

Complex Care Management Toolkit



Introduction

The following document is a guide to improving and implementing a complex care management program for individuals with multiple chronic conditions, limited functional status, and psychosocial needs, who account for a disproportionate share of health care costs and utilization. This toolkit summarizes ideas to improve an existing complex care program, or implement a new one. In the document, there are links to numerous resources and tools that you can adapt as you build or test changes for your program.

The following graphic provides an example of where a complex care management program might fit in your organization, as it relates to other efforts for population, disease or case management.

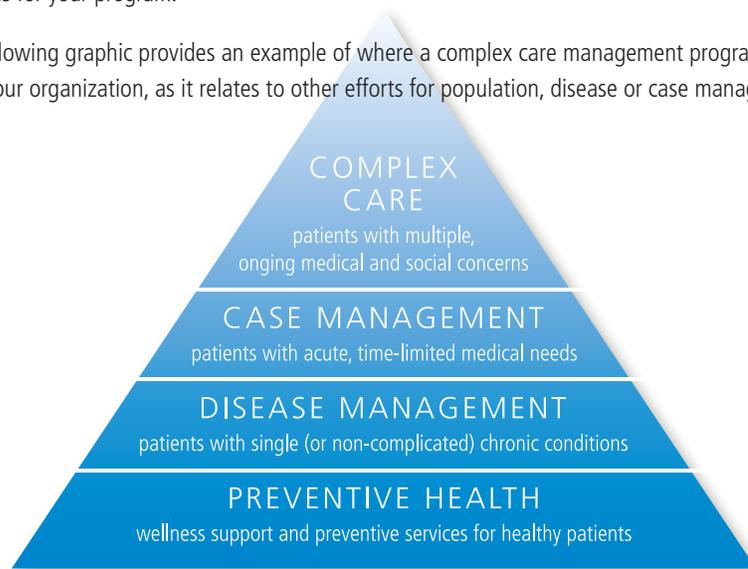


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The changes suggested in this change package were gleaned from a variety of sources:

- ▶ Learning from a 12-month Complex Care Management Action Community, funded by the California HealthCare Foundation (CHCF) – The Action Community convened eight California organizations that are working to redesign and improve care for their “complex” patients. Its purpose was to: 1) facilitate peer learning among the organizations so that they could learn about, share, and test improvements in complex care; and 2) develop this toolkit based on the learning from these organizations
- ▶ Feedback from experts in the field
- ▶ Evidence-based practices cited in the literature

We hope you find this resource helpful. We would appreciate hearing from you about your experience using this guide in an effort to improve its use across organizations. Please contact CQC with suggestions, comments or questions:

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If you've received a paper version of this toolkit, please visit our website (www.calquality.org) to download an electronic version, which will allow you to access all of the links to the resources within the toolkit.

Getting Started

As you get started, ask these important questions to determine if you can/should move forward with developing a complex care management program:

- ▶ Can the organization articulate the purpose of a complex care program? How the program would help physicians and patients?
- ▶ What is the business case behind improving care for high-risk patients? For example, does your group accept full-risk for patients or are there management fees or shared savings dollars available?
- ▶ Is the organizational leadership engaged as evidenced by the commitment of financial and staff resources?
- ▶ Can you identify your target population (both who you would start with and ultimately who you would like to serve)? What data do you have that can help you identify and stratify your high risk population (utilization, diagnoses, pharmacy data, etc.)?
- ▶ Is there adequate capacity within primary care and disease case management within your organization so that patients can “graduate” out of high-risk programs, when appropriate?
- ▶ Are physicians engaged and do they understand the program? (proxy: if you ask physicians what the intervention is, can they describe it and do they visibly support it?)
- ▶ Are patients involved in the design of the program? Is there a process in place to get feedback from patients and their families/caregivers on an ongoing basis?
- ▶ Are the practice site and facility leadership involved and engaged – do they buy in?
- ▶ Are the necessary partners aligned, such as payers, hospitals, and specialists? Do you have what you need from these partners, such as data or a process for data flow?
- ▶ Do you have a data measurement plan in place to measure effectiveness of the program?

