

## BEST PRACTICES

# Managing Patients with Multiple Chronic Conditions

## ARCH HEALTH PARTNERS CASE STUDY

### Organization Profile

Palomar Pomerado Health, a public hospital system that includes 2 hospital campuses and 2 skilled nursing facilities, and Centre for Health Care, a multispecialty medical group established in 1992, came together in April 2010 to form Arch Health Partners—a medical foundation. Arch Health Partners has 2 locations in California, one in Poway and one in Ramona, and serves the northern region of San Diego County. Arch Health Partners has more than 40 physicians, including 22 primary care physicians and multiple specialties (dermatology, neurology, ophthalmology, gastroenterology, orthopedics, and ear, nose, and throat.) Arch also has an Urgent Care Center on its main campus that is open 7 days a week. Patient visits approach 150,000 annually. Arch physicians began using the Next Gen electronic medical record (EMR) in 2009.

### Project Summary

Arch Health Partners implemented a coordinated care management team approach, driven from within the primary care environment and focused on whole-person, proactive disease management, use of a nurse practitioner in the skilled nursing facility (SNF) setting, transition coordination, and special attention to complex cases.

### Program Goals and Measures of Success

As a medical group with financial responsibility for a population of Medicare Advantage senior patients, Arch placed responsibility for chronic disease care coordination and transition management with its primary care physicians (PCPs). The group's internal medicine physicians also act as hospitalists. Arch recognized that a team effort was required to support the PCPs and hospitalists and ensure success in providing coordinated care to improve patients' experiences and outcomes in a meaningful and measurable way.

The performance measures that Arch uses for the Medicare Advantage population are detailed in Table 1. For this project, Arch wanted to:

- Avoid poor transitions from the inpatient setting to home that result in unnecessary hospitalizations and readmissions
- Ensure all patients receive necessary chronic disease care
- Prevent issues caused when patients do not understand their discharge instructions

Prior to implementation of the care management team initiative, Arch looked at successful chronic disease care models for elements that could be effectively incorporated, including Stanford's Chronic Disease Self-Management Program, Coleman's Care Transitions Intervention, the Naylor Model, and the National Committee for Quality Assurance (NCQA) requirements for complex case management. Although Arch does not follow any single model in its entirety, it incorporated elements from these successful programs.

#### **Objectives for the care management program:**

- Coordination throughout the continuum of care
- Improved planning for care transitions
- Enhanced communication and engagement of the patient throughout all levels of care

#### **Performance has been evaluated in several ways:**

- Inpatient bed days (compared with Milliman well-managed benchmarks and Medicare Advantage network benchmarks)
- Inpatient length of stay (compared with Milliman well-managed benchmarks)
- All-cause inpatient readmission rates (compared against regional Medicare Advantage network benchmarks)
- Diabetes quality data as compared against the Integrated HealthCare Association's (IHA) pay-for-performance data.

#### **Highlights include:**

- Senior Medicare Advantage HMO bed day utilization has declined since 2007 and consistently exceeds the Milliman benchmark for well-managed delivery systems.
- Senior Medicare Advantage lengths of stay have declined by over 14% since 2007, from 4.9 to 4.2, and are now performing at the Milliman benchmark for a well-managed delivery system.
- Discharge appeals (not tracked explicitly) are nearly nonexistent, and the discharge decision is almost always upheld if an appeal does occur. They reflect patient expectations; ie, if a patient understands their discharge plan from day 1, they will not be surprised and appeal their discharge.
- Glycemic control levels, as measured by HgA1c levels < 8%, have exceeded the IHA 90th percentile for performance for the past 2 years. Preliminary internal results on all-cause readmission rates for Medicare Advantage plan members are at 9%—a very strong result that far exceeds the regional benchmark.

**Table 1**

Outcome Metric	2007	2008	2009	2010	Benchmark
Acute Senior Bed Days/1000 <sup>1</sup>	1038	954	959	974	1012 (Milliman Medicare well managed)
Senior Inpatient LOS	4.9	4.7	4.4	4.2	4.2 (Milliman Medicare well managed)
Diabetes A1c Control < 8% <sup>2</sup>	n/a	91.1%	89%	86%	84% (90th percentile 2010 IHA pay for performance; Medicare population)

<sup>1</sup> Includes Acute Rehab, Psych, Med-Surg

<sup>2</sup> Based on IHA testing results for 2008, public data for 2009, preliminary result submitted to IHA auditor 2010

## Population Identification

Historically, Arch's primary target for chronic disease management has been the HMO population, with a particular emphasis on Medicare Advantage seniors.

