Overview: Henry Ford Health System

- **Henry Ford Health System**, one of the country's largest, most comprehensive and integrated health care systems links together inpatient, outpatient departments, primary and secondary care, preventative care, community care services (dialysis, home health care, hospice and community retail services), a health insurance plan and acute care and speciality care, backed by excellence in research and education. *Winner 2011 Malcolm Baldrige National Quality Award.*

- HFHS includes the 1,200-member Henry Ford Medical Group, five medical/surgical and two psychiatric hospitals, over 30 primary care sites throughout southeast Michigan.

- Medical Home includes over 200 primary care, family practice physicians and pediatricians in 26 BCBSM PGIP-Designated Medical Center sites.
Overview: Henry Ford Health System

- Provider Delivered Care Management Pilot involved:
  - > 50 Primary Care Physicians at 4 PGIP Medical Home Designated Medical Centers:
    - Detroit Internal Medicine- Campus of Henry Ford Hospital
    - Taylor
    - Sterling Heights
    - Fairlane
  - 2012- Spread CM to all 26 Medical Ctrs.
Patient-Centered Team Care (PC-TC)
Ambulatory RN Case Management Model for High-risk Patients

- Patients with chronic disease-DM, COPD, Depression, Asthma, HTN, CKD, CAD, HF
- Patients with disease process and self-management knowledge deficits that significantly impact health
- Patients with social or economic difficulties that impact health
- Patients with frequent ED/Urgent Care visits
- Patients with multiple hospital admissions
Staffing Model

Registered Nurse Case Managers

- Part of the Primary Care Clinic team which includes; physicians, residents, nurse practitioners, registered nurses, medical assistants, clinic service representatives, clinical pharmacists, diabetes educators, dieticians and administrative assistants

- Case Manager (CM) credentials- RN with minimum (3) three years of nursing experience; strong problem-solving, analytical and decision making skills; excellent customer service and interpersonal skills including the ability to interact with internal and external customers and all levels of the organization required

- Pilot sites selected based on high prevalence of chronic disease with ~ 34% total HFMG CD population covered at ~1:3500 CM to patient ratio
Case Manager Training Requirements

- Chronic Disease competency training online/checklist demonstration
- Health Coaching/Self-Management - 3-day course in Health Coaching, Stanford Chronic Disease Self-management Program, several CCM certified
- Lean workshops
- IMPACT Model: Improving Mood - Promoting Access to Collaborative Treatment
  - Problem-Solving Therapy partnership
  - Evidenced-based counseling technique that helps reduce depressive symptoms impacting disease self-management
  - Short-term, goal focused, empowers the patient
  - Expands CM skill set w/applicability across all diseases they manage
Practice Role Versus PO Role

- Role of the PO in the Care Management process:
  - Primary Care Steering Committee- direct oversight in development of Patient Centered Transformation, implementation of PCTC-CM, Diabetes Care Centers, Depression Care Program, Anticoagulation RN Program, Polypharmacy Program→ now transformed to MiPCT Steering Committee
  - Involved in hiring process and evaluation of CM
  - Program oversight with monthly full-day staff meetings committed to systems approach to education, process development, documentation, performance improvement, policy and protocols, team building/networking, review of outcome metrics/performance measures, & employee engagement

- Role of the practice in the Care Management process:
  - CM direct report to nursing supervisor; considered part of the clinic team
  - “Physician-Guided Care Team Rounds” to facilitate patient care planning
  - CM and physician meet weekly for 20-30 minutes and as needed (also as needed with other members of the team)
Lessons Learned/Barriers

- Acceptance of new role- what helped?
  - Planning and preparation with sites
  - Primary Care Development Team support
  - Primary Care Learning Collaboratives
- Continuous education in large, complex system
- Complex data reconciliation process within an all-payer model
- Practice standardization and ongoing re-design- LEAN
  - CMs became LEAN savvy and joined re-design teams
- No high-risk stratification process to define CM population
  - High risk for readmission process developed later with recent enhancements of electronic medical record.
Lessons Learned/Barriers