Good foundational resources

- ▶ [Robert Wood Johnson Foundation: The Synthesis Project. Care management of patients with complex health care needs.](#) Several summary documents can be found here.
- ▶ [The Promise of Care Coordination: Models that Decrease Hospitalizations and Improve Outcomes for Medicare Beneficiaries with Chronic Illness. A Report Commissioned by the National Coalition on Care Coordination.](#) By Randall Brown, PhD, Mathematica Policy Research.
- ▶ [IHI White Paper on Care Coordination Model: Better Care at Lower Cost for People with Multiple Health and Social Needs](#)
- ▶ [Summary and evaluation of Boeing’s Intensive Outpatient Care Program \(IOCP\) in the Puget Sound area in Washington.](#) Health Affairs Blog.
- ▶ [Evolution of Complex Care Programs from the California Improvement Network](#)



Getting Started – Step-by-Step

Define the business case for your organization.

- ▷ What are the clinical and organizational problems that you are trying to solve? The business case will vary by business line: Medicare Advantage? Accountable Care Organization (ACO)?
- ▷ How will you know if you are solving them (i.e., lower rates of emergency department use or hospital admission)?

Identify patients. Work with a health plan partner that can identify candidate patients via a predictive risk tool, then refine the patient list based on clinical input, functional status, patient activation and social support. If you do not have a health plan partner, try a simple risk algorithm using existing data, then refine the patient list in the same manner. Start small, with 10 patients for example. Knowing who your target patients are will likely inform your initial care model design and target practice sites.

Determine the care model. Consider existing resources and staff. *For example*, it may be easiest to start with an existing, centrally located care manager who is accustomed to working with more complex cases, and with 1-2 practice sites where you have physician buy-in.

Define care manager role and provide training. Slowly ramp up the responsibilities and caseload of the care manager over time, starting off with recruitment phone calls, transitioning to intake visits and assessments, and eventually to independently managing a panel of patients. Develop a plan for training that includes shadowing internal experts, 1:1 mentoring, motivational interviewing and care transitions support training within the first several months.

Recruit and enroll patients. An initial call from the PCP's office staff, followed by a letter on physician office letterhead, then followed by a call from the care manager or an enrollment specialist to enroll the patient is a good starting point for your process. Engage patients by asking them for feedback on the recruitment and enrollment process so you can refine over time.

Intake, assess and stratify. Develop an initial intake and assessment process that includes establishing an initial care plan and goals and identifying any critical care needs. Consider having the initial visit face-to-face to build trust between the patient and care manager.

Provide support and interventions through your care team:

- ▷ Ongoing outreach and care coordination
- ▷ Care transitions support
- ▷ Patient engagement and activation
- ▷ Case conferences
- ▷ Ongoing communication with PCP

Create a systematic approach to identify, assess, and engage larger numbers of patients and providers. Expand your program by adding targeted subsets of patients and engaging practice sites or providers that are receptive.

Measure and continually adapt/improve the approach. Set up a measurement plan early in the process. Refine your approaches, tools, and processes on an ongoing basis.

Starting as a Pilot

Start the program as a pilot, with engagement of a limited number of physicians and patients. This approach enables the following:

- ▷ Rapid testing and process development
- ▷ Relationship development and identification and engagement of program/clinical "champions"
- ▷ Refinement at small scale
- ▷ Starting with a sub-population the organization, payers, providers, and partner organizations care about as a way to engage and build interest
- ▷ Making an informed decision about spread

Throughout the process above: Engage leadership, physicians, staff and patients in the planning process through rapid testing



PATIENT IDENTIFICATION AND RISK STRATIFICATION

CHANGES TO TRY:

Develop an initial algorithm or set of criteria to identify candidates for your high-risk/complex care program. If your organization has access to claims data, there are several off-the-shelf claims-based tools that produce a prospective risk score based on some combination of the following: demographics, utilization, diagnoses, medication/prescription fill information, existence of co-morbidities, and previous costs. These tools provide objective, replicable methods, but are imperfect; therefore, it is important to refine the list of identified patients using other inputs (see below for stratification ideas).

