Solutions Center Interactive

The Tools and Teamwork of Risk Stratified Care Management

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Solutions Center Interactive Team

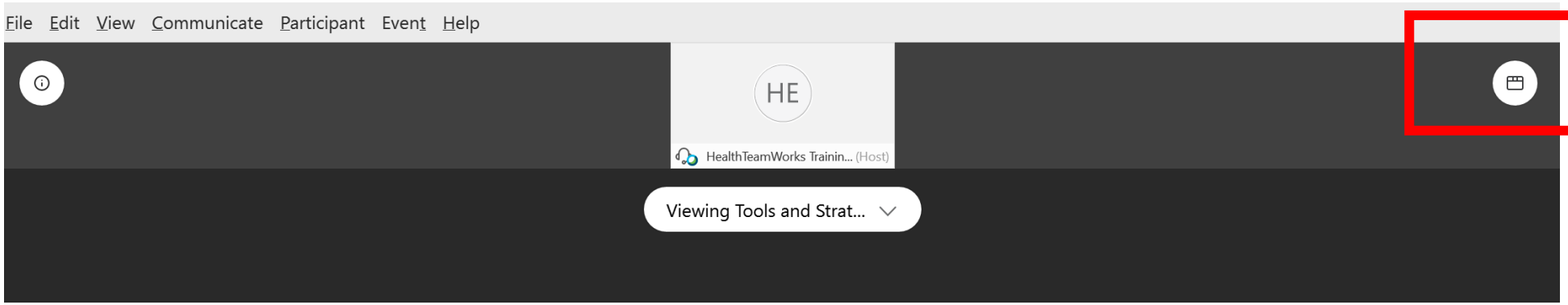
Karen K. York, MA, CPHQ, CPMSM, Solutions Center Consultant, HealthTeamWorks

Karen York is a healthcare consultant with more than 30 years of experience in a variety of healthcare settings, including hospitals, emergency physician groups, physician practices, medical plans, and hospice care. She is a skilled facilitator and has led organizations to better outcomes. Karen is certified in the areas of Healthcare Quality Improvement, Medical Staff Services, Clinical Healthcare Coaching, and Lean Healthcare Management. She is currently an Adjunct Faculty in the Healthcare MBA Program at Belmont University teaching Patient Centered Care and Healthcare Quality Improvement. Karen earned her Master of Arts degree in Organizational Leadership and holds a BA in Education.

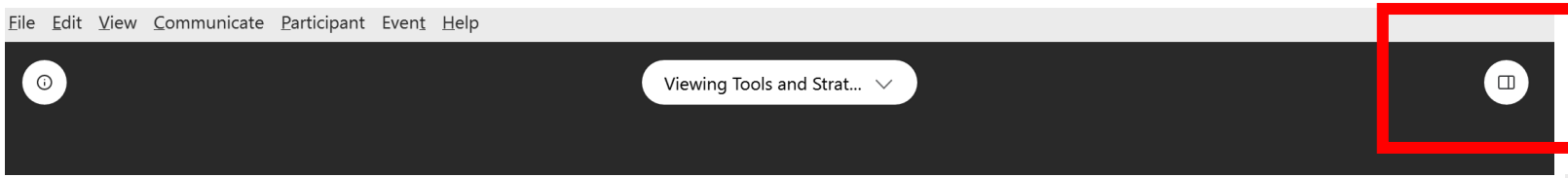
Heather Walker, Learning Experience Designer – HealthTeamWorks

Heather has earned certificates in Designing Learning and Evaluating Learning Impact as well as the designation of Master Instructional Designer from the Association for Talent Development. At present, Heather is pursuing a Master's of Science in Information and Learning Technology with an emphasis in Instructional Design and Adult Learning from the University of Colorado Denver.

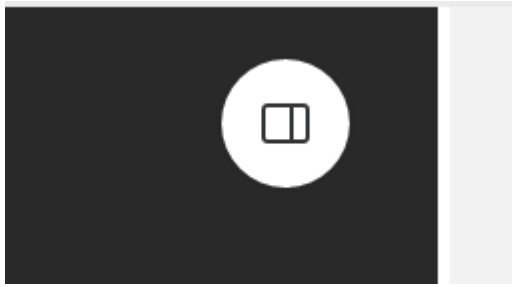
Navigating Your WebEx Screen



Video Strip View



Side-by-Side View



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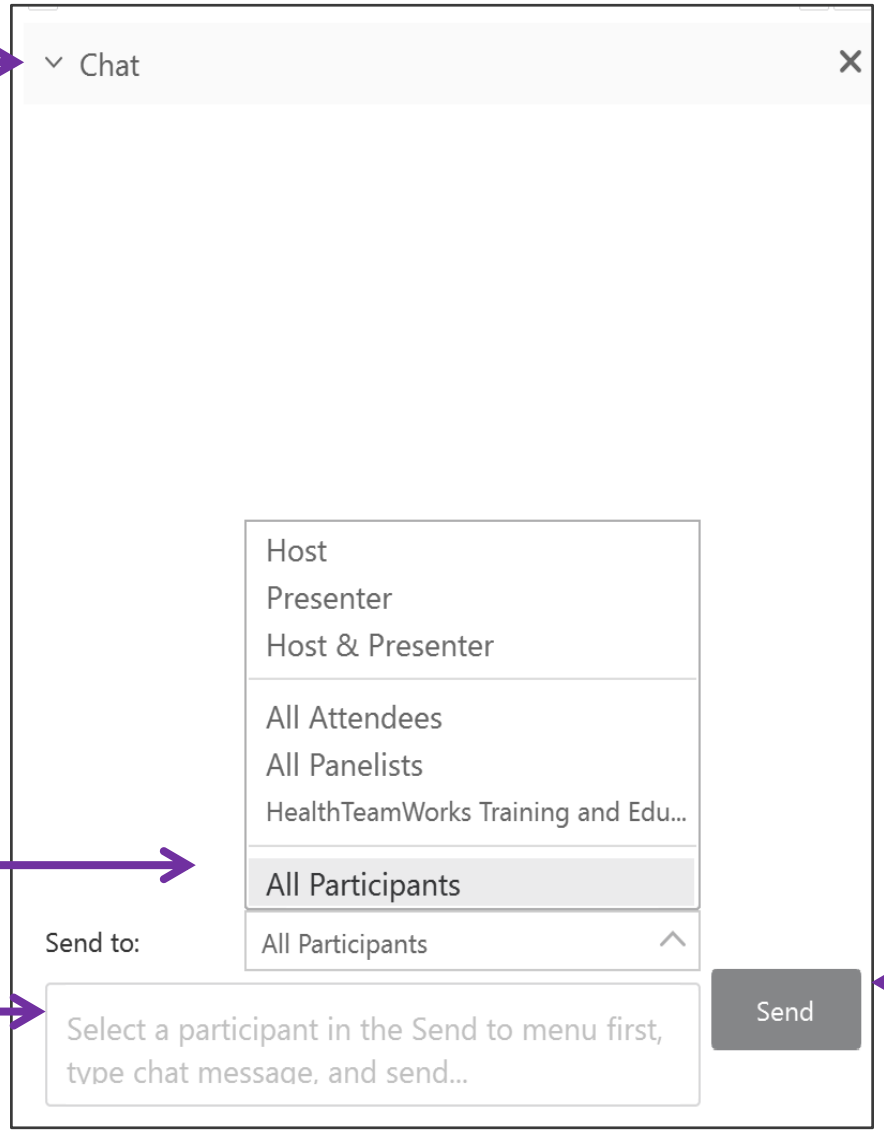
Using WebEx Chat

