Care Plans

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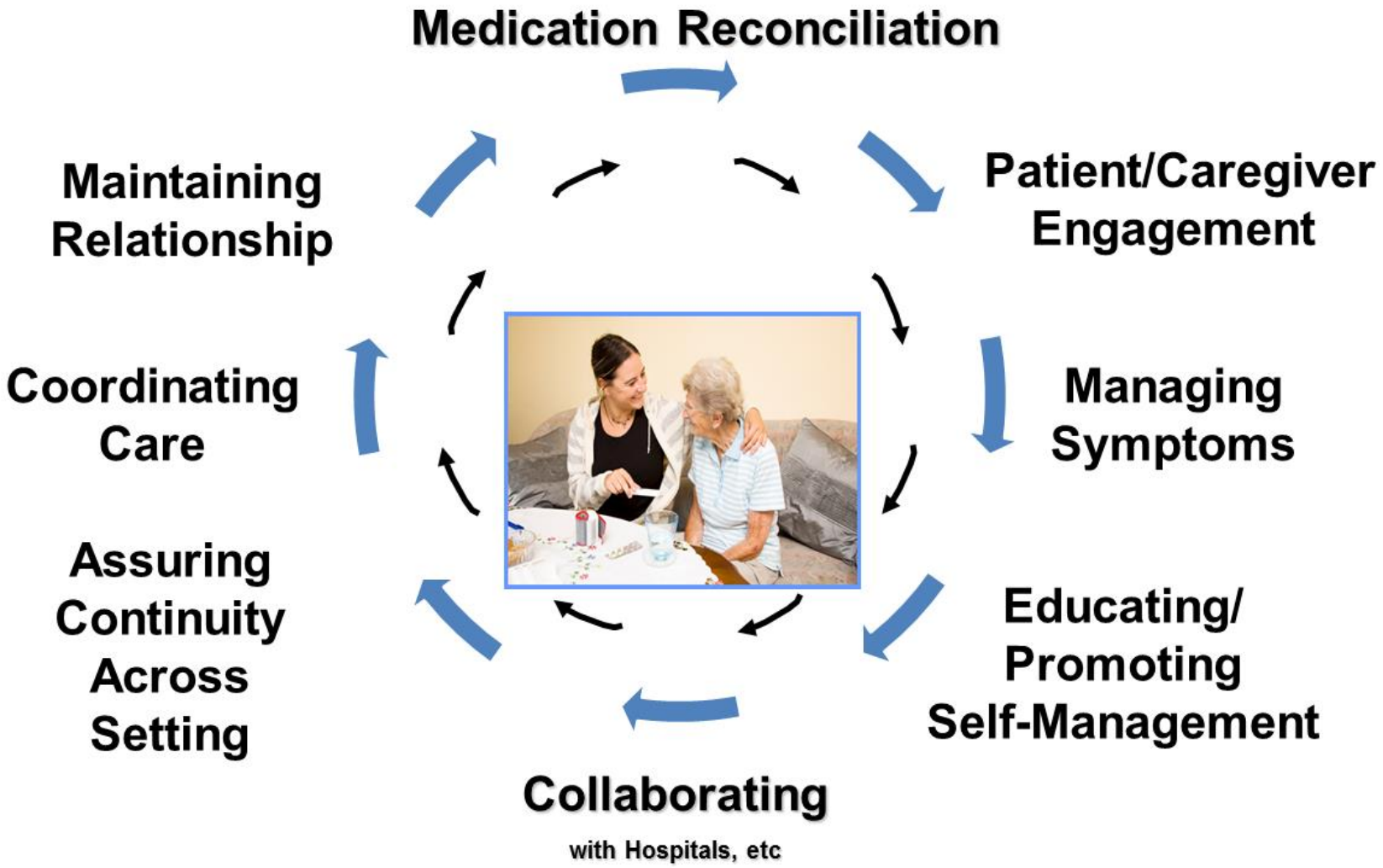
Bon Secours Medical Group

Nurse Navigator Role

Primary Role: *The Nurse Navigators represent a culturally competent team of nurses that bridge the gap between the health systems and our highest risk patient population. The Nurse Navigators intervene with complex patient care needs to minimize care fragmentation and safely navigate the patient with acute and/or chronic illness across all health care settings. The Nurse Navigators provide the organization with a unique set of skills to manage these complex care issues that requires extensive use of coordination of resources.*