In the absence of claims data, see the “tip sheet” on the right for a starter set of variables to use in the development of a risk algorithm – a basic list should include age, hospital/emergency department utilization, volume of medications, and key diagnoses.

Keep in mind:

- ▷ No approach/algorithm will be perfect – start simple with the data you have readily available, or by building a panel through PCP or post-discharge referrals only
- ▷ Looking at the data coupled with clinical review (care team reviewing charts, PCP clinical assessment, or asking the PCP) seems to yield the best results (see stratification tips below)
- ▷ There will be high-risk patients who are not identified using your approach – use multiple methods to identify high-risk patients to help mitigate this risk
 - ▷ Other methods include: direct referrals from PCP, disease case managers, or health plans; or identification at significant care transitions
- ▷ There will be patients identified by your approach who do not need a high-risk intervention – further stratification and assessment should help to make these distinctions.

RESOURCES:

[Tip sheet for identification of high-risk patients](#)

Examples of tools:

- ▷ [Risk stratification tool \(CalOptima\)](#)
- ▷ [Identification and stratification tool \(MemorialCare\)](#)
- ▷ [Vulnerable Elders Survey \(VES-13\) instrument and information](#)

[Predicting the Financial Risks of Seriously Ill Patients by Stuart Levine, MD et al \(paper published on the CHCF website\)](#)

Once candidates for a high-risk program are identified, **stratify them into different levels of interventions and outreach intensity** by one or more of the following:

- ▷ Apply an assessment or triage process by having care managers make initial phone calls or meet face-to-face with each patient
- ▷ Develop a risk stratification tool that includes elements not readily available in the data, such as social support, functional status, health assessment scores, and patient activation
- ▷ Psychosocial factors are difficult to capture in an algorithm, but are a significant predictor of utilization – they should be included in any stratification process
- ▷ Apply clinical input – for example, send a PCP his/her list of candidate patients and ask the physician: “Identify patients who you would not be surprised if they were in the emergency department or hospital in the next 6 months.” Or for Medicare patients, the above question and: “Identify patients who you would not be surprised if they became seriously ill or died in the next 12 months.”
- ▷ Use a “no wrong door” approach – your referral and stratification processes will not be 100% accurate, so build flexibility and expectations into your system so that staff can move patients into the program that best suits their needs

Examples of tools:

- ▷ [Assessment and stratification tool \(Humboldt\)](#)
- ▷ [Identification and stratification tool \(MemorialCare\)](#)

(Also see Care Management Model Design below for examples of levels of care)

Assess readiness and activation to assist with triage by using the Patient Activation Measure (PAM):

- ▷ [Article on development of PAM](#)
- ▷ [Article on short form PAM](#)
- ▷ [Link to vendor website – InsigniaHealth](#)

PATIENT IDENTIFICATION AND RISK STRATIFICATION

CHANGES TO TRY:	RESOURCES:
<p>Over time, refine your identification and risk stratification approaches as you gain more experience and information.</p> <ul style="list-style-type: none"> ▶ Test your approach against your data – does the approach/algorithm capture patients with persistent, actionable and costly conditions? ▶ Review patients that you thought your program should serve but who were not identified as being eligible – Are there common characteristics that define these patients that could be added to your identification or risk stratification algorithms? ▶ Review patients who matched your initial criteria, but really weren't "complex" – Are there common characteristics that define these patients that might be removed from your identification or risk stratification algorithms? ▶ Evaluate whether risk scores correlate with actual costs over time 	<p>Presentation on refinement of risk stratification and definition of case types (CalOptima)</p>
<p>Re-assess patients enrolled in your complex care program on an ongoing basis to ensure they are in the appropriate level of care/intervention and to take a periodic "roll-call" – the high-risk population is dynamic due to disenrollment, transfer to hospice care, improved ability to self-manage and death.</p> <ul style="list-style-type: none"> ▶ Seniors in a complex care program will likely need to be reassessed approximately on a quarterly or semi-annual basis, whereas commercial members in your program may be reassessed yearly ▶ Lower acuity patients may have changing risk factors that require increased outreach and support by licensed individuals ▶ When deciding whether to transition patients between levels of care, factors that have been found to be useful are: stages of disease, psychosocial evaluations, assessment of functional status (including ADLs and Vulnerable Elders Survey VES13), and clinical input from the care team ▶ When graduating a patient to a lower acuity level, an interdisciplinary care team meeting may be useful to reach consensus 	<p>Presentation on re-assessment of patients (High Desert Medical Group)</p> <p>SF-12 functional health assessment and licensing information</p> <p>UCLA health and aging resources and Fall screening questions</p> <p>PHQ 9 depression screening</p>