### *Demographics*

40% of patients are aged 65-74 years

40% of patients are aged 75-84 years

20% of patients are over aged 85 years

Patient information is provided monthly by the Medicare Advantage health plan and Ingenix, a subsidiary of United Healthcare (United Healthcare's Secure Horizons is Arch's largest Medicare Advantage plan). This patient management report includes proprietary risk stratification, risk adjustment factor (RAF) scores, chronic medical conditions, and contact information. The chronic medical conditions identified include:

- Congestive heart failure (CHF)
- Chronic obstructive pulmonary disease (COPD)
- Diabetes
- Coronary artery disease
- Dementia
- Cancer
- Rheumatoid arthritis
- Asthma
- Cardiovascular disease
- Peripheral vascular disease
- Depression

## Registries

Comprehensive data registries (provided by Intelligent Healthcare), which are updated bi-monthly with relevant lab, pharmacy, and visit data, are maintained for seniors with:

- Ischemic vascular disease or recent cardiac procedures
- Chronic disease and comorbid depression
- Diabetes
- Persistent medications (angiotensin-converting enzyme inhibitors [ACEIs], angiotensin II receptor antagonists [ARBs], digoxin, diuretics)

Finally, lab and medication data for all patients in the Coumadin Anti-coagulation Clinic are maintained in a database.

## The Intervention

### “Whole Person” Disease Management

Arch believes that single-focus disease management, without integration of the patient’s comorbid conditions and hospital stays, is not as effective as programs that deal with all of the patient’s problems. This is a key disadvantage of many disease management efforts. Instead, the group strives to offer programs that engage the patient, the provider, and office staff through a combination of data and feedback, incentives (where appropriate), and education.

Lab monitoring is an example of how this coordinated approach can provide better care. A patient on Coumadin, who also has diabetes and is on long-term medications, will be contacted by the disease management RN to have any needed labs (International Normalized Ratio, diabetes panel, serum K+, and blood urea nitrogen/creatinine) done all at once, not by multiple sources for disease-specific labs.

#### Programs include:

- In-house Coumadin Clinic: run by an RN under protocol to manage patients on anti-coagulation therapy. The RN is responsible for educating the patient regarding this therapy, ensuring that the appropriate lab tests are done regularly to monitor coagulation status, and titrating medications.

- Diabetes management: provided by an RN as well as a certified diabetes educator (CDE) who educate and activate patients regarding their diabetes. Where appropriate, medication is titrated to achieve glycemic control goals. An extensive classroom education series is offered, along with a monthly support group. Recently, Arch piloted small patient incentives (gift cards for a local health food grocery store) for achieving screening and control goals. Personal consultations are offered at no charge, with a protocol that allows the RN to reach out to patients with poorly controlled diabetes for this service.
- Smaller disease management programs: offered for patients with depression and comorbid chronic disease, CHF, COPD, and asthma.

### Personalized, Proactive, Inpatient Case Management

Inpatient case management was previously done remotely via review of the patient’s clinical notes and contact with hospital discharge planners. This approach was impersonal and inconsistent and did not provide direct communication with Arch hospitalists to understand and coordinate the plan of care.

The inpatient case manager’s responsibilities were revised to include daily, on-site rounding at the primary admitting hospital to review the patient’s plan of care with the hospitalist and to meet the patient and family to personally discuss the discharge plan and post-discharge needs. Patients with chronic conditions that require careful monitoring in the ambulatory setting are introduced to Arch disease management staff, and patients transitioning to skilled nursing are given the name and role of the SNF nurse practitioner.

To be successful, a highly motivated RN or LVN with excellent interpersonal and communication skills is needed. The inpatient case manager must also be very well versed in the level of care requirements for acute rehabilitation, SNF, or long-term acute care.

Apart from an improved bed day trend, this approach has proven very popular with Arch hospitalists (internal medicine physicians). It also has virtually eliminated the “Friday afternoon fire drill,” as all plans are in place well in advance of the patient’s discharge.

### **Nurse Practitioner in the SNF Setting**

With shorter hospital lengths of stay, patients in SNFs today have a much higher level of acuity and often have multiple chronic medical conditions, such as diabetes, CHF, atrial fibrillation, COPD, and dementia. Many are facing end-of-life care or long-term placement decisions. A monthly visit from a physician, though meeting regulatory requirements, is not always optimal to address their complex needs.

