

Care Coordination in Wyoming

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Presented by:

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Goals for Today

Enhance current knowledge or learn something new

- Discuss the Chronic Care Management (CCM) pilot program in Wyoming
- Demonstrate the impact of team-based care and care coordination on the lives of patients
- Discuss the effect of team-based care and care coordination on the culture of the practice



About Us

We are collaborative.

Part of a national network of quality improvement organizations; operate locally to improve health care by supporting providers, practitioners, patients and other stakeholders

We provide solutions.

To achieve better care and better population health and to lower health care costs through quality improvement

We are nonprofit.

Contract with Centers for Medicare & Medicaid Services (CMS), Office of Rural Health, FLEX grants, state departments of health and several other funding sources



Brandi Wahlen

- Over 15 years in health care
- Four years of experience supporting hospital and physician practices through state and federal reporting programs
- Works with facilities on various improvement projects
- Born and raised in Wyoming

Chronic Care Management

Wyoming

About the Project

Mountain-Pacific Quality Health is bridging the gap between health care professionals, patients, families and community through chronic care management (CCM).

Rapid Cycle Transformation

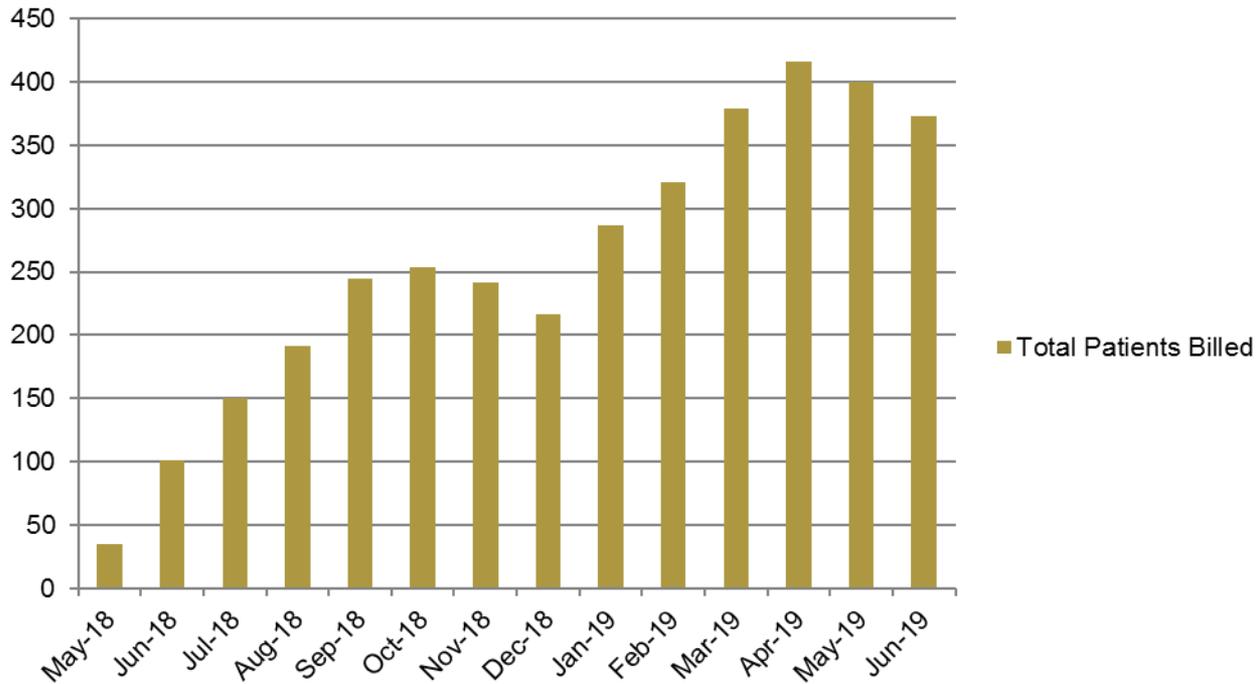
- Workflow Assessment
- Tools and Supplemental Resources
- Orientation and Training of Staff (Primary Care Coordinators for CCM)
- Share Best Practices
- Supportive Environment for Continued Learning (Transitional Care Management [TCM], Annual Wellness Visit [AWV] and Advanced Care Planning [ACP])