COMPLEX CARE MANAGEMENT MODEL DESIGN

CHANGES TO TRY:	RESOURCES:
<p>Consider at a high-level how your complex care program will be structured. Based on results from Medicare Coordinated Care Demonstration projects, these elements were found to be part of successful programs¹:</p> <ul style="list-style-type: none"> ▷ In-person contact with patients ▷ Timely information on hospital and emergency room admissions ▷ Close coordination between the care manager and PCP ▷ Coordination of care transitions and close follow-up ▷ Patient self-management support and activation, including medication education ▷ Social support <p>Complex care programs are typically offered in one (or a combination) of the following models:</p> <ul style="list-style-type: none"> ▷ Embedded care manager model (contains most of the recommended elements listed above) where complex care managers are assigned to one or more dedicated practice sites and are located onsite – this model promotes close coordination with primary care, but may not work well if patients are not concentrated in a few practices ▷ Centrally located care management where complex care managers are located at a central office and provide care to multiple practice sites – this model may not work as well as models that integrate care management with primary care upfront, but simplifies the distribution of care manager resources across multiple sites ▷ “Bricks and mortar” clinic where an “intensivist” is assigned a high-risk patient panel. Patients are temporarily reassigned from their PCP to this intensivist. Some 20-50% of patients may decline care offered in this setting, especially in an IPA; patients tend to prefer “local” and “familiar” for their care. A bricks and mortar clinic might be better used as a supplemental option given the decline rate. 	<p>The Promise of Care Coordination – Summary of models that decrease hospitalizations and improve outcomes for Medicare beneficiaries</p> <p>Evaluation of Medicare Coordinated Care Demonstration Projects by D. Peikes et al in JAMA</p> <p>Example high-level process flows:</p> <ul style="list-style-type: none"> ▷ Sample complex care management process flow ▷ High Desert Medical Group Connections for Life process flow
<p>Use continual process improvement methods to develop levels within your complex care program that vary based on severity of illness and other key factors, such as social support – with varying levels of outreach frequency and intensity (telephonic vs. in-person). Some patients may be able to self-manage well with only telephonic support, whereas others will need face-to-face visits in the home or at the clinic.</p>	<p>Examples of levels of care:</p> <ul style="list-style-type: none"> ▷ HealthCare Partners approach ▷ High Desert Medical Group complex care program description ▷ CalOptima levels of care ▷ Humboldt levels of care

¹ *The Promise of Care Coordination: Models that Decrease Hospitalizations and Improve Outcomes for Medicare Beneficiaries with Chronic Illness. A Report Commissioned by the National Coalition on Care Coordination.* Randall Brown, PhD, Mathematica Policy Research.