Nurse Navigator Model 2012



Nurse Navigator Workflow 2016

Transitions of Care

Ensures High Risk Patients seen within 7 days of discharge
Develops Care Plans for High Patients
Monitors' the integrated care continuum and patients' interactions, between the continuum and responses to care

Communication Across Continuum

Daily communication with Providers, both Primary Care and Specialty.
Communication with Hospital/Payer Care Managers, Home Health Nurses, Hospice, Palliative Team, Dialysis Centers, (Post-Acute Settings) and At Home Team
Communicate patient and families

Data Management

Review 20 different patient lists a month for each Pay for Performance Programs:
High Risk, Daily Inpatient, High ED utilizers, Monthly/Quarterly Gaps in Care, Attribution, etc.
Manages 7 different data base sources
Reports manually all activities

Annual Wellness Visits

Intro to CCM
Intro to Advance Care Planning
Care Plan Development
Close Gaps in Preventive Care and Chronic Disease
Patient Care Assessment Forms

Complex Case Management

Improved quality of life by patient centric care
Takes proactive steps to coordinate plans of care among health care providers
Identifies needed supports and community resources
Identify and implements care management plan that best meets the needs of the patient to reduce care fragmentation

Disease Management

Removes barriers to care for patient, providers and systems of care (ie, affordability of medication, educational needs, and links the chain of care to specialist)
Develops Care Plans based on Evidence based guidelines and patient self-management plans

Advance Care Plans

Initiates and manages the conversation with high risk patients on Advance Care Planning
Ensuring patients and families understand process (ie. wishes communicated, form completion and proxy identified

ED Outreach

Call all high risk patients released from ER within 24 to 48 hours post ER visit to ensure appropriate follow-up with practice.
Proactively outreaches to patient who are high utilizers of the ED to reengage in primary care setting.
Develops care plan to engage the patient for high utilizers

Payment Model For Nurse Navigator

Direct:

- Chronic Care Management (CPT code 99490)
- Transitions of Care (CPT 99495 and 99496)
- Medicare Wellness Visit (CPT GO438 and GO439)
- Advance Care Planning Coding (CPT 99497 and 99498)
- Pay for Performance PMPM- Coventry, Anthem, Cigna, Humana, Virginia Premiere

Indirect:

- Avoidable Readmission
- Avoidable ED Visits

Learning Objective

- Review of CMS Guidelines
- Components of Care Plan
- Remember your Nursing Diagnosis
- Your Role on the Care Team
- Management of Common Symptoms and Challenges
- Remember your Colleagues (Home Health, Pharm Ds, Mental Health, Hospice, Community Resources)

Chronic Care Management (CCM) Services overview

- Effective ***January 1, 2015***, as part of its growing emphasis on primary care and chronic care management
- Medicare began paying for certain *non-face-to-face care management services* provided to Medicare beneficiaries covered under the traditional Medicare fee-for-service program
- services include, but are not limited to,
  - development and maintenance of a plan of care,
  - communication with other health professionals,
  - and medication management.

Chronic Care Management (CCM) Services overview

- Medicare beneficiaries must consent to receive these services and this consent must be documented in the patient's electronic medical record.
- Claims for CCM services can be submitted for services furnished in calendar months in which at least 20 minutes of services are provided and are subject to coinsurance and deductibles
- The CPT code that will be used to bill for CCM service is **99490**

Eligible Population

Chronic Care Management (CCM) applies to patients with:

- Multiple (two or more), significant chronic conditions that are expected to last at least 12 months or until the death of the patient
- Significant risk of death, acute exacerbation/decompensation, or functional decline
- Comprehensive care plan is established, implemented, revised or monitored

Scope of Service Requirements

- Patients must have must have two or more chronic conditions
- Certified EHR technology that fulfill the following:
  - Structured recording of demographics, problems, medications, medication allergies, and the creation of a structured clinical summary record. A full list of problems, medications and medication allergies in the EHR must inform the care plan, care coordination and ongoing clinical care
- Access to care management services 24/7 (providing the beneficiary with a means to make timely contact with health care providers in the practice to address his or her urgent chronic care needs regardless of the time of day or day of the week)

CMS definition of Care Plan

- “The structure used to define the management actions for the various conditions, problems, or issues.
- A **care plan must include** at a minimum the following components: problem (the focus of the care plan), goal (the target outcome) and any instructions that the provider has given to the patient. A goal is a defined target or measure to be achieved in the process of patient care (an expected outcome).”

