

# Care Coordination Case Studies

## Rural Health Innovations

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# TEXAS RURAL ACCOUNTABLE CARE ORGANIZATION

The primary purpose of this project is to support the formation, implementation and sustainability of a rural-focused Accountable Care Organization (ACO). The Network's providers deliver care in a region characterized by persistent poverty, high rates of chronic disease, and chronic health manpower shortages. A secondary purpose is to expand and enhance existing network programs—a Diabetes Self-Management Training program (DSMT), a Health Information Exchange (HIE) and a payer/managed care contracting program—to serve as the foundations of the ACO. (The DSMT and HIE are results of previous federal grant programs.)

The Network, through their project the "Texas Rural Accountable Care Organization" (TRACO), seeks to aid their region's rural hospitals and physicians, who are the Network Members, to meet CMS' triple aim of better health, better care and lower cost to the citizens in the region. A fourth aim, creating sustainable financial viability for the participating safety net providers, is essential for the future of rural Texas medicine.

## Care Coordination Approach

### Target Population

The Primary focus is to look at 10-15% of the costliest patients (per site), the data for what is causing them to be so expensive and then working with their providers to develop a care plan. Initial target population is traditional Medicare.

### Care Team

Their care team consist of utilizing social workers, transition nurses, care coordinators and the patient's provider(s). They are very site and patient specific, meaning every case is different and they may use a different model of care/approach for each patient.

### Engaging Patients

To engage patients they used the motto, "What can we do for you and/or how we can help you model."

### Business Model

- National Rural ACO (NRACO)

### How they are utilizing HIT

Each facility link their clinical flat files to lightening – so they can pull clinical quality measures. Primary task is the annual wellness visit. In the process of looking at templates and what their EHRs can work. Looking at codes to see if the codes are there – linking the service provided to the codes when the drop the bill it is all there. Link the G codes to the quality measures. Using the lightening data and crosslinking to the EHR data.

Care Plan – some EHR has CP templates. – CCM is the other template  
Nurse live is their example. There is a CP built into lightening.

## **Challenges and Lessons Learned**

- Cold Call is not an effective way of coordination. Instead they have learned that it is much easier to coordinate potential care coordination patients thru patient appointments where the physician introduces the care coordinator.
  - A few ways to engage with the physician, prior to meeting a potential care coordination patient, is to ask which patients have missed their appointments and/or share high ER utilization reports. Sharing patient specific Medicare claims data and discussing costly/high utilization patients with providers has increased the number of care coordination referrals as well as increased patient interest/participation in care coordination activities. They found that this approach leads to better outreach.
- The biggest challenge they face is that their RHC/FQHC members cannot bill for their care coordinator's services (CCM).
- Monthly call for all PM and CC and ask questions like; what is frustrating them? What are you seeing? How did you deal with this?
- Physician peer group calls to share best practices. For example, currently Annual Wellness Visits are a priority for the network. Current discussions include:
  - How are you tracking the quality measurement data in your EHR?
  - What percentage of time (provider) is spent with the patient versus what are you delegating to other staff?
  - How/what is your process in outreaching to patients regarding the Annual Wellness Visit?

## **What is next?**

- Continuing to utilize claims data to identify high cost patients
- Analyzing Part A claims data and where attributed patients are receiving other healthcare, the costs associated with these claims and next steps to potentially decrease healthcare costs
- Continuing to increase care coordination referrals and enrollment (the proposed 2016 physician fee schedule includes reimbursement to RHCs/FQHCs for CCM services)
- Continue to transition TCM (transitional care management) patients, as appropriate, into care coordination
- Quality measures- continuing to work with each member to ensure quality measures are captured appropriately in EHR systems in order to reduce the number of manual data extractions for quality reporting
  - In addition to using claims data to identify patient that are lacking quality measures and following up with the provider to schedule appointments
    - Annual Wellness Visits capture 11 quality measures during this 1 appointment

## KREIDER SERVICES

The “Pediatric Development Center” project (PDC) will serve children (ages 0-18) in Lee, Ogle, Carroll and Whiteside counties, who are exhibiting developmental, emotional, social, and/or behavioral concerns. The goal of this program is to make specialized pediatric services more accessible and decrease the time for children to receive an accurate diagnosis and needed treatment; thus improving the rural healthcare system for children. This project will improve the outcomes for children and their families through the PDC using a variety of creative and innovative strategies.