COMPLEX CARE MANAGEMENT MODEL DESIGN

CHANGES TO TRY:	RESOURCES:
<p>Take a broad and interdisciplinary approach to building your complex care team – Build on what you have and align with the needs of the patients you are managing:</p> <ul style="list-style-type: none"> ▷ Typical care teams consist of a nurse care manager who has responsibility for the care management of a patient in partnership with the patient’s PCP, with support from a social worker, behavioral health specialist, and other care providers as necessary (such as a respiratory therapist) ▷ The “right” care manager / patient ratios will evolve over time as your program matures. <ul style="list-style-type: none"> ▷ The ratios will vary based on your population and acuity levels – panels tend to be larger with commercial patients than with Medicare patients ▷ A common ratio seen in complex care programs is one care manager per 200 commercial patients, or one care manager per 50-60 highest-acuity patients ▷ Analyze the particular needs of your population by looking at top diagnoses (or top causes for admission) to determine the need for respiratory therapists for COPD, or home health support resources for frail elders or homebound patients, for example ▷ If fully dedicated behavioral health and social work resources are not available, work with these departments to designate an individual to be your complex care program’s point of contact ▷ Consider one dedicated medical director (or physician advocate/champion) for the program who can work with a number of care teams and contribute clinical oversight and guidance, especially for case review and triage – this may be more scalable than having a series of part-time physicians per team 	<p>Sample staffing model for an intensive outpatient care program pilot</p>
<p>Promote face-to-face interaction between care managers and their patients.</p> <ul style="list-style-type: none"> ▷ The first care management visit is ideally face-to-face ▷ If management is primarily telephonic for lower acuity patients, initiate the relationship with a home visit or a clinic visit, or attend a PCP visit with the patient, to build a foundation for the relationship ▷ If care managers are centrally located, designate certain times and days of week where they can visit practice sites on a rotating basis to meet with patients and providers in person 	<p>Examples of agenda setting forms, goal setting forms and action plans to use in patient interactions on CHCF’s Team Up for Health Website</p>
<p>Emphasize patient self-management techniques and include the patient’s support system.</p>	<p>Resources to promote self-management at CHCF’s Team up for Health website: http://www.teamupforhealth.org/</p> <p>CQC summary of patient self-management resources</p>

COMPLEX CARE MANAGEMENT MODEL DESIGN

CHANGES TO TRY:	RESOURCES:
<p>Make care transitions support a priority among the daily tasks for a care manager.</p> <ul style="list-style-type: none"> ▷ Work with hospital partners to ensure you receive same-day notification of emergency department (ED) or hospital admissions ▷ Conduct a daily admissions and ED census review with relevant parties to ensure the important, non-clinical information is transferred from one provider to another ▷ Contact patient 24-48 hours post discharge ▷ To facilitate safe and smooth care transitions, some provider organizations have employed: <ul style="list-style-type: none"> ▷ Inpatient case manager or hospitalist coordinator to conduct daily inpatient reviews; meet with hospitalists, any independent physicians, specialists, or surgeons; facilitate care; educate and manage patients; ensure follow-up care is arranged ▷ Associate medical director with inpatient responsibilities to conduct daily inpatient discharge rounds with case managers and hospitalists, and to conduct weekly phone rounds with SNFist 	<p>Presentation on continuum of care initiatives (Greater Newport Physicians)</p> <p>The Post-Hospital Follow-Up Visit: A Physician Checklist to Reduce Readmissions by Eric Coleman, from CHCF</p> <p>IHI resources on reducing readmissions</p> <p>Transitions of care policy (St. Joseph Heritage)</p>
<p>Engage leadership, develop relationships, and be explicit about expectations to ensure high quality of care at skilled nursing facilities (SNFs).</p> <ul style="list-style-type: none"> ▷ Schedule quarterly meetings (with SNF’s administrator, director of nursing and physical therapy, discharge planners, etc.) to build relationships, improve communication, discuss cases, and improve transition processes ▷ Consider assigning a case manager with responsibility for SNF patients ▷ Develop a SNF dashboard with measures such as admission rates, readmission rates, ED visit rates, appeals, grievances, and member satisfaction – display the performance of other SNFs used 	
<p>Use virtual or in-person multi-disciplinary case conferences to facilitate communication among all providers caring for a patient, to identify additional resources needed, to discuss transition of patient to a different level within the complex care program, and to modify the individualized care plan as necessary.</p> <ul style="list-style-type: none"> ▷ Include complex care managers, social workers, PCP, medical director/physician champion, specialist, behavioral health specialist (on an as-needed basis) ▷ Benefit of including specialists is that they can help educate the team and build competencies ▷ Reach out to PCP in advance of case conference to invite them to attend, explain the purpose of the conference, and to ensure them they are not “losing” control of their patient ▷ Hold on a bi-weekly or monthly basis for 1.5 – 2 hours ▷ If possible, rotate locations of the meetings among practice sites to engage different providers ▷ Consider using the “SBAR” format (Situation, Background, Assessment, Recommendation) 	<p>Case conference sample agenda (MemorialCare)</p> <p>Information on SBAR Technique for Communication: A Situational Briefing Model</p>
<p>Provider organizations have found it helpful to expose care managers to the concepts of advance health care planning and make resources available internally, to promote meaningful conversations with patients to consider their wishes regarding end-of-life care and selecting a surrogate decision-maker.</p>	<p>Training resources and information available at: http://www.capolst.org</p>

