Community Health Program

Outpatient Care Management Program

Beverly Dowling

Assistant Vice President

Community Health Network

Office of Health Policy and Legislative Affairs

The University of Texas Medical Branch

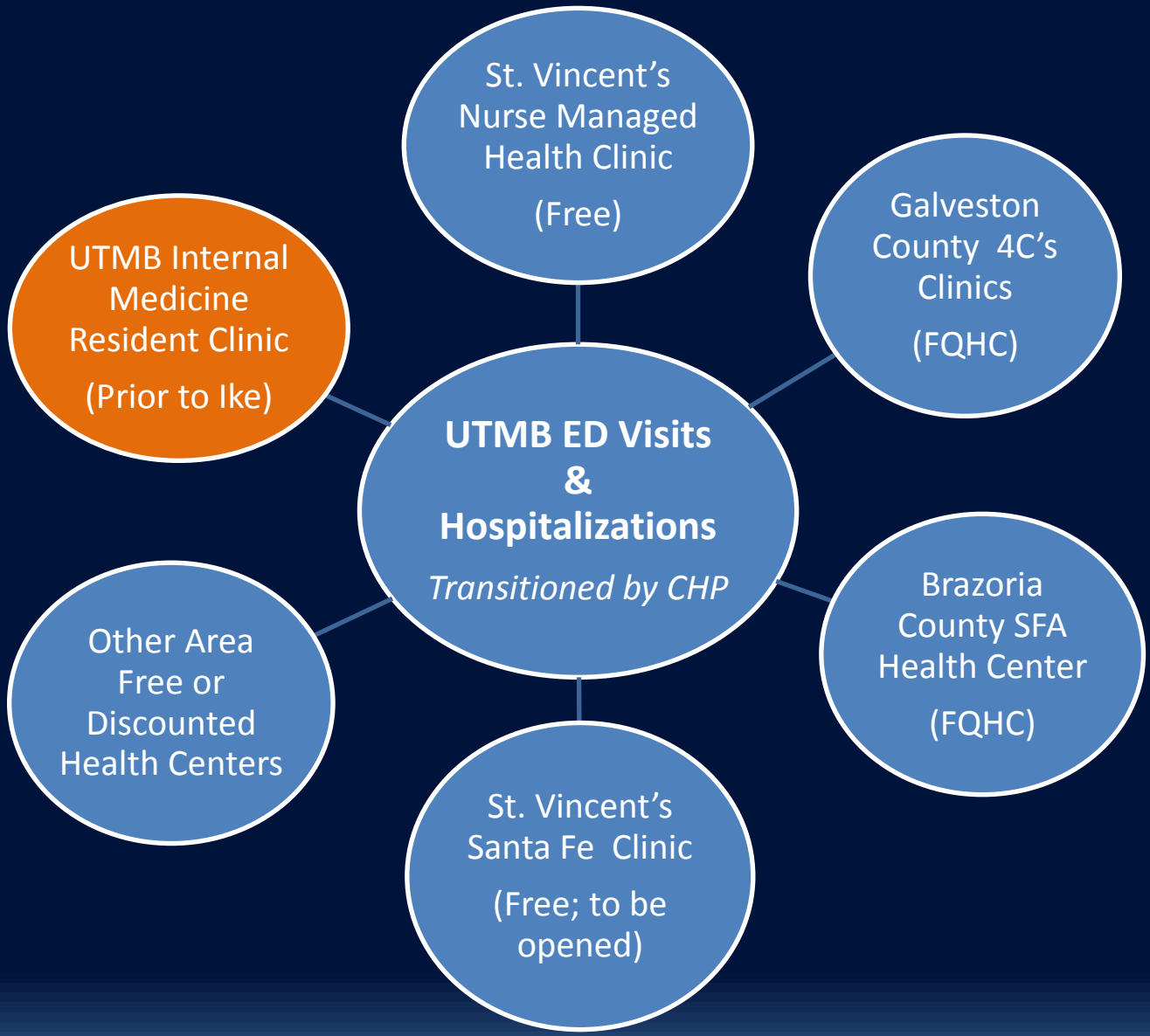
Community Health Program (CHP)