Arch’s nurse practitioner visits patients at several SNFs at least bi-weekly, paying careful attention to medication reconciliation and taking time to discuss end-of-life planning where appropriate. The nurse practitioner also ensures that a follow-up appointment is scheduled with the appropriate physician prior to discharge. This appointment is communicated electronically to the patient’s PCP and into the EMR, along with the discharge summary and medication updates.

The SNF staff are made aware of the discharge plan early. Calls regarding patient care are handled by the nurse practitioner until 8 pm Monday through Thursday. This easy access ensures that SNF staff report even minor changes in patient condition promptly, rather than waiting until an issue becomes acute. This promotes timely intervention and reduces the likelihood of a hospital readmission.

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### Post-ER and Postdischarge Follow-up

The practice's goal is to reach at least 75% of all Medicare Advantage members who have visited the ER within 48 hours regarding:

- Symptom resolution
- Confirmation of PCP follow-up if indicated
- Education regarding alternatives to ER care for non-emergency medical conditions (such as the Urgent Care Center)

Patients with frequent ER use are identified as candidates for possible complex case management and the PCP is alerted.

Follow-up calls also are made to seniors discharging from inpatient and SNF settings. The goal is to reach at least 75% of these patients within 48 hours of discharge. Key discussion topics are included in a pull-down menu within the EMR. Call summaries are sent to the patient's PCP. If a need is identified, the appropriate referral or physician communication is initiated. For complex cases, this call also serves as the first complex case management contact and assessment data are gathered.

### Complex Case Management for High-risk Patients

Patients with poorly controlled chronic medical conditions are at risk for hospitalization and are drivers of today's unsustainable medical costs. Approximately 2% of the group's senior population falls into this category (as defined by the Ingenix risk classification system.) The clinical judgment of team members is relied upon heavily to supplement these data. These patients are enrolled in the Complex Case Management Program and assigned to a complex case manager. These are not dedicated positions; instead, the inpatient case manager, SNF nurse practitioner, and disease management RNs fill this role. The caseload is 10 complex patients for the nurse practitioner and disease management RNs and 2 to 5 for the inpatient case manager.

Patients are discussed at conferences under the guidance of the medical director. Following NCQA guidelines for complex case management, an assessment is completed, short- and long-term goals and potential barriers are identified, and a self-management care plan is created. A follow-up contact schedule is established. An essential element of this program is patient access to the direct contact information of the assigned complex case manager.

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## Workflow and Process Changes

Inpatient and SNF discharges are noted on the “board” and assigned to a care team member for follow-up. ER visit logs are provided by Arch’s hospital partner (PPH) for follow-up calls.

Complex Case Management Program candidates are identified regularly (from inpatient activity, ER activity, physician referrals, Ingenix data) and assigned to the appropriate team member.

## Information Technology

Arch has access to electronic data from its hospital partner, and this is helpful. Ideally, the group would like to have automated delivery of summary information with every transition of care. Case management documentation is currently done stand-alone in Excel, which is very cumbersome. The group wants to develop a Next Gen template for this purpose.

## Leadership Involvement and Support

Arch’s medical director recognized that more effort was needed in managing care transition “danger zones.” He had a strong conviction that care coordination services are most effective when driven from within the PCP environment, not from an outside agency or health plan. As a result, the board of directors agreed to a reorganization plan to strengthen disease and care management efforts.

In early 2008, the medical director lobbied the board to strengthen Arch’s efforts. At one point, some of the positions that ultimately helped the group succeed were at risk for elimination. He argued they were needed to maintain the quality of services, and instead of being eliminated, they were retained and another position was added.

Physicians receive financial incentives for successful diabetes management. They also receive incentives for referring at-risk patients to the diabetes educator and RN for disease management education. Referrals to our Care Management programs are incentivized when high-risk patients are referred. We believe that the patient is more likely to participate with this endorsement by the physician management education programs.

## For Additional Information

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## Lessons Learned

Arch's goal is to ensure safe, effective, and efficient clinical care. The organization relies on the commitment of its leadership to maintain support for its programs.

Challenges to Arch's continued success include:

- Finding, developing, and funding IT solutions to minimize the documentation time required by care team members and maximize productivity.
- Obtaining financial support for the professional staffing costs required to maintain a high-quality care team.

Arch's advice to others:

- Get commitment from the top.
- Communicate the benefits early and often, even if they are qualitative and anecdotal, until you have objective data.
- Arch's approach is grounded in the belief that the future of health care depends upon a rather dramatic change in how care is delivered, and believes it is essential to improve chronic disease management and continuity of care for the senior population.



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