Minimize & Maximize chat panel



Choose **All Participants** to make entries visible to all attendees

Type Chat Message Here

Click Send

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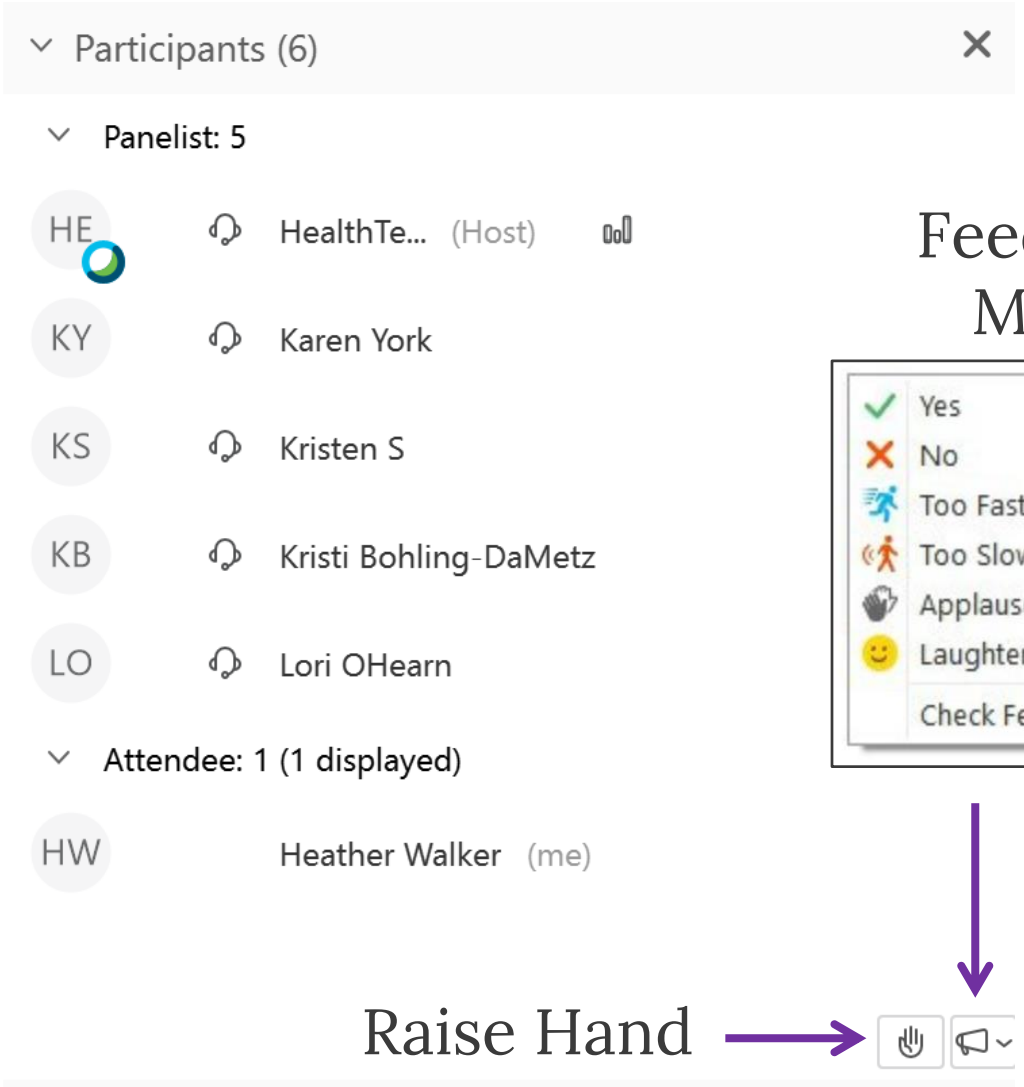
Using WebEx Feedback Tools

