The Perfect Fit:
Clinical Nurse Specialist (CNS) & Care Transitions

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Learning Objective

- The learner will be able to describe the expanded focus of the CNS in a transformed Community Case Management (CCM) Program.

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Significance

- IHI Triple Aim
- Aurora Health Care: system wide care delivery redesign
- Assignment of best provider fit based on client complexity
- Analytics:
  - Data driven care
  - Identification of at-risk population

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Driving Forces of Health Care Change

- Care delivery
- Reimbursement shift
  - volume-based services to value-based
- Expectations of clients & health care providers
- Population health management

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CCM Program Transformation

CBCM department within:

- Quality Improvement Department
- Corporate Department
- Population Health

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Community Case Managers

- Advanced practice RNs (NCMs) & Master's prepared SWs (SWCMs) partnering to serve vulnerable individuals with complex medical conditions to improve health, self management skills, & care coordination.

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Target Population

- Adults at risk for readmission & excessive utilization within AHC related to chronic medical illness
- Multiple chronic medical illness(es) compounded by multifaceted psychosocial issues
- Insured by Medicare, Medicaid, or uninsured

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Characteristics of Target Population

- Illness / Medical picture / LACE score
- Utilization pattern
- Medication management system
- Status of social support system

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CCM Aim: Transitions of Care

- Initial face to face while in ED/IP/Clinic
- Frequency of visit determined by need & reduced over time; length of service 2-4 months
- NCM attends appropriate provider appointments
- SWCM addresses financial & psychosocial needs

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Focus of Interventions

- Therapeutic relationships
- Individualized client-centered plan of care
- Client's self-determination & advocacy within context of the health care team
- Self-management of chronic illness
- Resource mobilization
- Cross-continuum care coordination

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Transformed Practice

A. Motivational Interviewing
- Conversation about change
- "Collaborative conversation, for strengthening a person's own motivation & commitment to change." (Miller & Rollnick, 2013, p.12)

B. Client Centricity
- "Providing care that is respectful of and responsive to individual…& ensuring that patient values guide all clinical decisions." (IOM, 2001)
- Goals – client's words

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Transformed Practice (con't)

C. Partnership Building

Liaison effort:
- Acute care facilities
- Clinics–RN Care Coordinator as contact
- Home care

Activities:
- Education
- Communication
- Collaboration on plan for transitional care
- Address risk for readmission

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Transformed Practice (con't)

D. Readmission Appraisal
- Representation at system task force
- Provide context to readmissions using clinical & experiential expertise

E. Inclusion of community resources
- Broader community based partnerships
- Enhanced collaboration

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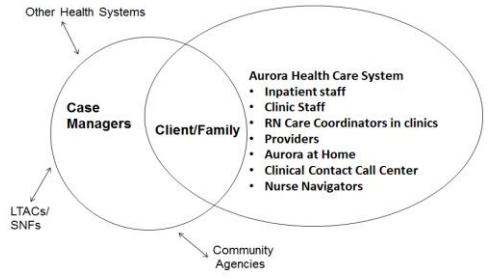
External Partnerships/Relationships



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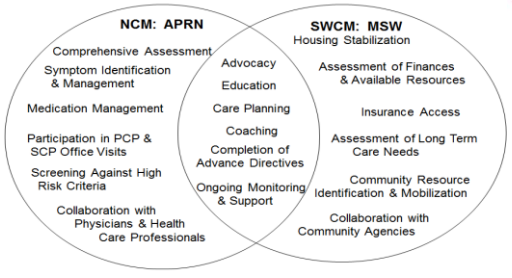
CCM Partnership: Client-centric



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The Perfect Storm: Electronic Health Record (EHR)

For patients who are:

- Seeing multiple specialists
- Making transitions between care settings
- Receiving treatment in emergency settings

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Cross continuum EHR

- Integration
- Real-time medication lists
- Immediacy
- Standardization of care
- Access to experts
- Population management
- Disease management

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What changed with the EHR?

- Ambulatory platform
- Department workflow
- Communication
- Reporting
- Laptops & hotspots

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Ambulatory Platform

- Same platform as clinic providers
- Comprehensive view of clinic providers' activities

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Department Workflow

- Old system: faxed order, med record review, emails, access database
- Referrals: via order entry
  - Ease of generating referral
  - Timeliness
- Triage:
  - Determine eligibility
  - Communicate triage decision – to referral source and department for staff assignment

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Communication Improvements

- Referral response time
- Timeliness of communication
- Awareness of involved providers
- Greater ease in coordinating care

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Reporting

- Referral volumes
- Referral locations
- Clinical & Financial outcomes

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Use of Laptops & Hotspots

- Portability of documentation
- Real time documentation
- Opportunity to contribute timely health information
- Improved case manager efficiency
- Quicker response to referrals

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Evaluation

- Referral Volumes
- Readmission causes:
  - Lack of access to providers
  - Nonexistent advanced directives
  - Disjointed medication systems
- Self-management ability
  - Medication adherence
  - Depression screening
  - Tobacco use
- Readmission cause analysis: ccm'd patients

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Psychosocial Outcomes

- Health care access
- Transportation
- Supportive in-home services
- Finances
- Housing

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Clinical Metrics (2015 data)

System Indicators	Goal	CBCM Result
Advance Directives	≥50%	61% (A)
Influenza	>50%	75-87% (A)
Tobacco use	≤17%	25% (C)
Readiness to quit tobacco	≥ 90%	96%
Department Indicators	**Goal**	**CBCM Result**
PCP established	≥ 95%	96% (A)
Pharmacy use – single	≥ 95%	93% (A)
Depression screening	≥ 90%	83% (A)
Medication adherence	New in 2016	

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Medicare Impact (2015; n=273)

	1 yr before	1 yr after	% Change
ED visits	1457	730	50% decrease
Inpatient admits	619	263	58% decrease
Inpatient days	3310	1501	55% decrease
30 day readmits	246	98	60% decrease

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Medicaid Impact (2015; n=117)

	1 yr before	1 yr after	% Change
ED visits	904	599	34% decrease
Inpatient admits	344	140	59% decrease
Inpatient days	1585	656	59% decrease
30 day readmits	156	49	69% decrease

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Self-pay Impact (2015; n=30)

	1 yr before	1 yr after	% Change
ED visits	31	9	71% decrease
Inpatient admits	15	1	93% decrease
Inpatient days	64	3	95% decrease
30 day readmits	3	0	100% decrease

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Overall Utilization Impact (2015)

ED visits	Decreased by 1041	43% reduction
Inpatient admissions	Decreased by 576	58% reduction
Readmissions	Decreased by 261	63% reduction

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All Payors Impact (2015)

Medicare savings	$433,258
Medicaid savings	$864,459
Aurora Employee savings	$165,586
Self-pay savings	$120,217
Total Annualized Savings	**$1,583, 520**

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Conclusions

- CCM program redesigned the delivery model focusing on care transitions.
- The multidisciplinary practice model achieves financial, psychosocial, & quality outcomes through partnerships with providers & community based clients.

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Next Steps

- Communicate client-identified goals across care continuum.
- Augment EHR functionality
  - cross-continuum care coordination
  - describe case managed population
- Strengthen liaison relationships
  - proactive health care delivery
  - reduce readmissions

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