- Integrated care and disease management model begun in 2007 to redirect acute high-risk unsponsored patients with chronic disease to most appropriate care settings
- Primary service area: Galveston County
- Top three diagnoses of participants:
  - Heart Disease
  - Diabetes
  - Hypertension

Program Goals

- Manage health system bed capacity
  - Decrease avoidable ED visits
  - Decrease hospitalizations
- Establish medical home for each patient
- Increase patient/family understanding of how to navigate and appropriately use health care system
- Increase patient/family understanding of chronic disease(s) and appropriate self-management
- Improve health outcomes

Medical Home Development



UTMB

Patient Referrals Sources

- Initially
  - ED and admissions data
  - Congestive Heart Failure Clinic
- Area Clinics
  - County 4C's Clinics
  - St. Vincent's Nurse Managed Clinic
- UTMB Inpatient Care Managers
- UTMB daily ad hoc reports on acute visits to ED & hospital

*Program Eligibility Review

CHP Outpatient Care Management Team

- RN + Community Health Worker (CHW) coordinate care for their assigned patient panel

- Current Staffing
  - 3 RNs
  - 3 CHWs (one position vacant)
  - Social Worker
  - Part-time Nutritionist (vacant)
  - 1.5 Registration/Financial Screening Staff

Enrolling New Patients

- RN initiates enrollment through home visit
  - Evaluates home environment, diet, food supply and prescriptions
- RN creates individualized nurse care plan for patient
- Program encounters include: telephone, site of care visits, home visits
- Average monthly encounters per active patient = 3.4 (approx. one/week)

RN Initial Visit

- Initiates disease education
- Provides limited durable medical equipment (i.e. glucometer, BP cuff, scale) and education on its use
- Reviews prescription(s)
  - Verifies all medications are taken as prescribed
  - Identifies barriers to filling prescriptions
  - Coordinates with provider if generic equivalent available
  - Applies for applicable pharmacy assistance programs
- Coordinates care with medical home
- Helps patient establish self-management goals
- Identifies need for social and mental health services
- Arranges transportation assistance for clinical appointments

Community Health Worker

- Provides comprehensive care coordination under direction of RN
- Assists with social needs and makes social referrals when needed
- Follows through with care plan detailed by the nurse care manager
- Provides diabetes self management curriculum training at patient's home if needed
- Assists with patient encounters
- Monitors medical supply needs
- Assists patients with clinic visit reminders, care support

Preliminary Program Outcomes*

- **50% cost reduction in inpatient hospital encounters**
- **62% cost reduction in acute outpatient encounters (e.g. ED, day surgery, observations)**
- **143% cost increase in outpatient clinic encounters (visits coordinated with medical home or specialists)**
- **50% of patients have seen their primary care physician in the last six months**
- **Improved key patient biometric indicators**

* Initial QA data currently being reviewed for retrospective program evaluation

Success Stories

- **Member E.W.—Prior to enrollment, hospitalized five times in 12 months for uncontrolled hypertension and was out of medication; has not been hospitalized in more than a year since enrollment.**

- **Member T.D.—Prior to enrollment, hospitalized three times in nine months for uncontrolled diabetes; has not been hospitalized in more than a year since enrollment and has been able to return to work.**

Lessons Learned

- Financial screening completion time extended to six months and performed in patients' homes due to transportation issues
- Incentives (e.g., $10 Kroger food card) encourage completion of financial screening
- Clinic visits more effective when Care Management Team teaches patients how to prepare/what to expect and meets patients at clinic
- Electronic case management system for tracking encounters is more efficient than paper
- Software (e.g., RxTracker) valuable in managing patient Pharmacy Assistance Program applications

Lessons Learned

- Take Action Diabetes Self-Management Course needs to be divided into modules and taught one-on-one at patient's home, due to transportation issues
- Interdisciplinary team – RN, CHW, Social Worker, Nutritionist, providers – key to success
- Nutrition counseling in patient's home and grocery store important for success