Minimize & Maximize participant panel



Feedback Menu

Raise Hand

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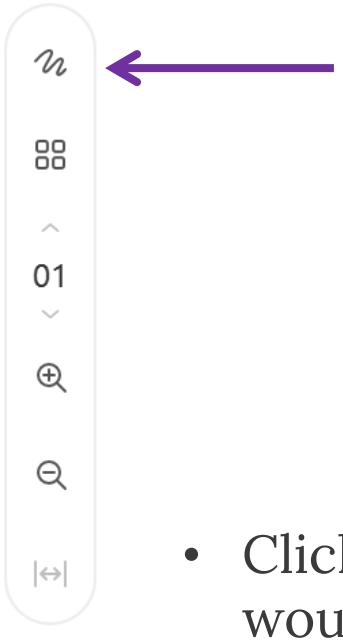
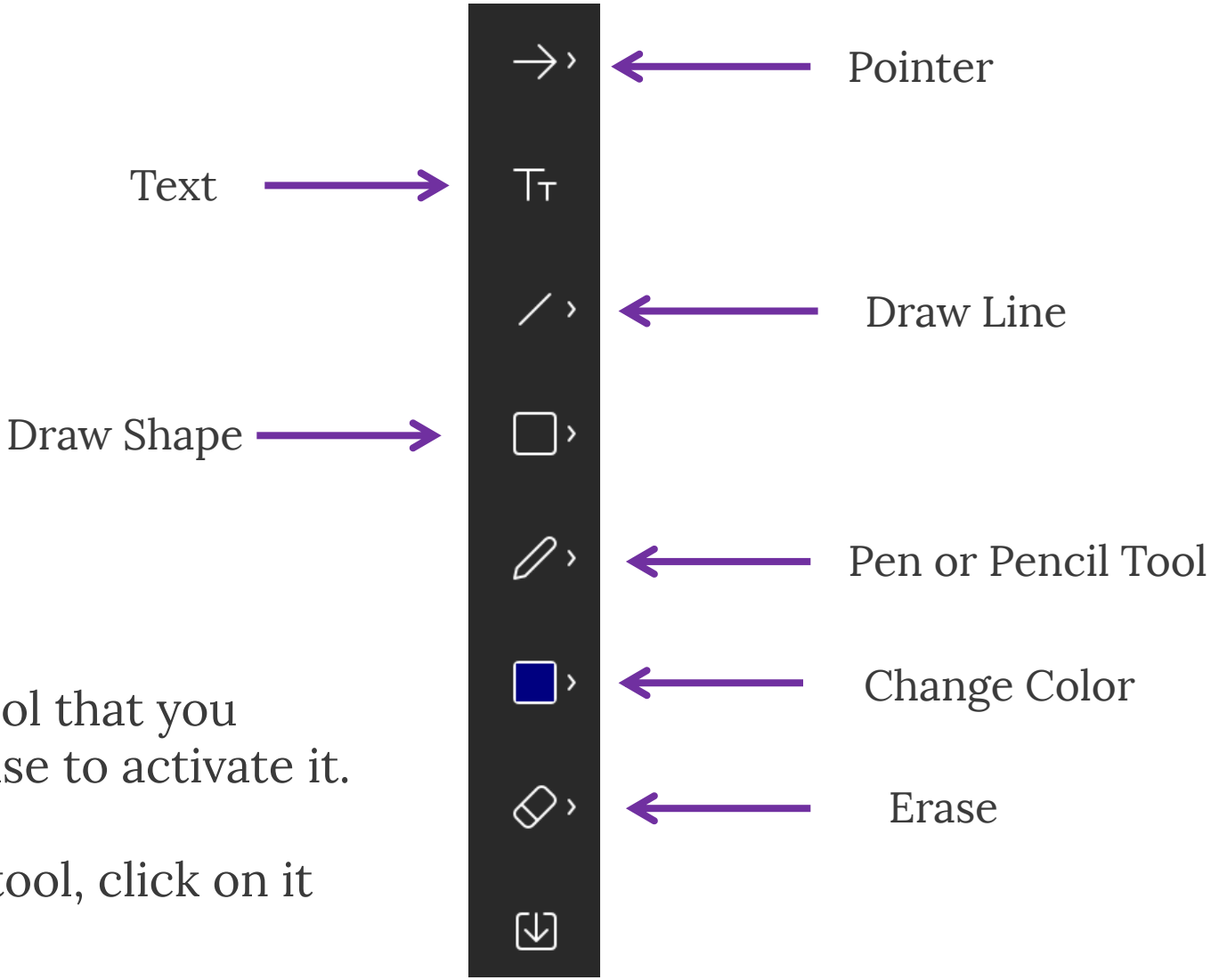
WebEx Annotation Tools

"Squiggly line" icon must be blue/active to use annotation bar. Click to activate





- Click on the tool that you would like to use to activate it.
- To deactivate tool, click on it again.

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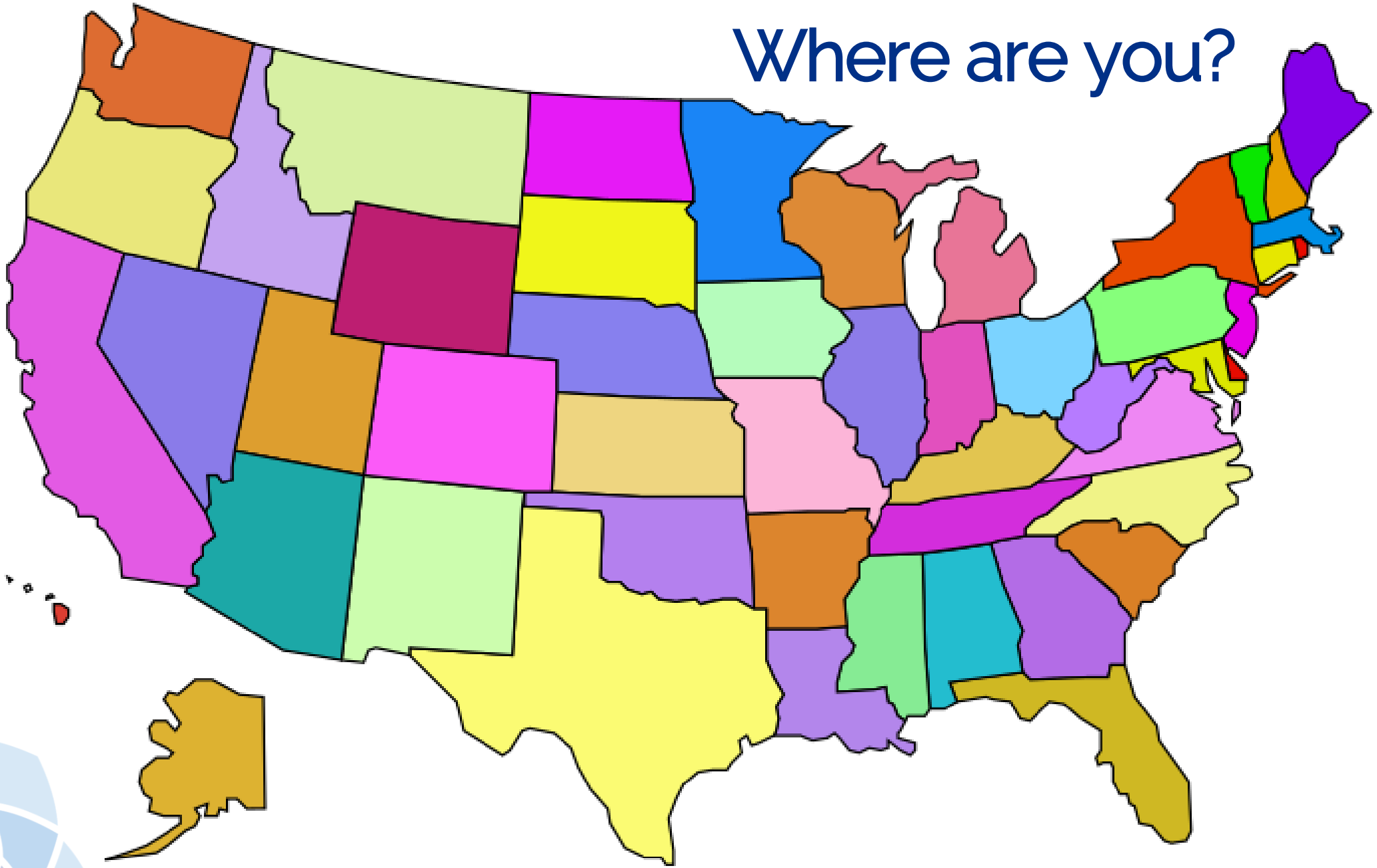
Where are you?