- Duplicate documentation in first year was a dissatisfier until case management notes were created with EMR enhancements.
- Application beyond depression for problem solving therapy techniques learned
  - CMs required to complete 13 modules and 9 audio-taped patient problem solving therapy sessions with expert critique and debriefing sessions with Impact Trainers
  - Computer lab sessions with role play and debriefing sessions with Behavioral NP and Clinical Psychologist
  - Review MiPCT list for certification requirements
# PC-TC CM Initial Visit Documentation in EMR

**Patient Name:** FLINTSTONE, FRED  
**DOB/Age/Gender:** 01/01/1948 63y Male  
**Location:** HF, HF Medical Center-Columbus INTERNAL MEDICINE

**MRN:** HF 92079097  
**Service Date/Time:** 02/15/2011 15:13  
**Provider:** ADRIENNE WILLIAMS-LUCKEY (UAT)  
**Responsible Staff:** ADRIENNE WILLIAMS-LUCKEY (UAT)

### Visit Detail

- **Encounter**
  - **Visit date:** 02/15/2011  
  - **Location:** HF, HF Medical Center-Columbus INTERNAL MEDICINE
- **Encounter type**
  - Office visit  
  - Phone encounter

### Providers

- **Case manager**
  - Administrative Data  
  - Clinic RN  
  - Clinical Pharmacist  
  - Education Program Follow-up  
  - ER Discharge Process  
  - HAP  
  - Home Health Care  
  - IPD Discharge Process  
  - Nurse Practitioner  
  - Patient  
  - Patient Family Member  
  - Primary Care Physician  
  - Sub Specialist

- **Referral source**
  - PCP

### Disposition

- **Disposition**
  - Accepted Case Management Intervention
  - Refused Case Management Intervention
  - Not responding to outreach
  - Case Management Not Appropriate

### Acuity

- **Level 1 - Intensive Treatment Phase**
- **Level 2 - Active Treatment Phase**
- **Level 3 - Lifestyle Management Support Phase**
- **Level 4 - Maintenance Phase**
- **Level 5 - HOLDING (care coordination)**
### Past Medical
- **Benign Renovascular Hypertension**, onset Bef. 02/14/2011
- **Sedative, Hypnotic or Anxiolytic Dependence, Continuous Use**, onset 01/31/2011
- Ischemic stroke (disorder), onset 01/24/2011
- Bronchoscopy (procedure), onset 01/20/2011
- **Other Malignant Secondary Hypertension**, onset 01/20/2011
- **Atrial Fibrillation**, onset 01/17/2011
- **Pain in Joint Involving Ankle and Foot**, onset 01/14/2011
- **No History of Arrhythmia**, onset 01/06/2011

### Clinical
- At risk for falls
- Blood Pressure not in control
- Difficulty sleeping
- Extreme stress and anxiety
- Fasting Blood Sugar out of control
- Pain not in control
- Positive Depression Screen
- Underweight

### Behavioral
- Alcohol abuse
- Current smoker
- Not following disease management plan
- Not following prescribed diet
- Not taking medications as prescribed

### Knowledge
- Difficulty understanding disease management plan
- Difficulty understanding diet
- Difficulty with self-management skills

### Social
- Does not have support in the home
- Difficulty with transportation
- Does not have necessary DME
- Difficulty affording health care services
- No patient advocate designee
- Difficulty affording medications
- Difficulty with activities of daily living

### Miscellaneous
- Does not have an emergency plan in place
- Frequent hospitalizations
- Frequent Emergency Department visits
- Recent IPD Discharge
### Referrals and Interventions

#### Interventions
- Community resource information
- Disease management education and counseling
- IPD Discharge Follow-up Assessment
- List of free clinics
- Medication compliance education
- Medication reconciliation
- Nutrition Support Services
- Preventative Care Education and Counseling
- Self-Management training and support
- Weight loss counseling and support
- Problem Solving Therapy for Depression
- General Problem Solving Therapy
- Discharge Follow-up Assessment
- Other