CARE MANAGER AND CARE TEAM ROLES AND TRAINING

CHANGES TO TRY:	RESOURCES:
<p>Develop a complex care manager job description and expectations that include the following key components:</p> <ul style="list-style-type: none"> ▷ Take initiative with physicians and patients as the manager of the patient’s care – delegate, direct and coordinate in a leadership role ▷ Set expectation that care managers have a dual role of managing the patient and maintaining contact with the PCP; PCPs must be able to see notes from care manager discussions ▷ Prioritize support for patients currently in the hospital or ED, or currently in the discharge process – care transitions are critical life moments when patients develop trust in the system or lack thereof ▷ On a daily basis: Triage incoming phone calls; Check upcoming appointments for potential patients to meet and recruit them; Check upcoming appointments for existing patients to meet them face-to-face; Conduct intake visits; Place recruitment calls; Place outreach calls; Coordinate care; Pre-visit planning ▷ Some programs have found it more efficient to have a non-licensed individual handle administrative tasks, such as making appointments, rather than use valuable nurse care manager time 	<p>Sample nurse care manager responsibilities (Humboldt)</p>
<p>When hiring care managers, use a case scenario interview approach and involve a team in the interview process:</p> <ul style="list-style-type: none"> ▷ Use case competencies in the interview process – give several case studies to candidates about one week before the interview; use those case competencies to drive questions and discussion in the interview (there is no right or wrong answer, but this helps to assess critical thinking and mindset of the candidate and helps to tailor the training if they are hired) ▷ Involve a team of people in the interview process, such as peers, direct manager, upper management, clinic manager, and other nurses 	<p>Care manager recruiting and training tips</p> <p>Case study samples for nurse care manager interviews (Everett Clinic)</p>
<p>Develop and offer training modules over time for new and existing care managers that include the following components:</p> <ul style="list-style-type: none"> ▷ Orientation training – Orientation basics, such as case management software/EMR, how to enroll a patient and conduct an intake and assessment ▷ Provide motivational interviewing training, care transitions training, and proactive planning and management over time, but within the first three months ▷ Provide 1:1 support and training for the first three months – for example, on a weekly basis, have a care manager or leader sit down to review cases with the trainee ▷ Provide opportunities to learn from internal experts and peers through some of the following ways: <ul style="list-style-type: none"> ▷ Shadow content experts in the first couple weeks after hire, such as disease management leads, diabetes educators, CHF clinic leads ▷ Shadow more experienced care managers dependent on their strengths – have them complete an intake and routine follow-up call, home visit, clinic visit, and/or hospital visit with the trainee ▷ Meet 1:1 with each of the department heads that interfaces with the complex disease program – discuss how the departments interact and mutual expectations ▷ Partner a new care manager with a mentor over the course of 3-6 months, so the new arrival has a dedicated resource; it may be necessary to bring in temp resources to assist the mentor during this period ▷ Ramp up the responsibilities and caseload of the care manager over time – for example: have the care manager responsible for only recruitment phone calls and scheduling intake visits the first couple weeks; do not have the trainee responsible for on-call for the first three months; only do home visits with peers the first three months 	<p>Care manager recruiting and training tips</p>