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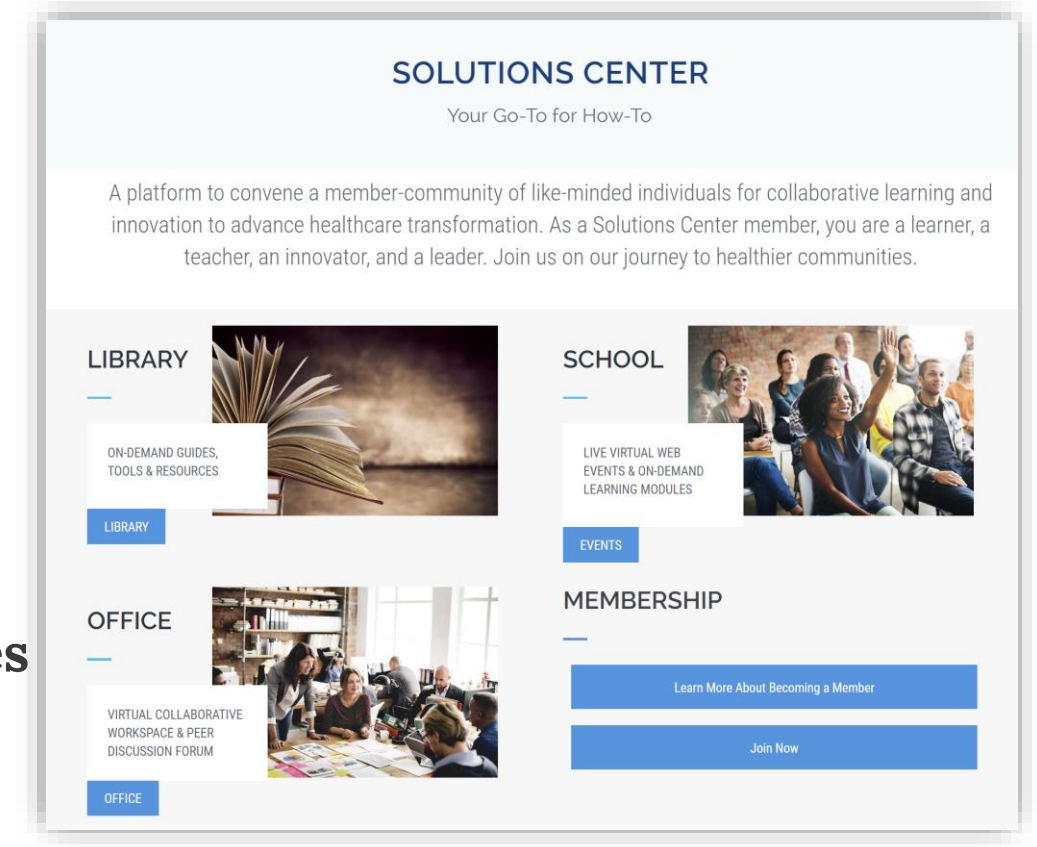
Your Interaction is Rewarded!

We are giving away 5 complimentary 1-year Individual memberships to the Solutions Center

Every time you participate in today's event, you will receive an entry into a drawing for 1 of 5 memberships.

Participate through Chat = 1 entry
Use Raise Hand feature and speak to the group = 2 entries



**Winners will be announced via email after the event.*

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Solutions Center Interactive Team

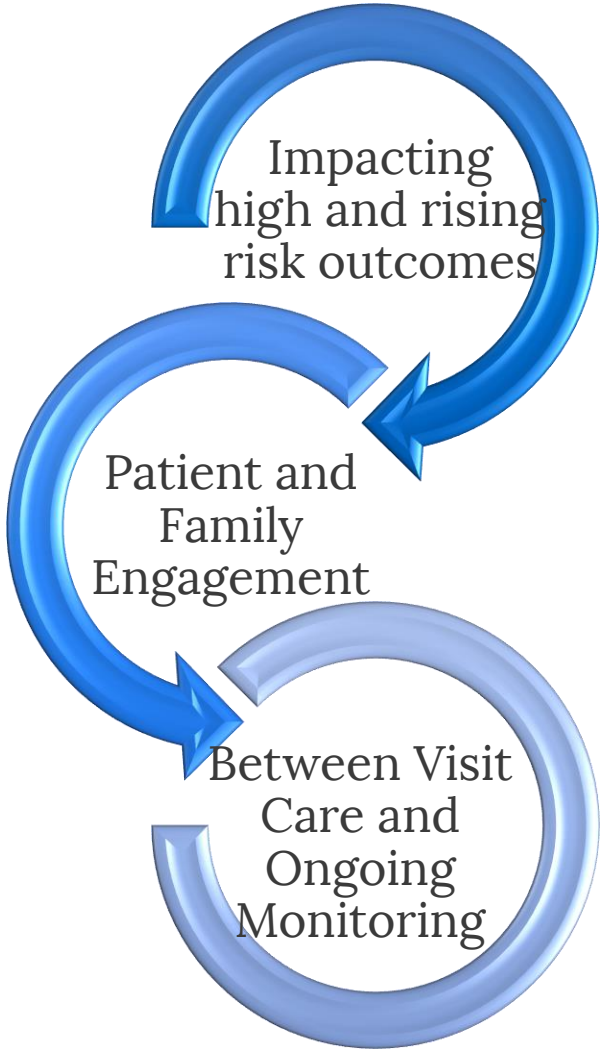
Moderator: Kristi Bohling-DaMetz, RN, BSN, MBA, Chief Strategy Officer - HealthTeamWorks