## Care Coordination Approach

### Target Population

Care Coordination services have been present in the community for several years and have been provided to children and families who are experiencing challenges accessing needed services to improve the social, emotional and behavioral functioning of at risk children. Referrals are received from a variety of sources including schools, social service agencies, primary care, and the juvenile court system. A recent refinement of the family care coordination program is to identify those children and families who may have been referred multiple times for services and are failing to engage or follow through. Children and families who drop out of services prematurely are also a priority. Efforts will also be directed towards educating pediatricians and family practice providers about the care coordination services in order to enhance cooperation and collaboration between medical and behavioral health care.

### Care Team

A Family Care Plan is developed with the family driving the components of the plan and determining who will be part of their care team/provider network. The care Coordinators will complete an assessment of the family’s needs and gather screening information on every family member to help determine who would be most helpful to the family and in what order services or concrete needs will be approached. Sometimes it is more urgent to get food on the table or utilities restored before other therapies can be initiated. The model is family centered and strengths based.

### Engaging Patients

Family Care Coordinators are selected for their roles in large part because of their personality and knowledge of the communities, so they already bring strong engagement skills to this role. However, even with these existing skills there are families who remain resistant to and lack trust in service providers and “the system” in general. We are seeking to expand the care coordinators skills set by further training in motivational interviewing, recognizing the stages of change, reflective listening practices, and improved self-awareness of internal biases and negative beliefs about certain families who fail to make expected gains. We are also seeking to find ways to better link with the medical community to increase referrals and improve effective communication.

## **Business Model**

- Fund raising
- Some grant supported services available
- There is some payer assistance – with appropriate diagnosis and other documentation, mental health Medicaid can be billed in Illinois. However the child must have a mental health diagnosis which may cause some families to hesitate.
- In the next year or two tackling the PCMH requirements.

## **How they are utilizing HIT**

They are not using HIT yet for family care plan.

## **Challenges and Lessons Learned**

- Learned that there are often multiple points of view which must be brought together:
  - 1. What does the family want/prefer
  - 2. What does the referral source think needs to be done
  - 3. What are other providers recommending
  - 4. What does the care coordinator believe is the best way to integrate this into a meaningful care plan for the family
- Lessons Learned in Training –FCC Meeting and supervision at least every other week, if not every week; the value of frequent meetings with other programs and providers to share information and coordinate services in an effective and family sensitive manner.
- Learning how to market and promote programs and services has been a significant challenge. Efforts continue to refine and improve outreach and marketing throughout the community and among providers.
- It is helpful to offer to host training or assist in community screenings
- Lessons learned – It is very helpful for the care coordinator to have a mental health background to help understand the child and family's needs and to help the care coordinators be more effective advocates...
- It is essential to understand and keep in mind at all times that many of the parents they are working with may have their own struggles with mental health, substance abuse, trauma, criminal history, learning problems, cognitive limitations, and other challenges.
- When hiring staff it is important to look for individuals who are self-starters, well organized, willing to go into home some very difficult home settings without being judgmental, and are able to work independently.
- It will be helpful to better define the target population to be served.