CARE MANAGER AND CARE TEAM ROLES AND TRAINING

CHANGES TO TRY:	RESOURCES:
<p>Promote face-to-face interaction between members of the care team to build strong relationships and trust and to facilitate communication about patients via:</p> <ul style="list-style-type: none"> ▷ Routine in-person multidisciplinary case conferences ▷ Co-location of care managers in primary care offices, or presence of the care manager at the primary care office at regular intervals 	
<p>Create a system for internal best practice sharing and peer support, which increases internal consistency, facilitates purposeful cross-fertilization, and supports care managers.</p> <ul style="list-style-type: none"> ▷ Recognize burn-out and staff fatigue – provide support for your staff, just as you provide care to your patients and their caregivers ▷ Implement weekly huddle calls (15-30 minutes in length) with the complex care team to discuss: what is going well; what is not going well; what barriers management can break down so that care managers can focus on the patients. ▷ Train care teams on effective facilitation and communication skills and role clarification – use scenarios and case-based learning. 	

PHYSICIAN AND OFFICE STAFF ENGAGEMENT

CHANGES TO TRY:	RESOURCES:
<p>Solicit input from physicians and care management staff in the development of the program.</p>	
<p>Identify a physician champion or medical director to pave the way in conversations with physicians to recruit them to participate in the program:</p> <ul style="list-style-type: none"> ▷ Meet face-to-face with providers to: educate them on the plan for a complex care program; share information on how complex care programs have worked in other geographies; share with the physician a vision of the end state and a roadmap with milestones of how you will get there ▷ Discuss one or more of that physician’s patients as examples – prod physicians to think about what it would mean to have a care manager involved in the patient’s care as a way of demonstrating how the program can be of value to them ▷ Come prepared with talking points – they are likely to be curious about how the high-risk patients were identified; give them the opportunity to make referrals themselves ▷ Providers will want to be engaged in different ways – for some, a 1:1 conversation will work, whereas others may prefer a group discussion ▷ Practice respectful listening in these conversations ▷ Start with high-volume providers ▷ No matter how many times you have spoken with a provider regarding your program, always start from the beginning 	<p>Resources on effectively engaging physicians</p>

PHYSICIAN AND OFFICE STAFF ENGAGEMENT

CHANGES TO TRY:	RESOURCES:
<p>Once you have a list of candidates for your complex care program, engage the practice in refining the target list of patients. Ask the physician to rank the patients on the list, which are best candidates for care management, which are the least.</p> <p>(If applicable, ask the office manager to confirm whether the patient attribution using claims is correct.)</p>	
<p>Maintain communication between the complex care manager and PCP through:</p> <ul style="list-style-type: none"> ▷ Virtual case conferences – invite PCPs to attend, either in-person or on the phone ▷ Ensure that PCPs have access to notes from care manager appointments ▷ Consider co-location or designated times for care manager to be onsite 	
<p>Share successes internally with physicians, office staff, and care management staff so that they see progress – anecdotes or case studies can build support and enthusiasm.</p>	

PATIENT ENGAGEMENT AND ENROLLMENT

CHANGES TO TRY:	RESOURCES:
<p>Solicit feedback from patients on your program’s logo, name, recruitment process, and materials, such as enrollment letters; for example, Humboldt learned that calling “Priority Care” a service, rather than a program, appeals more to patients.</p> <ul style="list-style-type: none"> ▷ Words matter – involve patients in your communication strategy ▷ Get continual feedback from patients ▷ Train patients to be a part of team meetings 	
<p>Have the physician office staff lead recruitment of patients into the program, rather than any central IPA staff or the physician; patients grow concerned when they receive a call from the physician and associate office staff with the practice.</p> <ul style="list-style-type: none"> ▷ Introduction to the program by the PCP/PCP’s office staff improves enrollment and trust in the program ▷ An initial call by the PCP’s office, followed by a letter on physician office letterhead, then followed by a call from the care manager to enroll the patient is a good starting point for recruitment, but may require testing and refinement ▷ Be flexible as patients may prefer different approaches to enrollment and outreach ▷ Consider using an “Enrollment specialist” instead of the care manager to make the initial recruitment call and schedule the first visit 	<p>Sample patient enrollment letters (Humboldt)</p> <p>Sample patient participation agreement (Humboldt)</p>
<p>Stagger outreach to patients for recruitment to “smooth” demand for intake and assessment of these patients; give office staff a list of 5-15 patients at a time, for example.</p> <ul style="list-style-type: none"> ▷ Once the physician reaches out to the patient, follow-up very soon after to enroll or the patient will forget 	