Kristi comes to HealthTeamWorks with more than 20 years of healthcare delivery, training, and transformation experience. Previously, Kristi was Program Director at TransforMED for CMMI's Patient-Centered Medical Neighborhood Health Care Innovation Award. She led a team to improve outcomes related to quality, cost savings, patient experience, and scalability across 15 health systems and communities. Kristi received her Bachelors of Science in Nursing from Wichita State University and her MBA from Friends University.

Panelist: Lori Lahrmann-O'Hearn, RN, BSN, Healthcare Learning Faculty – HealthTeamWorks

Lori joins HealthTeamWorks with thirteen years' experience in the healthcare industry, with a focus in care coordination, practice transformation, and population health. Her strategic vision informs and guides every aspect of her work, whether she's developing and implementing new clinical programs or leading a team through significant change. Lori holds a diploma in nursing from The Christ Hospital School of Nursing, and a Bachelor of Science in Nursing from the Wright State University in Dayton, Ohio.

Importance of Effective Care Management



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Question for the Learning Community…

Participants, please use the following options to respond:

- **Chat feature** (make sure your chat is set to "all participants"), or
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What are the two greatest impacts of care management you've experienced in your organization?

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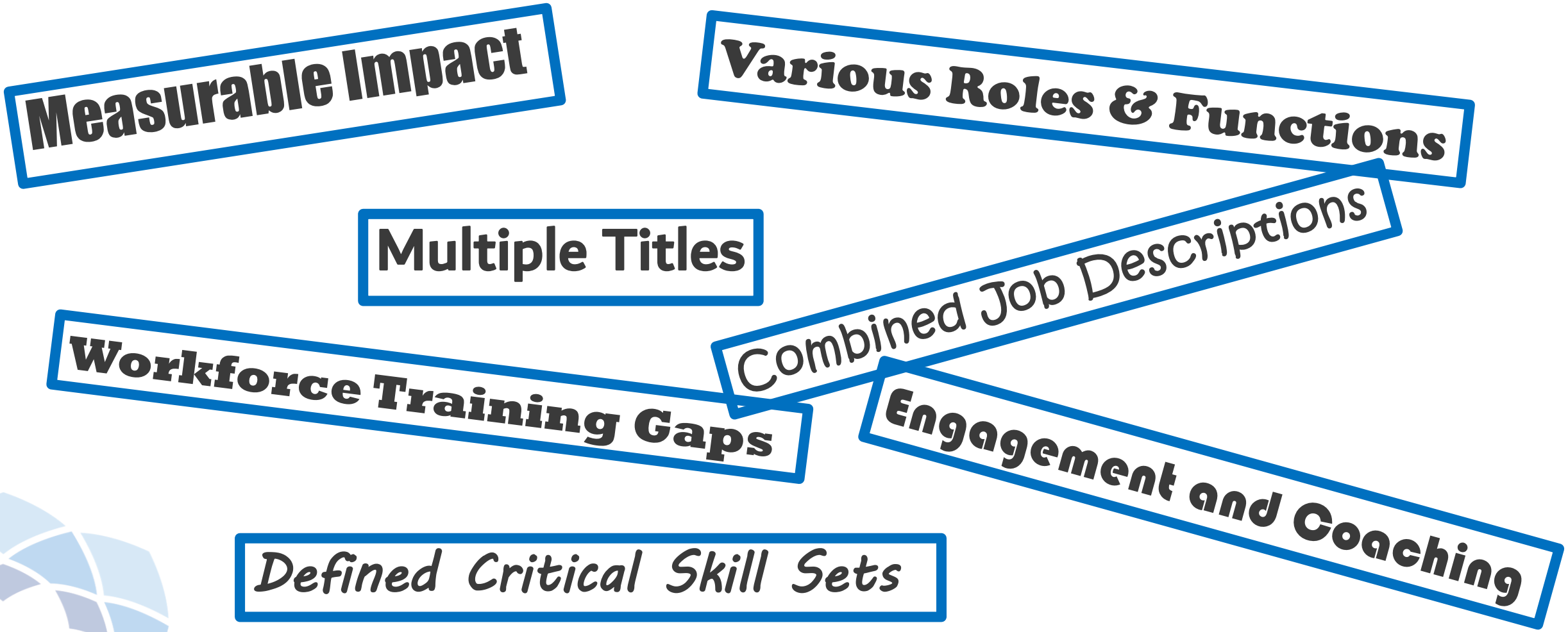
Evolution of the Care Manager Role



