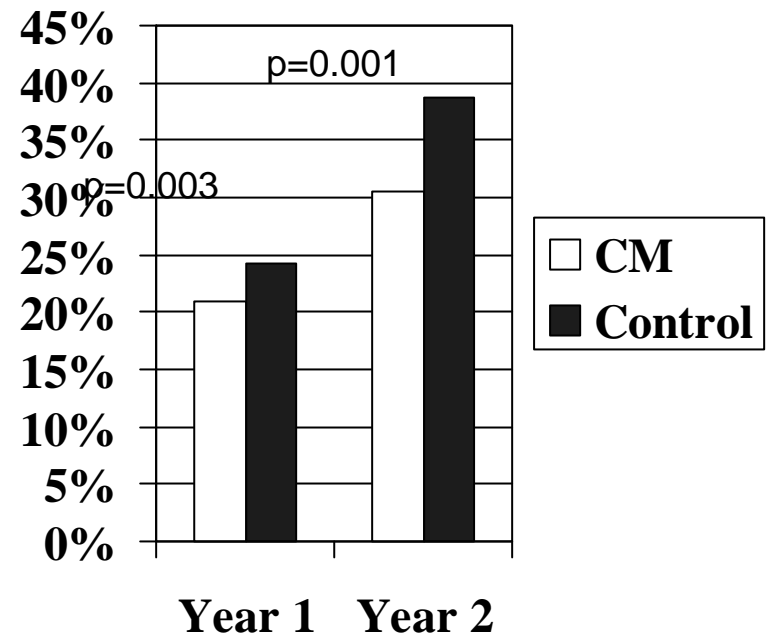
- Patients who were sent to care managers were significantly less likely to die in the first and second year



Diabetes Outcomes

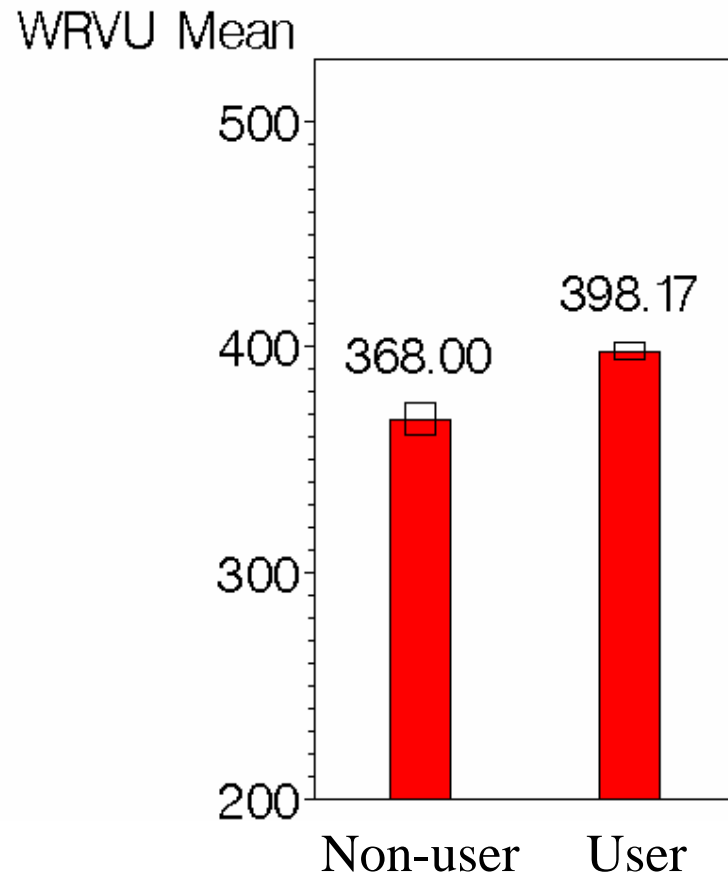
- Patients who were sent to care managers were significantly less likely to be hospitalized in the first and second year

Hospital Admission



Physician Productivity

- Physicians who referred to care managers for any reason were 8% more productive than their peers in the same clinic.



8%



CDE's as CM's...Grant Results

- Education and motivational counseling for guideline adherence and disease self-management
- Connecting patients to community resources
- Facilitating necessary communication among providers
- Coordinating care and problem solving
- Cost Effective and financially viable
 - URN 4 CM's in each of our Primary Care Clinics
 - UCR added 4 CM's multiple clinics
 - CM position is funded by the Physicians



Opportunity for Innovation

- \$2.5 Million Hartford Grant to expand CMP (Care Management Plus) to other sites
- CM training
- Patient Summary Worksheet
 - Registry
 - EMR summary
 - Alerts/reminders
- Care Management Tracking Database
 - Diabetes
 - ADA Recognition
- Websites: (caremanagerplus.org)
(intermountainhealthcare.org/caremanagers)



Summary

- Clinic based CDE/CM's make a difference
- Health Literacy focus improves outcomes
- Hartford Grant expands the opportunity for Care Management at other sites
- Integrating Mental Health into Primary Care



Questions