**Interventions performed**

#### Referrals

<table>
<thead>
<tr>
<th>Category</th>
<th>Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral Health</td>
<td></td>
</tr>
<tr>
<td>Behavioral Health Services</td>
<td></td>
</tr>
<tr>
<td>Depression Management Nurse Practitioner</td>
<td></td>
</tr>
<tr>
<td>Community Agencies</td>
<td></td>
</tr>
<tr>
<td>Area Agency on Aging</td>
<td></td>
</tr>
<tr>
<td>Community Agency</td>
<td></td>
</tr>
<tr>
<td>Family Independence Agency</td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
</tr>
<tr>
<td>Diabetes in Active Control</td>
<td></td>
</tr>
<tr>
<td>Diabetes Self Management Education Program</td>
<td></td>
</tr>
<tr>
<td>Palliative Care</td>
<td></td>
</tr>
<tr>
<td>In-Home-Palliative Care Program</td>
<td></td>
</tr>
<tr>
<td>Palliative Care Clinic</td>
<td></td>
</tr>
<tr>
<td>Hospice</td>
<td></td>
</tr>
<tr>
<td>Providers</td>
<td></td>
</tr>
<tr>
<td>Clinical Pharmacist</td>
<td></td>
</tr>
<tr>
<td>Dietician</td>
<td></td>
</tr>
<tr>
<td>Home Health Care</td>
<td></td>
</tr>
<tr>
<td>MSW</td>
<td></td>
</tr>
<tr>
<td>Nurse Practitioner</td>
<td></td>
</tr>
</tbody>
</table>

*Using telemedicine service for Heart Failure*
Why We Think This Works....

- Case Managers are located in the clinics and work closely with the physicians and clinic staff and document in the EMR.
- Physicians introduce the CM concept, role and value of working with a case manager to patient.
- Easy access to PCP to address any urgent issues.
- Physician-Guided Care Team Rounds to facilitate care planning
  - CM and physician meet weekly
  - Entire care team huddles daily
- Case Managers use a tele-monitoring tool with select HF patients to help manage symptoms on a daily basis
- Patient advisors at pilot sites provided us with valuable feedback on materials, workflow concepts, tools we use—even our name “Patient Centered Team Care”
- Cultural transformation seen at the practice unit level
# Ambulatory RN Case Management Patient Feedback Survey

<table>
<thead>
<tr>
<th>My Case Manager</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. was friendly and helpful to me.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>2. was available to me.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>3. explained my chronic condition to me.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>4. listened to my concerns.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>5. used words I could understand.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>6. considered my views when planning my care.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>7. helped me choose goals that were appropriate for me.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>8. As a result of working with my case manager I am confident in my ability to better manage my health condition.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>9. I would recommend this case manager to others.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

Comments and Suggestions:  

__________________________________________  

__________________________________________  

If you would like to be contacted regarding any concerns, please leave a number and the best time to call.  

__________________________________________
Outcome Measures

- **Operations Measures**
  - Case load – acuity and complexity
  - Encounters, referrals, interventions, goal setting
  - Chronic disease competency education & check lists

- **Clinical Improvements**
  - A1c Control
  - LDL-C Control

- **Utilization Reductions**
  - Inpatient Stays- Average Length of Stay (LOS)
  - Outpatient Visits
  - Emergency Department Visits (ED)

- **Patient and Provider satisfaction**
Additional Thoughts

- Need to identify patients that are most appropriate for CM – continuous reinforcement of inclusion/exclusion criteria for CM referrals

- Provide outcome reports and feedback to providers based on referral patterns

- IT support: Share data, share data again and when you think you have shared enough...share more data at practice unit level

- Communication in busy clinic environments is a challenge - huddles work!

- Physicians are looking forward to expanding CM to all HFMC sites, continued collaboration and networking through MiPCT