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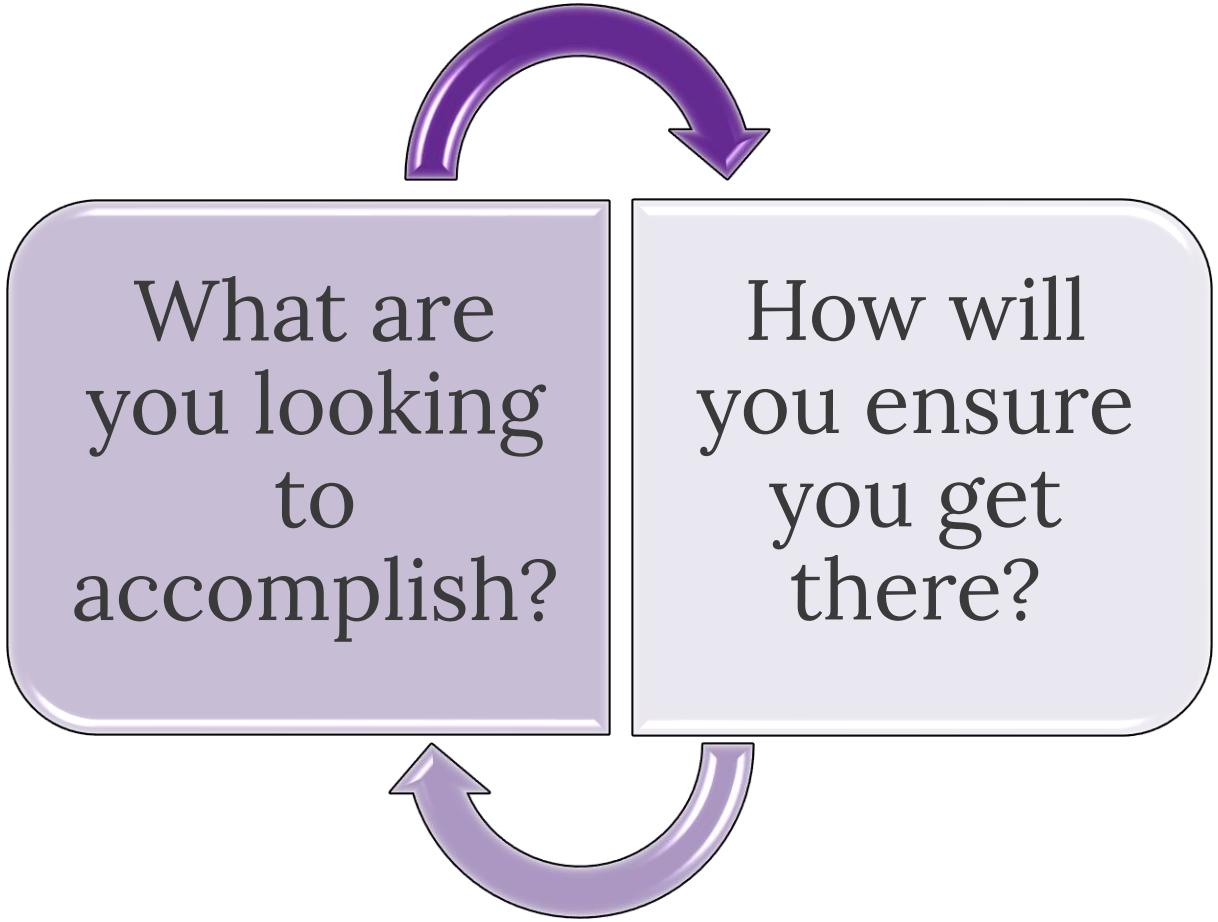
Considerations for Program Development



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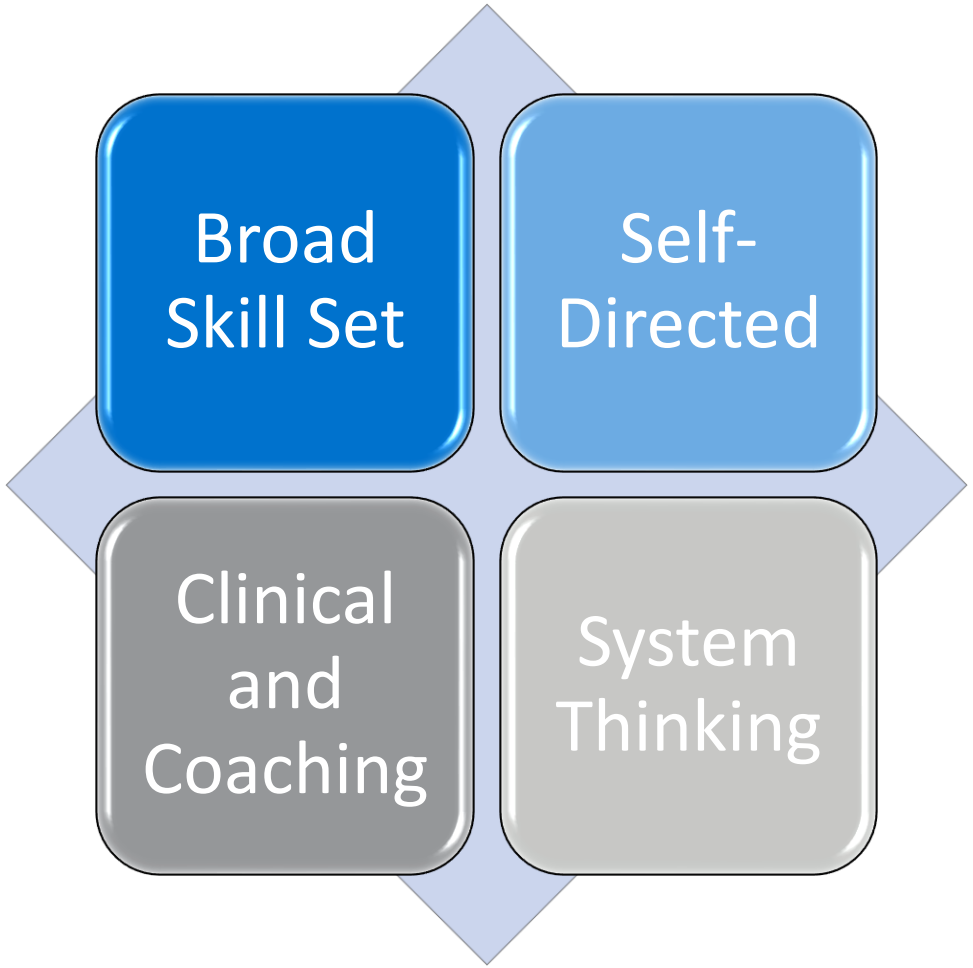
What tools have you used to define the role of your Care Managers?