Timeline

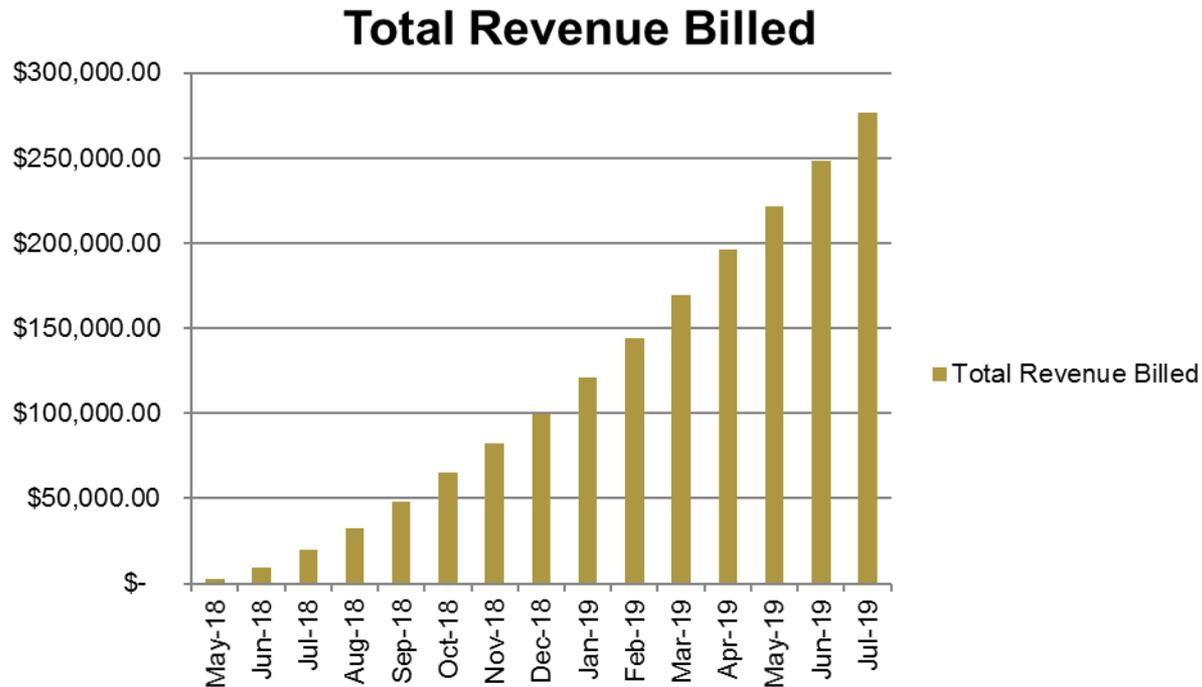


Chronic Care Management

Total Patients Billed



Chronic Care Management





**Micki Lyons,
NP-C**

- Over 15 years experience in the field of nursing
- BSN from University of Wyoming in 1999
- MSN, FNP from University of Mary in 2013
- Currently working on DNP in Organization Leadership through University of Mary
- Currently employed as a Family Nurse Practitioner/ Clinics Manager at Crook County Medical Services District

Chronic Care Management



- Implementation Started in May 2018
- Started with RN Care Coordinator in Place
- Goal: 10 CCM Enrollments per Month
- Slow Start to Enrollments
 - One enrollment in first month
 - Two enrollments in second month
- Transitioned Three Care Coordinators
- 62 Patients Currently Enrolled

Practice Culture

How has the CCM pilot project effected the culture of your practice?

- Improved identification of patients that would benefit from chronic care management
- Improved communication between primary care provider (PCP) and outside resources
- Improved communication with care transition
- Improved communication between patients and PCP
- Improved medication reconciliation



Challenges

What were some of the challenges experienced?

- Care Coordinator also working in emergency room (ER)
- Three care coordinators in a year
- Nurses not documenting in CrossTX
- Providers not identifying potential CCM patients
- Lack of training to hospital staff

How have those challenges been overcome?

- DNP project to implement CCM program at CCMSD
- Formal education process
- Full-time Care Coordinator
 - Nurse that is proactive versus reactive is key to success
- QAPI project to improve nursing documentation
- Medical staff training to providers on CCM program

Recruits

What patients do you recruit and why?