## **What is next?**

- Focusing more on pediatric care and family care.
- Refining target population to include the highest risk and most difficult to engage.
- Furthering their efforts to improve relationships with pediatric care and family practices
- Developing additional training for their care coordinators.
- Incorporating more video conferencing to help make weekly staff meetings and visits with families more convenient.
- Different revenue stream to bill for all the services they are supplying

## APPENDIX



## Patient Stories supplied by Texas Rural Accountable Care Organization

### Case #1:

A patient presents to her primary care provider with shortness of breath, weight loss and generalized weakness. She has severe emphysema, anorexia, tobacco dependence and other chronic conditions. Her provider is determining the next step in her care. The patient is placed on 24 hour oxygen and referred to home health. She is also referred to care coordination. The care coordinator (CC) makes a home visit and meets with the patient and the family. Teaching is completed with education given regarding her illnesses and how to better manage them at home. Her advanced directives are discussed and completed. Her weight is discussed and goals are set for her to eat two meals daily with a snack. Routine weekly follow-up is completed and continued education is provided. Over a one month period, the patient is no longer utilizing home health. She is eating three meals daily and has gained over five pounds. The patient has met her goal of mowing the lawn independently again (with a mask and portable oxygen). She is adapting to new equipment and new routines, however, the patient has a positive attitude regarding her quality of life and is enjoying each and every day.

### Case #2:

Female patient was referred for CCM (Chronic Care Management) by local NP (Nurse Practitioner). Patient with multiple co-morbidities, including diabetes, hypertension, congestive heart failure, Asthma, Chronic Kidney disease and Depression. Patient missed multiple doctor visits due to family problems and lack of transportation. Patient has a history of multiple falls. A social work consult was requested to be done by her existing home health agency but they did not have social work available. Because of the difficulty getting the patient into the office, the NP (Nurse Practitioner) and CC scheduled a home visit to communicate with the patient and assess the home situation. Before they could go, the patient was hospitalized after calling EMS (Emergency Medical Services) for shortness of breath. Patient was treated for fluid overload and hypoxia, discharged with home oxygen, and prescribed Levaquin and Medrol. When the CC called the patient the day after discharge, she was short of breath while talking on the phone. The patient admitted she wasn't wearing the oxygen because she "didn't go to the hospital to get oxygen". After the CC spoke with the patient about "why" she went to the hospital and "why" she needed oxygen she agreed to wear it.

However, during the conversation the CC discovered the oxygen was not set up correctly. The CC called the home health agency to visit the patient immediately to ensure that oxygen was being used correctly. The patient had also not picked up her prescriptions. When the CC reviewed her discharge med list, it showed she was allergic to Levaquin, yet Levaquin had been prescribed. The CC confirmed the allergy with the patient, instructed her to wait to pick up the medication, and called the doctor to report the discrepancy. The physician called in an order for a different antibiotic. The NP and CC recently followed up with the patient at her home and also met with her daughter. They confirmed with the daughter that she would be available to take the patient to appointments. Patients also agreed to switch home health agencies to one that has social work available to obtain help with financial assistance for her power bill, application for a provider through DADS

(Department of Aging and Disability Services), possible Meals on Wheels, and a walker. The home health nurse did a complete medication reconciliation and found that the patient had medications in various places all over her house. The patient was also taking several medications that had been discontinued by the NP. Medication reconciliation was performed with the NP, an accurate med list was created, and home health visits were increased to provide enhanced monitoring/teaching of medication management.