Considerations for Hiring Exceptional Care Managers



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Hiring Exceptional Care Managers

Assess ability to understand basic concepts of population health and disease management

- **Risk stratification**
  - Share an example of the risk stratification algorithm used at your practice
  - Pull together a list of 10-15 (deidentified) patients with risk score and several key clinical data points (diagnoses, psychosocial factors, lab results) *Be sure to include a variety of patients with different risk levels and clinical/psychosocial factors*
  - Have the candidate talk through which patients they would consider enrolling in care management

Purpose of this exercise: *To assess candidate's ability to collect multiple pieces of data, integrate the information, and critically think through which patients might benefit from a care management intervention and why other patients might not benefit.*

- **Managing a diabetes (or other chronic disease) registry**
  - Share a copy of your protocol for management of diabetes
  - Pull together a list of 5-10 (deidentified) patients from the diabetes registry.
    - Include risk score, most recent Hgb A1c and date completed, recency of DM education with a dietitian or DM educator, other pertinent factors
  - Have the candidate talk through a very basic plan for each patient, ba upon your protocol for diabetes management

Assess understanding of key concepts in collaborating with patients

- **Teach Back:** Ask candidate to role play with one of the interviewing panelists, using teach back on any medical/clinical concept of their choice
- **Motivational Interviewing:** Ask candidate to describe what motivational interviewing is and give an example of how they have used this technique with a patient/caregiver

Purpose of exercise: *Skill in these areas is critical to working with patients and helping them make progress toward goals for self-management. The RN Care Manager should demonstrate at least a moderate level of skill and understanding of the importance of meeting patients where they are. This includes letting go of the 'prescriptive' way of telling patients what to do, and using techniques to explore individual motivation to make positive change.*

Assess ability to lead a care team *(team may include LPN's, MA's Community Health Workers, Health Coaches)*

- **Use behavioral based question(s). Some examples are:**
  - Care Management is a relatively new concept in primary care. Some of the staff in the practice may struggle with accepting this role, and may challenge you in different ways. What strategies might you employ if a staff member creates roadblocks to your integrating into the practice culture?
  - You are working in a practice with four providers. Three of these providers are excited about the addition of Care Management, and one is not. What strategies would you try to gain buy-in with the provider that is not interested in having his patients care managed?

Assess proficiency in Microsoft Excel

- **Create a blood sugar log in Microsoft Excel:** Candidate will complete this as homework, before the interview
  - Provide a list of pretend blood sugar results to the candidate (Include date/time of result and value)
  - Candidate will create an excel spreadsheet template for a blood sugar log and complete the following:
    - Enter the blood sugar results from the sample provided
    - Average the results in the way that they believe will be most useful for the practitioner
    - Email the completed spreadsheet to interview panel lead (this is critical – a paper copy of the spreadsheet will not allow you to assess use of formulas)
  - At the time of interview, ask candidate to talk about their process in developing the spreadsheet

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https://www.healthteamworks.org/solutionscenter

What Works in High Performing Networks 4:

Not All Data is Created Equal – The Power of Transformative Clinical Analytics

September 12, 2018

11:00 a.m. MST/12:00 p.m. CST

Open to the Public

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Characteristics of Risk Stratified Care Management

- Based on multiple criteria (clinical, behavioral, social)
- Identifies patients who would most benefit from additional care management support (high and rising risk)
- Includes care team's ability to upgrade or downgrade risk

Risk Stratification Algorithm

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ADENA CARE

Risk Stratification Tool

Category	Item	Points
Utilization	One hospitalization in the last 12 months	1
	Two hospitalizations in the last 12 months	2
	Three or more hospitalizations in the last 12 months	3
	2 or more visits to ED in the last 6 months	3
Age	0 – 49 years old	0
	50 – 59 years old	1
	60 – 69 years old	2
	70 and older	3
Health Conditions (any history of)	CAD	1
	CHF	1
	MI	1
	Atrial Fibrillation	1
	Peripheral Vascular Disease	1
	HTN	1
	Hyperlipidemia	1
	CVA	1
	Dementia	1
	BMI 30 or higher	1
	COPD	1
	Asthma	1
	Mild liver disease	1
	DM w/o end organ damage	1
	DM w/ end organ damage	2
	Hemiplegia	1
	CKD stage 3-4 (moderate to severe)	2
	Any tumor (without metastasis)	2
	Leukemia	2
	Lymphoma	2
	Moderate or severe liver disease	3
	AIDS (not just HIV positive)	6
	Metastatic solid tumor	6
Mental Health*	Depression	1
	Anxiety	1
Behavioral	Current Smoker	1

*** to score any points, the mental health issue **must be concurrent with at least two of the listed chronic conditions***

Risk Tiers, based upon tallied score:

Low Risk	0 – 6 points
Medium Risk	7 – 12 points
High Risk	13 or higher

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What is your approach to risk stratification?

How do your Care Managers determine which patients need additional support?

Evidence-Based Protocol Example

2018 Diabetes Care Guidelines

Clinical Goals

Glycemic Goal[1]			Blood Pressure Goal[4]	Premeal Glucose Targets[1]
$HgbA_1C$	≤ 7%	For most diabetics	<130/80	80-120 mg/dL
	< 8%	For h/o severe hypoglycemia, advanced age, advanced micro &/or macro vascular complications, extensive co-morbid conditions & long-standing DM when goal difficult to attain despite DSME		

Standards of Care

Office Visit Frequency		Lab Work			Screenings		Medications	
Condition	Schedule	Indicator	Level	Schedule	Type	Schedule	Type	Prescribed if:
Hospitalized	3-5 days post discharge	$HgbA_1C$[1]	>7.0%, or not meeting goal	Every 3 mos	Tobacco Abuse* *offer pharmacological therapy if patient is interested in quitting. e-cigarettes = not supported as alternative or to facilitate cessation[11]	Every Visit	Statins[2]	Treatment driven by risk status (See Table on reverse side of this document)
Treatment goals NOT being met[3]	Every 3 mos	**Consider fasting plasma glucose test or oral glucose tolerance test if there is disagreement between A1C and blood glucose levels[5]	≤7.0%, or meeting goal	Every 6 mos			empagliflozin or liraglutide[3]	Consider if known cardiovascular disease
Treatment Goals ARE being met[3]	Every 6 mos	Lipid profile[3]		If not performed or available within past 12 months; as needed	Eye Exam[3]	Type 1 (≥5 years) & Type 2 - Every 2 years if normal	Ace Inhibitor[2]	In cases of known CVD
Education		Spot urinary albumin-to-creatinine ratio[3]		Every 12 mos	PHQ-2[1]	Every 12 mos	ACEI, ARB,Thiazide-like diuretic or dihydropyridine calcium channel blocker[3]	HTN and negative albuminuria
Home blood pressure monitoring[5]		Serum Creatinine & estimated GFR[1]		Every 12 mos	Neuropathy[3]	DM Type 1 (≥5 years) & DM Type 2 - Annually		
Monitoring carbohydrate intake[1]		Serum Potassium (if on ACE, ARB or diuretic)[1]		Every 12 mos	Sleep patterns[3]	*Each visit*		
Medication administration (insulin or oral meds)[1]		ALT[1]		Every 12 months	Foot Exam[1]	Normal-annual; Abnormal-each visit	ACEI or ARB (only in the non-pregnant patient)[3]	Recommended if urinary albumin 30-299 mg/g; Strongly recommended if urinary albumin ≥300 mg/g
Blood glucose monitoring[1]		B12 Level (if on long term metformin therapy)[3]		As needed	Cormorbities[3]	*Each visit*		
Limit alcohol consumption[1]		Thyroid Stimulating Hormone (TSH) - Type 1 diabetics		Every 12 months	Psychosocial determinants[3] & literacy	*Annually & prn*		
Proper foot care, surveillance, protection (especially if has abnormal foot exam)[1]					Cardiovascular risk factors[3]	At least annually	Aspirin or clopidogrel (if known ASA allergy)[3]	Known ASCVD (if not contraindicated); increased CV risk
Exercise[1]								