- Eligible Patients Being Seen in the Clinic
- Patient with Supplemental Insurance
 - No Co-Payment for Patient
- Patients with Complex Co-Morbidities
 - Specifically Patients with DM, CHF, COPD, Asthma, CAD, A-fib
- Eligible Patients Discharged from ER or Hospital

Care Coordinator

What patients do well on CCM and why?

- Patients with Complex Co-morbidities
 - Having someone to keep patients on task with clinic visits, recommended labs and medications
- Patients that See Specialists
 - Coordination of care between PCP and specialists
- Patients on Multiple Medications
 - Care Coordinator provides education on using medication appropriately
 - Medication reconciliation
- Patients Living at Home with Few Resources
 - Care Coordinator provides support and access to resources

Our Enrollment Process

- Identify CCM eligible patients with Medicare Part B and those with a supplement and two or more chronic conditions from electronic health record (EHR) report
- Care Coordinator communicates closely with billing department on insurance coverage
- Care Coordinator follows clinic schedule and meets with CCM eligible patients prior to provider visit
 - Has enrollment paperwork ready
 - Gets written consent for those that are agreeable in the room
- Care Coordinator meets with CCM eligible inpatients prior to discharge to discuss program and how she can manage transition of care

Patient Satisfaction

What do patients say they like about CCM?

- Communication with PCP and specialists
- Someone to call with questions
- Someone to help patients and families get information
 - Medical Records
 - Answers to Questions



Misunderstandings

What do patients say they DO NOT like about CCM?

- Patients state they do not understand why Medicare is spending money on this service
- Some with co-pay do not want to pay
- Do not feel they need the service
 - State they feel they are managing well
 - Don't feel that they need help

Care Plan Progress

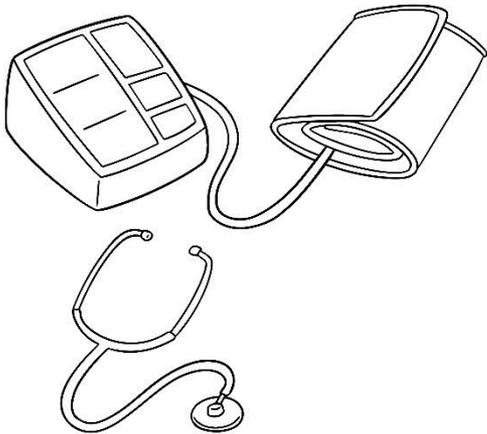
Do you feel patients are making progress with their own care plans?

- Communication Between PCP and Specialists
- Remaining at Home



Expanded Services

What would you like to expand with your CCM program?



- Medicare Annual Wellness Visits
- Advanced Care Planning
- Discharge Planning
- Behavioral Health
- Self-Measuring Blood Pressure, Blood Glucose and Weights

Impact of CCM

How has the CCM program impacted the internal team?

Negatives

- Staff has frustration with duplicate documentation
- Providers express frustration with CrossTX and having another system to navigate

Positives

- Improved communication between Diabetic Educator and Pulmonary and Cardiac Rehab Staff
- Improved adherence to clinic visits
- Keeping patients out of the ER or bringing them to the ER before they are really sick
- Improved transition of care
- Added a vital staff member in Care Coordinator

Program Evolution

What would you do differently if you started over?

- Full-time Care Coordinator
- Improved provider and staff education prior to implementation
 - Formal education program
 - PPT, hand-outs, FAQs, contact information
 - Part of new employee training
- Better understanding of available community resources
- Post-Implementation survey for improvements



**Nahida Khan,
MD**

- Attended medical school at Ross University School of Medicine in Dominica
- Completed her residency in Internal Medicine and completed a Fellowship in Geriatric Medicine at Mount Sinai School of Medicine in New York City
- Is currently practicing at Campbell County Medical Group's Main Clinic
- Hobbies include: Hiking, Reading, Traveling
- Attempted 2/7 Summits (Kilimanjaro/Elbrus)

Patient Case Study #1

- 78 F w/ PMhx DM, OSA, Hypothyroidism, HL, chronic LBP
- Soc Hx: widowed. One son diagnosed w/ Multiple Myeloma. Second son undergoing gender reassignment.
- Meds: Lantus, Novolog, levothyroxine, gabapentin, metformin, Hydrocodone
- Multiple visits to ER for LBP
- Unable to carry out ADLs

Patient 1: Concerns/Needs

- Polypharmacy
- Pain
- Fall risk
- Depression/anxiety
- RESPITE

Patient 1: Chronic Care Management

- Coordinate nursing home (NH) stay for four weeks
- Post-discharge medication management
- Coordinate care with other specialists

Patient 1: Most recently...