### **Case #3:**

A local community patient was recently transferred to a new physician provider after her primary care provider resigned from his community practice. After the patient's first visit with the new provider, the CC received a provider referral for care coordination, requesting emphasis for oversight of patient's medication management. The patient had not brought her pill bottles to the provider appointment and was unable to advise the doctor of what she was actually taking. The patient is 95 y/o, lives alone in her home, recently lost a son who was her primary caregiver, and presented with the chief complaints of shoulder pain and foot pain. The patient has known congestive heart failure, coronary artery disease, hypertension and Osteoporosis. Another son stops by daily, a daughter also assists and she has a homemaker visit twice a month. During the initial CC phone call with the patient, the patient stated "everything is fine; I set up my own meds and prepare my own meals." The patient agreed to a CC home visit as the CC explained that it would be beneficial to both she and the physician if the patient's pill bottles could be visualized. During the home visit, the CC discovered that the patient was using a plastic container with nine separate sections for seven different pills that had old, yellowed, handwritten labels, none of which matched the medications! Surprisingly, the patient was able to identify the pills by sight. The physician's med list contained 22 medications while the patient was actually taking 29. Some of the physician's listed meds were also different from what the patient was actually taking. The patient had many supplemental medications of which her provider was unaware. The patient was keeping her cranberry tablets and probiotics in containers that were labeled as Lipitor (she did know what was in each container). Patient was not taking 80mg of Lasix daily as prescribed; instead she was cutting the Lasix tablet into fourths stating, "I've been doing that for a long time." The patient has difficulty w/foil wrapped meds so she or her daughter takes the meds out of their wrappers and places them in unlabeled containers. She has a weekly pill box which she uses for some meds and keeps others in containers in various places. Needless to say, a lot of re-organization was necessary in this situation. The patient agreed to use the weekly med box for all of her meds and allowed the CC to relabel the containers to increase safety. The CC typed a new, simplified med list for the patient and family to use. The CC also conferred with her physician and spoke with the son and daughter. The CC states "maybe now she'll live past 100!"

### **Case #4:**

An example of an effective community care management partnership: A patient under the care of a local Home Health agency being followed in the Care Coordination program was not able to be reached by phone. The Care Coordinator reached out to the agency to request their help with intervening. An agency RN (Registered Nurse) not assigned to the patient agreed to check in on the patient that day for the Care Coordinator and report patient status. The Home Health agency RN identified that the patient had not picked up the

refill of his Amiodarone. After ensuring that the patient had a refill ready to be picked up, the agency RN notified the Care

Coordinator of her intervention with the patient. The Care Coordinator then called the patient the next day to ensure that family had picked up the med and reviewed the importance of consistently taking this medication.

#### **Case #5:**

A newly diagnosed Diabetic patient with an HgbA1c of 11.4 was seen by an endocrinologist who ordered patient to be on a carb count diet. After several discussions with the patient, wife, dietician and the Care Coordinator, comprehension level regarding a carb count diet remained low. The Care Coordinator researched different solutions for this patient and collaborated with the physician. After meeting with the physician, the diet regimen was altered to a regular no concentrated sweet diet. This patient's biggest concern was he thought he could never have an Arby roast beef sandwich or his pumpkin dessert. The Care Coordinator sat with the patient and his wife and came up with a plan that allowed for his preferences. The Care Coordinator demonstrated how this could be done by making pumpkin cupcakes for him with a sugar free cake mix, a can of pumpkin and some spices. The patient was so happy that he could have what he loved so much. He also liked sundaes. Again, the Care Coordinator came up with a plan for frozen yogurt and Splenda on the patients strawberries for his sundaes. He was a happy man. His blood sugars are running 120-150. The patient will be scheduled for his next HgbA1c in August. So far, he has had a dose reduction in both his sliding scale and long acting insulin.

#### **Case #6:**

56 y/o female with Type 1 Diabetes (since age 24), M.S., hypertension, Diabetic retinopathy and neuropathy. Referred to Care Coordination program by primary care provider. Patient was currently seeing the Diabetic Educator at a local hospital who had initiated the patients Insulin Pump therapy as ordered by physician. Upon the initial Care Coordination encounter, it was noted that the patient had never seen an Endocrinologist. Patient presented with blood sugars running in a range of 200-300. HgbA1c was 12.1. The patient had not been rotating her pump site, restricting injections to her front abdomen area only. The Care Coordinator reached out to the primary care provider who agreed to an Endocrinology consult. The Care Coordinator successfully arranged a timely consult for July 8th in which the endocrinologist confirmed that patient was not getting full effect from her insulin due to scar tissue accumulation on her abdomen. The patient began rotating her injection sites as instructed and her blood sugars are running 100-200. Her next HgbA1c is scheduled for August. The Care Coordinator continues to see this patient every 2 weeks to assist patient with pump site rotation adherence. The Care Coordinator is able to concurrently monitor the patient's blood sugars on a website called Care Link. As of 7/9/15, the patient's weight is down 8.2 lbs. due to improved glycemic control. The patient's blood pressure is also improving and she enjoys her regular Care Coordination visits every two weeks.