Smoking cessation[1]	Referrals	
Weight loss/Weight Management[3]	**Type**	**Explanation**
Immunizations	Endocrinology	Consider referral if diabetic complications present; All individuals with Type 1 Diabetes; **patients with HgbA1c >8 x2 consecutive tests**
	Podiatry[3]	History of smoking, lower extremity complications, loss of protective sensation
Per CDC Guidelines	Nephrology	GFR < 60, anemia, metabolic bone disease, or etiology of kidney disease uncertain
	Registered Dietitian[20]	For Medical Nutrition Therapy-ALL diabetics (as often as needed to achieve treatment goals)
	Certified Diabetic Educator[21]	For diabetes self management education - group or individual sessions; referral annually for ALL diabetics not meeting A1C goal ***For Adena Care Members, diabetic education is a covered service.***
	Maternal-Fetal	All diabetic mothers
	Nurse Navigator[3]	If $HgbA_1C$ **persistently elevated (>9.0%) after 12 months of intervention;** any noted social determinants

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Contact Us
Adena Care 740-772-CARE

Created 1/22/13; Revised 6/21/13; Updated 1/31/14; 3/24/15; 2/13/16

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How do you reduce variation in care provided for high and rising risk patient populations?

Ongoing Learning and Development

How do you support continuous learning and growth in the role?

Upcoming Opportunities

Care Manager Training
La Vista, Nebraska
September 17 – 19, 2018

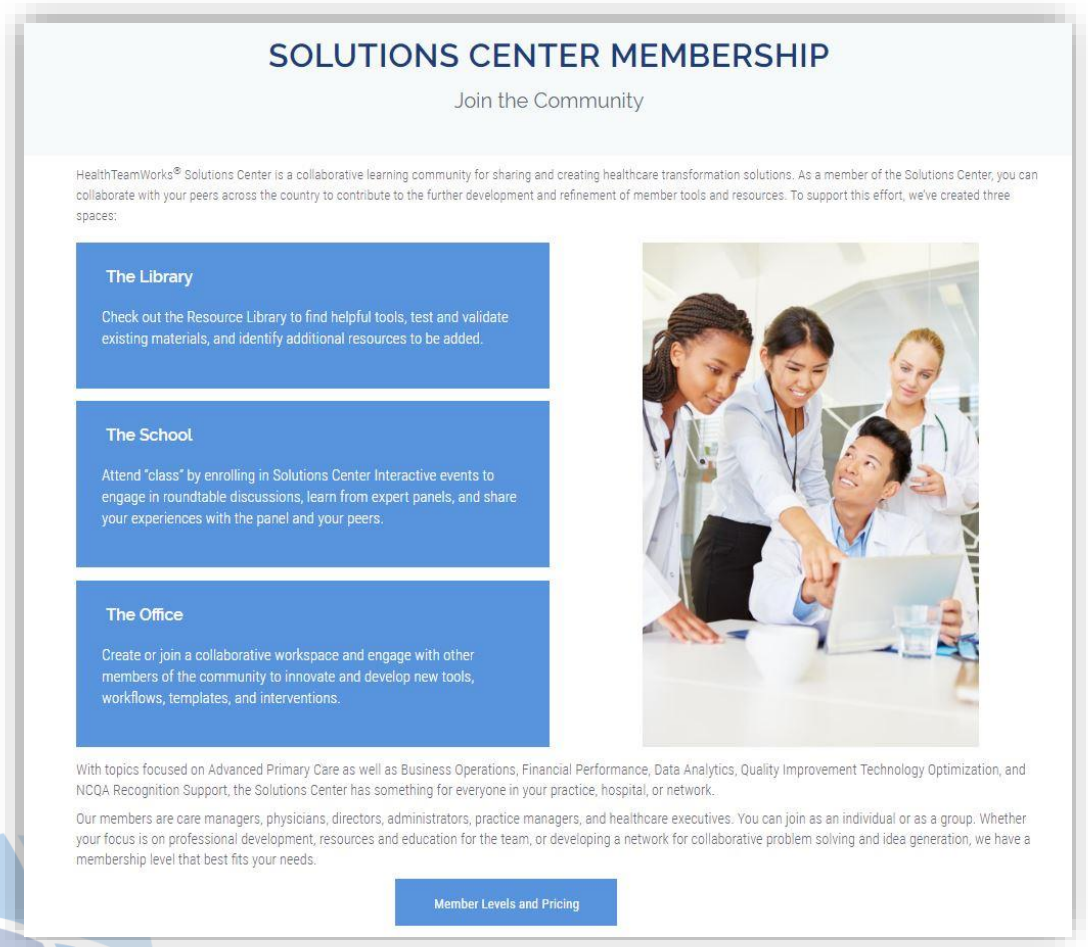
https://www.healthteamworks.org/event/care-manager-training-nebraska

Registration closes August 31!

Can't make it to Nebraska? Contact us about bringing the training to you.

Solutions@healthteamworks.org

Solutions Center Memberships



Individual & Group Levels

Founding Member Pricing

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