- Pt following through with appropriate providers r/t pain control (pain specialist and ortho)
- Pt considering behavioral health counseling

Patient Case Study #2

- 69 F legally blind w/ PMhx of DM, CAD, CHF, Neuropathy, HTN, RLS, PVD, hypothyroidism, Asthma
- Social Hx: widowed. No children. Relatives out of town.
- Meds: Insulin, levothyroxine, bumetanide, atorvastatin, coreg, Trulicity, oxycodone ER, percocet, potassium, macrobid, fosamax, ropinirole

Patient 2: Concerns/Needs

- Uncontrolled DM-can't check glucose
- Managing medications
- Learning to adapt to vision loss
- Transportation
- ADLs/IADLs

Patient 2: Chronic Care Management

- Worked DM educator for Libre CGM system
- Privately paid homecare to help w/ IADLs
- Assessing future financial needs (e.g., Medicaid)

Patient 2: Most recently...

- Reports:
 - Using her Libre CGM system effectively, very pleased no finger sticks
 - Medication management with assist. of paid caregivers

Patient Case Study #3

- 65 M PMHx of DM,HTN,CAD,CHF
- Soc Hx: Lives alone
- HbA1c: 12.1
- TSH: 51
- LDL: 233
- Meds: Lantus BID, Lispro TID, Levothyroxine, Plavix, coreg, crestor, lisinopril, spironolactone, metformin, aspirin

Patient 3: Concerns/Needs

- Medication compliance
- Did not like measuring glucose
- Motivation

Patient 3: Chronic Care Management

- PH-RN medication management- weekly visits
- Daily reminder calls
- Given pillbox
- Reminder calls for labs and visits

Patient 3: Most recently...

- Going for daily walks
- Still not monitoring glucose
- Hba1c: 7.9 (↓ from 12.1)
- TSH: 1.55 (↓ from 51)
- LDL : 59 (↓ from 233)



Maureen Hurley
BSN, RN

- Currently Chronic Care Coordinator for Campbell County Health Clinics (AKA, Healthcare Concierge)
- 25 years Home Health and Hospice, Dialysis, Medical-Surgical, Maternal-Newborn
- Born and raised in Brooklyn, NY
- Resident of Wyoming for 40 years
- Married 38 years
- Four sons and four (soon to be five) grandbabies (four of them boys)

Chronic Care Management at Campbell County Health

- Approximately 75 patients from Internal Medicine Practice, Complex Medicine Practice and Family Practice
- Team-based care, initiated most often with the PCP, then referral to CCM
- CCM utilizes resources throughout the community, based on needs identified by the patient on their plan of care

What's working

- **Abundance of resources in the community**
 - Comprehensive Health Care System
 - Public Health Nurse
 - Community EMS
 - Wyoming Independent Living
 - Library outreach
 - Senior Citizen Center (transportation, MOW's, in-home services, etc.)
 - Parks and Recreation Center
 - Council of Community Service
 - Department of Family Services
 - Medicaid Waiver Programs
 - Salvation Army
 - Veteran Services
 - In-Home Care (non-medical)
 - Churches
 - Community Education Programs and Support Groups

What's working (con't)

- A few providers proactive in CCM referrals
- A large population of qualified patients, growth potential is significant
- Tools provided by Mountain-Pacific, as well as our health care organization (educational tools, remote monitoring tools, etc.)

And, the obstacles...



Obstacles...

- Complex patients with many needs
- Selling CCM services to stakeholders
- Program in infancy stage, quickly moving to toddler stage...
- Human resources, there never seems to be enough
- Three clinics, one care manager

NUKA

- “Nuka” is an Alaska Native word that means strong, giant structures and living things
- Nuka is the name of Alaskan’s Southcentral Foundation health care system which provides comprehensive, team approached health care
- 65,000 Alaska Natives referred to as “customer-owners,” not patients
- Focus is on the customer-owner unique story
- **97% customer-owner satisfaction**
- **95% employee satisfaction**

SUCCESS

Thank You!