#### **Case #7:**

86 y/o female with end stage congestive heart failure, dilated cardiomyopathy with EF (Ejection Factor) <20% had a biventricular AICD (Automatic Implanted Cardioverter defibrillator) inserted earlier in the year for severe intractable congestive heart failure. With

her last hospitalization in March of this year, cardiologists' subjective narrative noted: "pursue conservative medication management. Her long-term prognosis is extremely poor. CONSIDER HOSPICE." Patient's total number of ED(Emergency Department) visit in year: 8 ED visits (this included a recent visit for leg pain/LE edema - neg DVT (Deep Vein Thrombosis) and 2 hospitalizations at her primary local hospital but approximately another 4-5 area hospitals admits for various procedures. primary care provider referred this patient to the Care Coordination program in March 2015. Patient is a Widow, retired nurse, has 4 children (3 out 4 live in the area including the Power of Attorney) youngest son lives with patient. Patient has home oxygen but only wears it at night. During first Care Coordination encounter, patient stated she was very stubborn, set in her ways, & direct. She had lived on a farm most of her married life and took care of her husband with end stage cardiac arrest until he was admitted into VA hospice. She presented guarded, telling the Care Coordinator (CC) that she did not trust people and really felt that the CC could be of no use to her. CC noted that patient was a full code despite Power of Attorney (POA) of record having a conversation with the case manager on most recent hospitalization about a do-not-resuscitate status. With the CC subsequent follow-up call, the patient politely told the CC that her services were not needed and to please not call her back. The CC provided the patient with her contact information and let the primary care provider know of the patient's wishes. The primary care provider asked the CC to contact the patient again in 2-3 weeks just to "touch base". The CC successfully connected at that time with the patient who sounded strong, reported minimal shortness of breath, had an order to resume cardiac rehab, and was cleared to return to volunteering at the local hospital. A few days later, the primary care provider called the CC stating that patient was in crisis and wanted the CC to call her (patient had lost the contact information). CC called patient and made arrangements for a home encounter. Upon visual assessment, the CC noted the patient was not wearing her oxygen, lips were ashen and patient was visibly upset. Patient's son was out of town so she had been home alone for the past couple of days. The CC spent 90 minutes with the face-to-face encounter ensuring that the patient had the needed tubing extensions to successfully wear her oxygen and facilitated a successful conversation about Home Health, ultimately getting patient consent for a referral. When contacting the primary care provider office to check on status of referral, the CC experienced office staff resistance (who know the patient well) stating that the patient will not accept HH so they had not called in the referral. The CC reinforced that the primary care provider had written the order and that the patient had already agreed.

The CC then called the home health agency and spoke to the supervisor herself, asking them to send staff for a start of care visit as soon as possible. The home health agency saw the patient the next morning at 0730 hrs. Patient was very pleased with the registered nurse and Physical Therapy staff. CC has been in frequent contact with the HH nurse up to 2-3 times/week, collaborating on an effective plan of care. This collaborative effort has led to the patient's use of a Life Line alert system. Advanced Directive discussions are needed but the patient is not open to CC and HH nurse discussions with her children about this. She is adamant about staying home and refuses to discuss other options. Despite the patient's disconnect with the family and the peaks and valleys of their chronic complexity of disease, there has been an avoidance of emergency department utilization due to exacerbation of illness. The patient is staying in her home where she desires to be and perhaps this great

care management team collaborative effort can lead to an Advanced Care Planning discussion in the future with the patient and her family.

# Texas Rural Accountable Care Organization Care Coordination Referral form

# Kreider Target Population Tools & Care Coordination Worksheet

## Example