PATIENT ENGAGEMENT AND ENROLLMENT

CHANGES TO TRY:	RESOURCES:
<p>Develop an intake process that includes these key components:</p> <ul style="list-style-type: none"> ▷ Initial assessment ▷ Establish an initial care plan and identify goals ▷ Identify any critical care plan needs and initiate action ▷ The initial visit is very important to build trust – have it face-to-face as a home visit, or at the hospital or clinic, for example 	<p>Sample intake/ recruitment process flow (Humboldt)</p> <p>Example initial assessment tools:</p> <ul style="list-style-type: none"> ▷ CalOptima ▷ Humboldt ▷ MemorialCare <p>Care plan template (PrimeCare)</p>
<p>Reinforce patient self-care and self-management, especially through motivational interviewing.</p> <ul style="list-style-type: none"> ▷ Set short-term and long-term goals ▷ Pay attention to the patient’s emotional wellbeing and look for anger and hopelessness ▷ Demonstrate empathy, listen to the patient, validate patient’s feelings and concerns – these are effective interventions in and of themselves ▷ Make sure patients/families are a part of the plan of care and that they understand what to expect in terms of health improvement, holding steady or palliation 	<p>Resources to promote self-management at CHCF’s Team up for Health website: http://www.teamupforhealth.org/</p> <p>CQC summary of patient self-management resources</p>
<p>If possible, develop a “flag” in your EHR to alert the physician or medical assistant if a patient comes in who is being followed by care management, has refused care management, or cannot be reached to discuss care management.</p> <ul style="list-style-type: none"> ▷ This will alert the physician to have a conversation with the patient about the availability of complex care management ▷ Develop flyers for the physician to use to explain the program and follow up with case management to enroll the patient 	<p>Flyer on Well Care program for patients (St. Joseph Heritage)</p>

MEASUREMENT PLAN

CHANGES TO TRY:	RESOURCES:
<p>Develop a measurement plan – consider the following domains and example measures and refine based on your data availability:</p> <p>Cost and utilization</p> <ul style="list-style-type: none"> ▷ Total cost of care ▷ Hospital and emergency department utilization (admits or bed days) ▷ Day-time emergency department use ▷ Readmission rates ▷ Ambulatory-care sensitive admissions <p>Clinical quality</p> <ul style="list-style-type: none"> ▷ For example, diabetes control, blood pressure control, LDL control ▷ Depression screening, such as PHQ9 ▷ Medication adherence <p>Patient experience and engagement</p> <ul style="list-style-type: none"> ▷ Patient experience survey results ▷ Functional assessment surveys, such as SF-12 ▷ Patient Activation Measure (PAM) <p>Provider and care team experience</p> <ul style="list-style-type: none"> ▷ Provider experience survey results <p>Process measures</p> <ul style="list-style-type: none"> ▷ % of patients receiving outreach call within 48 hours of emergency department discharge or hospital admission ▷ % of patients with PCP visit within 7 days of discharge ▷ Accept/decline rates ▷ Track time interval from referral to intake visit ▷ Referral origin 	<p>Sample data collection and measurement plan</p>
<p>Measurement must start at the beginning, not at the end:</p> <ul style="list-style-type: none"> ▷ Gather baseline data prior to starting your intervention ▷ Chart data over time on run charts 	<p>Run chart resources</p>
<p>A comprehensive approach to measuring effectiveness of high-risk programs is to track total cost of care for your entire patient population – this holds you to a higher bar, but avoids the mistake of taking credit for regression to the mean for a subset of the population. (Regression to the mean is a probability team meaning that, left to themselves, things tend to return to normal or average. In the case of complex patients, some will naturally improve, especially if the highest cost cases are sampled. It is easy to attribute improvement in this population to a particular intervention, when in fact it is an artifact of sampling.)</p>	
<p>Gather and document anecdotes and stories about your program.</p>	

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