MedStar Family Choice

Knowledge and Compassion
Focused on You

MedStar Family Choice (MFC) Case Management Program

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MCAC June 24, 2015

Case Management Program
Presentation Overview

- CM Programs
  - Disease Management
  - Complex Case Management
- CM Program Structure
  - Specific DM and CCM Programs
  - CM Staffing
  - Supplemental Staff and Resources (Care Coordination, Outreach)
- Program Examples
  - Diabetes DM
  - Complex Case Management
- Community Outreach and Education
- Needs Assessment & 2015 Initiatives

Case Management Program
Overview of Programs

Case Management Program has 2 major components:

1. Disease Management Programs (8 conditions)
2. Complex Case Management Program

DM and CCM programs follow standards set by:

- **NCQA**
- **DHCF contract**
- Case Management Society of America
- Evidence-based bodies of knowledge (ADA, MedStar Clinical Practice Guidelines, NIH, CDC, ..)

Case Management

Definition of Disease Management (NCQA)

A *multidisciplinary, continuum-based approach* to health care delivery that *proactively identifies populations* with, or at risk for, established medical conditions.

Case Management

Disease Management Programs

1. Adult Respiratory
2. Pediatric Asthma
3. Cardiovascular/Heart Failure/Hypertension
4. Diabetes
5. Early Intervention/Children with developmental and mental disability and delay
6. High Risk Pregnancy
7. HIV/AIDS
8. Substance Abuse/Behavioral Health

Case Management

Definition of Complex Case Management (NCQA)

Coordination of care and services provided to members who have experienced a *critical event or diagnosis* that requires extensive use of resources and who need help navigating the system to facilitate appropriate delivery of care and services.

Case Management
Complex Case Management Program

MFC inclusion criteria:

- Transplants
- Catastrophic Conditions
- Chronic Obstructive Pulmonary Disease (COPD)
- Special needs populations (not covered in DM program)
- Multiple chronic illnesses + high utilization
- Identified on High Utilization Reports
  - > 2 acute care admissions per month
  - > 6 different prescribers of medications
  - 'Top Ten Members by Expense' list and >$150,000 in expenses over rolling 6 month period

Case Management
Staffing

10 RNs – coordinate medical programs

2 SWs – coordinate SA/BH programs; provide SW support

1 LPC (Licensed Professional Counselor) + 1 Peer Support Worker

- for Intensive BH Case Management (through ValueOptions)

2 CM Assistants

1 RN Supervisor

1 RN Director

Supplemental Staff
Outreach, Care Coordination and Education

1. Wellness and Preventative Care Coordinators

Conduct Health Risk Assessments on new members

- May identify members for DM or CCM Programs or in need of other services

Provide Outreach Wellness Programs

Programs: Diabetes, Pregnancy, Post-Partum, EPSDT and Well Woman

- Staff identify gaps in care via multiple data bases (reports, registries, EHRs, etc)
- Provide members with coaching, assistance with appointments and follow up

2. External Outreach Workers

- Bilingual staff assist in locating members for HRA, Wellness Programs and CM Programs by phone and in person in the community

3. Community Relations Associates

- Educate community on benefits, wellness, chronic conditions, CM programs
- Partner with Outreach and CM staff in planning and staffing events

Case Management
Standard CM Processes for DM and CCM

1) Identification – referrals, reports, CM records, UR, EHR
2) Engagement - calls, letter, face-face visit
3) Assessment – standardized; outcome used to stratify
4) Stratification – low to high intensity level interventions
5) Interventions – based on stratification and goals
6) Treatment plan - mutually agreed upon goals

❖ Member remains in program until goals are met or contact is lost

Case Management
Identifying Members

- Referrals – self, provider, agencies, hospitals
- Health Risk Assessment
- Claims and encounter data
- Pharmacy and lab data
- UM and CM data/processes
- ER Review Process
- New member orientation
- Community events
- Disease Monitor (disease specific reports from McKesson system)
- EHRs (when applicable)

Case Management
Assessment

- Each DM Program has a *specific assessment tool*
- Per NCQA, standard assessments must be performed *initially and periodically* to monitor progress
- Assessments follow NCQA standards and include:
  - Condition monitoring (including self-monitoring and medical testing)
  - Patient adherence to the program's treatment plan and medication
  - Medical and behavioral health co-morbidities
  - Health behaviors
  - Psychosocial issues
  - Depression screening
  - Information about the patient's condition provided to caregiver with patient's consent
  - Encouraging patients to communicate with their practitioners about their health conditions and treatment
  - Additional resources external to the organization, as appropriate

Disease Management: Diabetes

Types of Interventions

- Initial and monthly assessment/barrier analysis
- Treatment Plans
- Interaction with providers
- Hospital visits
- Assistance with MD appointments (accompany if needed)
- Education regarding medications
- Dietary education to meet member needs
- Facilitation of self-management
- Blood glucose monitoring
- Coordination of DME--Ensure proper/working equipment
- Advocacy
- Access to appropriate services (transportation, housing, food, smoking cessation programs)
- Encouragement to achieve goals
- Community education

Disease Management: Diabetes
Stratification Levels

Eligibility: Diagnosis of Diabetes

Stratification:

Interventions:

- **High Risk -Level 3**
  - Newly diagnosed
  - 1 related ER
  - 1 related hospitalization
  - Direct or self referral to program
  - New insulin pump
  - A1C test 9 or higher

  Telephonic or face-to-face contact (as indicated by member need)
  Based on needs identified in assessment, Diabetes care interventions will be provided by some combination of the following:
  - Direct education by program coordinator (may be telephonic, in home or at MFC location)
  - Education with CDE or Nutritionist at hospital, private office or certified home care agency
  - Referrals to appropriate specialists (as indicated)

  Educational mailings

- **Medium Risk – Level 2**
  - Diagnosis of wound and not meeting other criteria

  Letter indicating importance of compliance with Diabetes management and wound care
  Quarterly educational mailing
  Letter explaining the Diabetes DM program, inviting member to call for enrollment or to contact program coordinator for assistance*

- **Low Risk- Level 1**
  - All members with Dx of Diabetes not meeting other criteria

  Quarterly educational mailing
  Letter explaining the Diabetes DM program, inviting member to call for enrollment or to contact program coordinator for assistance

*Any member with outstanding testing will receive a call from the Diabetes Wellness and Preventative Care Coordinator for assistance

Disease Management: Diabetes
Enrollment, Participation and Outcomes 2014

Enrollment and Refusals

- 446 Diabetes DM Cases initiated
  - 68 refusals

Measure Success-HEDIS	75th percentile
• A1c Testing Compliance: 81.57%	87.59 %
• A1c <8% Rate: 45.07%	52.89%
• Eye Exam Compliance Rate: 47.08%	63.14%
• Nephrology Compliance: 78.65%	83.11%

Complex Case Management Program
Enrollment, Participation and Outcomes 2014

Enrollment and Refusals

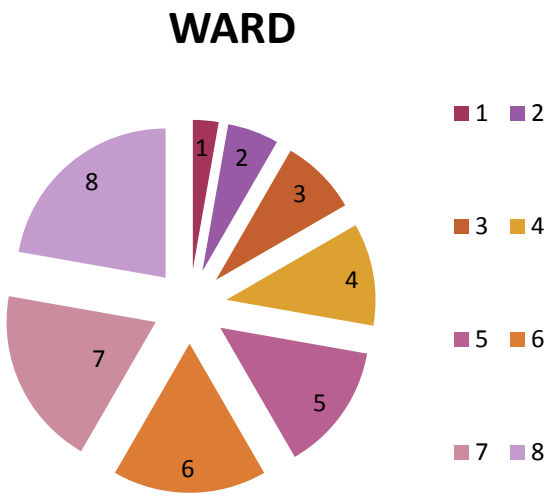
- 162 Cases initiated, 0 refusals

Measure Success

- Percentage decrease in ED and urgent care visits 90 days pre and post-case origination:
  - 72% decrease in ED and urgent care visits was achieved. This exceeded the baseline goal of a 40% decrease in ED and urgent care visits by 32%.
- Percentage decrease in inpatient admissions 90 days pre and post-case origination:
  - 23% decrease in inpatient admissions was achieved. This was a notable decrease, but did not meet the goal of a 30% decrease

Community Relations Programs
Key Outreach Events

MSFC Members



MFC signature events and key partnership outreach events target the highest membership Wards: 4,5,6,7 and 8. These events contribute to community health awareness, provide health education and screenings and engage members in case management opportunities.

Outreach efforts in each Ward (per quarter):

- 1- 2 signature events
- 2 – 4 Health education initiatives (smoking cessation, HPV, others) based in schools and faith-based institutions and community-based initiatives
- 2 – 3 General information initiatives

Targeted Latino community initiatives:

- 1 – 2 exclusive outreach events and/or initiatives with FQHC partner
- 2 - 3 Community-based organization partnership events

Community Relations Programss
Screening and Education

80 percent of Outreach initiatives provide health screening and education. These services are provided in collaboration with Case Managers and strategic partners:

- Diabetes
- Asthma (Adult and Pediatric)
- Heart Disease
- Hypertension
- Tobacco Cessation
- Obesity (Pediatric and Adult)
- Breast Cancer
- Dental

Community Relations Programs

Cultural Initiatives & Partnerships

- Beat the Streets
- Nationals Night Out
- Ward 8 Turkey Giveaway
- MLK Parade and Community Fair
- Heart Health Month– African American Focus
- School-based Black History Month initiatives
- Black AIDS Day outreach and screenings
- Congress Heights Day and Parade
- Annual Ward Day Family Celebration- DC Wards
- Partnerships with Greater Washington Urban League, Ward 8 Health Council, Ward 7 Health Alliance
- Hispanic Heritage

Case Management Program
Annual Needs Assessment & Initiatives

- An annual 'Needs Assessment' is conducted of member needs and effectiveness of CM programs
- Some of the 2015 Initiatives:
  - –Hepatitis C DM Program
  - –NavigatER Program at MWHC
  - –Telemedicine Pilot
  - – MFC Clinic Days (reserved blocks of primary care appointments)
  - – ZocDoc – online provider find and appointment scheduling system
  - – Bedside medication delivery prior to hospital discharge
  - – Expanded web access –health information, self assessments, care coordination
  - – Enhanced CM software capabilities – new system will provide data integration and analytics