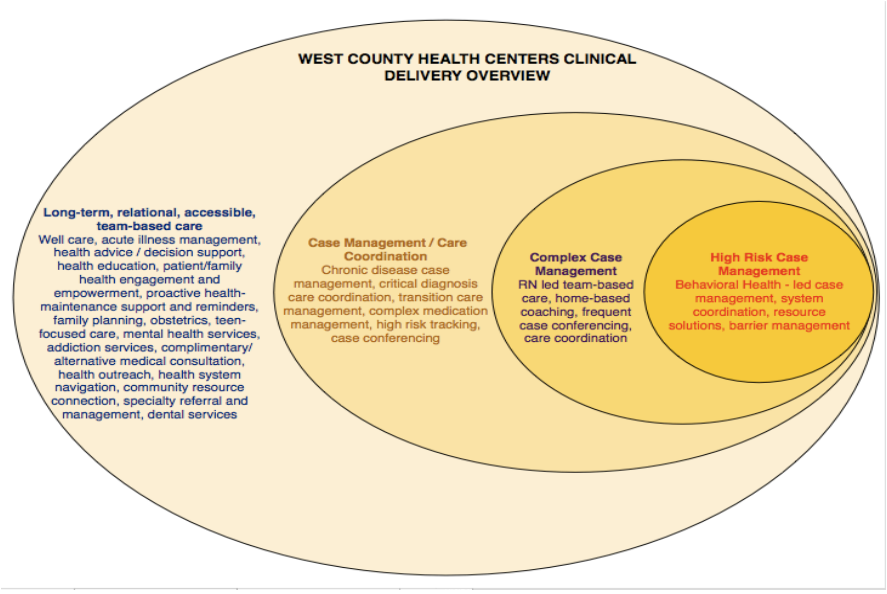
West County Health Centers
Caring for our Communities

West County Health Center High Risk Case Management

It is clear that patients will require different levels of investment as they move through different life stages and health challenges and will need to be empowered to engage more fully in health solutions. Additionally, as patients develop more complex health needs they will require a more comprehensive, system-wide approach that maximizes traditional healthcare delivery and provides additional case management and care coordination. A smaller number of patients, who utilize a disproportionate amount of resources in the current healthcare delivery system, will require a different approach to care delivery that focuses on behavioral interventions to change their clinical outcomes and move them towards more appropriate healthcare utilization.



High Risk Case Management

The following paper outlines the structure and approach to engaging these patients who utilize a disproportionate amount of healthcare resources and/or are in the highest risk for decompensation with a behavioral component.

Patient Identification:

1. "High Cost Outlier" as designated by Partnership Health Plan.
2. Identified by Primary Care Team as high risk for decompensation clinically or socially AND have a significant behavioral component.
3. Frequent use of Emergency Room or inpatient services.

High Risk Case Management Team:

1. Primary Care Team: Patient's Medical Provider, Care Team Medical Assistant, Front Office Coordinator, RN Case Manager, and Mental Health Provider (if established).
2. High Risk Behavioral Health Team: Behavioral Health Specialist, Patient Navigator/Health Coach, and hospital-based Licensed Clinical Social Worker (*see note)*.

Goals:

1. Engage patients to assist in changing high risk or adverse behaviors, reduce barriers to care, improve access to primary care services, enhance coordination of care, and improve self-management.

2. Improve patient self-perception of health as measured by the SF36 Health Survey.

3. Reduce "whole system" healthcare costs measured by comparing charges generated from Emergency Room visits, hospital in-patient stay, medication costs, specialty visits and diagnostic imaging for these patients for the 12 months prior to intake into the High Risk Case Management Program to the same charges for the 12 months after intake.

Intake:

1. Outreach by patient's Primary Care Team (1hr office visit)

    a. Begin focused engagement and trust building.

    b. Introduce Team's desire to invest in their health.

    c. Transfer trust to High Risk Behavioral Health Team.

    d. Identify the patient as a High Risk Case Management patient in the patient's problem list.

2. RN Case Manager Intake

    a. Review chart with Primary Care Team to understand known medical conditions, identify potential clinical risk factors, and understand co-morbid non-clinical risk factors.

    b. Meet with patient (and Family/Care Giver if appropriate) to complete Case Management Intake form and SF 36 Health Survey.

    c. Complete a Patient Activation Measure intake.

3. Behavioral Health Specialist Intake

    a. History of presenting (medical) complaints, including strengths as well as barriers to health

    b. Developmental History (mental and physical illness demographic in the family) alcoholism, abuse etc –ie factors that influence personality and relationships

    c. Mental Health History and diagnosis: Previous hospitalizations, suicide attempts, drug, Etoh use

        Mood, Thought, Personality or Anxiety Disorder?

    d. Support Systems, Family etc

    e. Current Meds and treatment providers

4. Home Visit (if welcomed by patient) by RN Case Manager and Behavioral Health Specialist

    a. Engage with patient in home environment to enrich trust and gain insight into potential personal strengths, motivators and risks.

    b. Complete home evaluation.

5. Engage larger circle of influence if necessary to gain insight and enlist support.

a. Contact other health care providers that may have influence or insight including specialty physicians, Hospital or ER staff, Home Health, etc.

b. Begin to communicate vision of High Risk Case Management program with these stakeholders with goal of coming to a common agreement and plan for improving the health and utilization of the patient.

Deep Dive:

Focused brainstorming session with High Risk Care Management team - Lead by Behavioral Health Specialist. (1½- 2hrs)

1. Gather all information, insights, relationships connections, potential motivators, potential personal strengths, perceived risks, etc and write on white board.
2. Open-minded brainstorming session about basic approach to engage with the patient.
3. Establish first Comprehensive Care Plan that addresses the following:
    a. Specific goals for the program.
    b. Approach to engaging patient, family members or care givers.
    c. Health Risks.
    d. Social Risks.
    e. Referral strategy.
    f. Follow-up plan including frequency of contact, which team member(s) should be involved.
    g. Plan for coordinating care delivery across the health system and potential community partners.
    h. Frequency of High Risk Case Management Team meetings for this patient.

Maintenance:

1. Most patients should have regular, scheduled visits with their Primary Care Team AND Behavioral Health Specialist in the short term to better understand complex dynamics of situation and increase potential of motivating change.
2. Coaching should be geared to improving patient self-management and may be guided by coaching for activation through Insignia PAM.
3. Behavioral Health Specialist will likely need to spend some focused time in the beginning working with Health System Care Providers to engage them in the process and understand factors that influence behaviors.
4. Behavioral Health Specialist will take on the responsibility of coordinating and managing care among the High Risk Case Management Team members.
5. Behavioral Health Specialist will present cases at monthly Site Case Coordination meetings to improve WCHC delivery and reduce barriers to care.
6. Cost and utilization analysis will be completed twice yearly or more frequently if needed.

7. Ideally SF-36 should be completed twice yearly to understand patient perspective of issues related to their health.

8. Care Plan should be regularly reviewed and changed as appropriate and shared with appropriate health partners. Documentation should be made in eCW using Care Plan Functionality.

Discharge:

The patient should remain in the program for 12 months after intake and can remain in the program as determined by the High Risk Management Team with a goal of patient empowerment to reduce need for ongoing intensive investment.

NOTE: Hospital-Based LCSW will be a paid hospital staff that focuses primarily on system engagement to improve safe discharge for high-risk patients. High-Risk Behavioral Health Team will actively work with LCSW to improve care coordination, care transition, and outpatient navigation for WCHC patients. Further, LCSW will participate in the Deep Dive and case conferences as appropriate and determined by the Behavioral Health Specialist.