Reporting (billing) challenges to note

- If other E&M or procedural services are provided, those services will be billed as appropriate. That time ***can NOT*** be counted toward the 20 minutes.
- The practice must have the patient's ***written consent*** in order to bill for CCM services
- Only ***one clinician*** can furnish and be paid for CCM services during a calendar month
- Incident-to ***is allowed*** under general supervision (physician does not have to be present in office at time services are rendered)
- Copayments (coinsurance and deductibles) ***DO apply***

Reporting (billing) challenges to note

- The following codes ***cannot be billed*** during the same month as CCM (CPT 99490):
  - Transitional Care Management (TCM) – CPT 99495 and 99496
  - Home Healthcare Supervision – HCPCS G0181
  - Hospice Care Supervision – HCPCS G9182
  - Certain ESRD services – CPT 90951-90970

Purpose of the Care Plan

- To communicate the patients specific care needs to staff who are caring for the patient.
- Care Plans change based on the needs of the patient and they need to be updated.
- Care Plans need to be patient specific with holistic focus.
- You want to drive care team members to see your notes and care plans.

Care Planning Process

- Develop an individualized case plan, including prioritized goals, that considers the patient's and care giver goals, preferences and desired level of involvement in the case management plan.
- Identification of barriers to meeting goals (patients, provider, system) or complying with plan.
- Facilitation of patients referrals to resources and follow-up process to determine whether patients act on referrals
- Development of a schedule for follow-up and communication with patients
- Development patient self-management plan
- A process to assess progress towards case management plans for patients

How are Care Plans Formed?

Assessments via subjective and objective data:

- Initial assessment of patients' health status, including medical and behavioral health condition-specific issues
- Review clinical history including medication

Forgotten Assessments:	
Difficulty Sleeping	Confusion
Drowsiness	Depression
Fatigue and Weakness	Breathing Problems
Appetite Problems	Constipation and Diarrhea
Pain	Skin
Problems with feeding	Urinary Retention and Incontinence

Assessment Continued:

Social Assessment	
Food/clothing, other concrete needs	Housing
Current Resources	DME Resources
Finances/benefits	Transportation
Health Literacy	Domestic violence/physical or sexual abuse
Health behaviors (smoking, treatment adherence, nutrition, and physical	Motivational level
Barriers to access and retention of care	Prevention/risk reduction issues (ie. where are they receiving care ED verses PCP)
Legal Services	History of Incarceration
Substance Use/Mental Health	Support System

Nutrition	Elimination	Activity/Rest	Chronic Pain	Anticipatory Grief
Impaired Swallowing	Alternation in Urinary Elimination	Disturbed Sleep Pattern	Quality of Life	Coping
Alteration in Appetite	Alternation in Bowel Elimination	Impaired Physical Mobility	Impaired Coping Patient/Family	Family Coping
Alternation in Nutrition	Urinary Incontinence	Self-care Deficit: Dressing, bathing, etc.	Pain Control	Grief Resolution
Knowledge Deficit	Risk for Constipation	Fatigue	Powerlessness	Psychosocial Adjustment: Life Change
Knowledge Deficit R/T changes in Nutrition Requirements	Bowl Incontinence	Impaired Ability to Perform/ Activity Intolerance	Fatigue	Care Giver Emotional Health

Remember Nursing Diagnosis

Health Function/Maintenance

- Alternation in Home Maintenance
- Alternation in Home Maintenance
- Impaired Coping/Ineffective Coping Patient/Family
- Caregiver Role Strain
- Risk for Powerless/Hopelessness
- Insufficient Support System
- Alternation/Disturbed Body Image

More on Assessment:

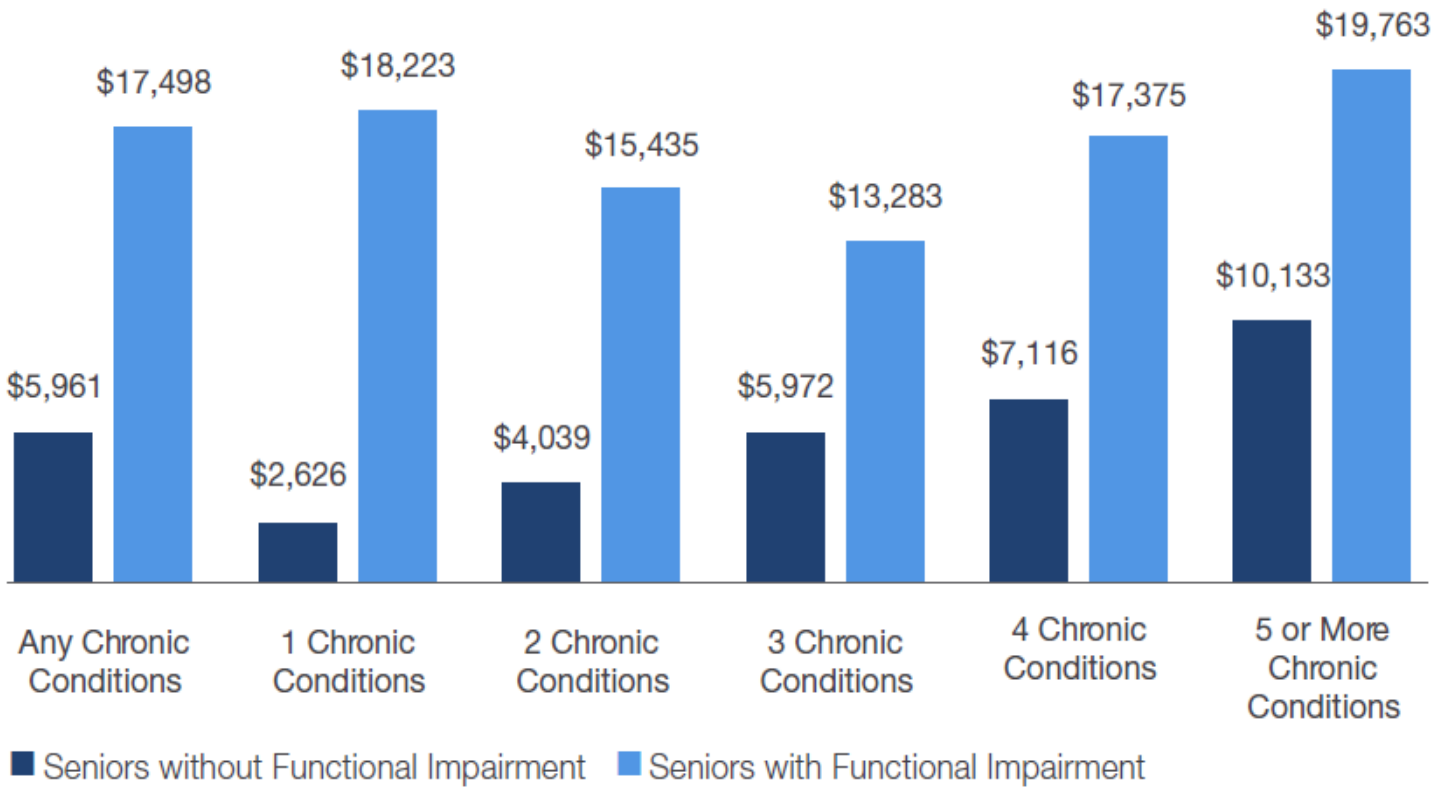
- Identifying the challenges the patients are experiencing.
- What is the patients/families perception of barriers, knowledge of disease, top priorities?
- How is the patient and family currently self managing health challenges?
- Are they attending regular appointments with their providers? Are they missing appointments?
- What is the economic impact of the disease process on patient and family (consider guardianship, power of attorney, assistance in home, insurance benefits, and funeral arrangements).

More on Assessment

- Is the current environment safe and manage their current and future needs?
- Where is the patient and family with Advance Care Planning (e.g. advance directives, living will, and healthcare surrogate)

Spending Chronic Care and Functional Impairment

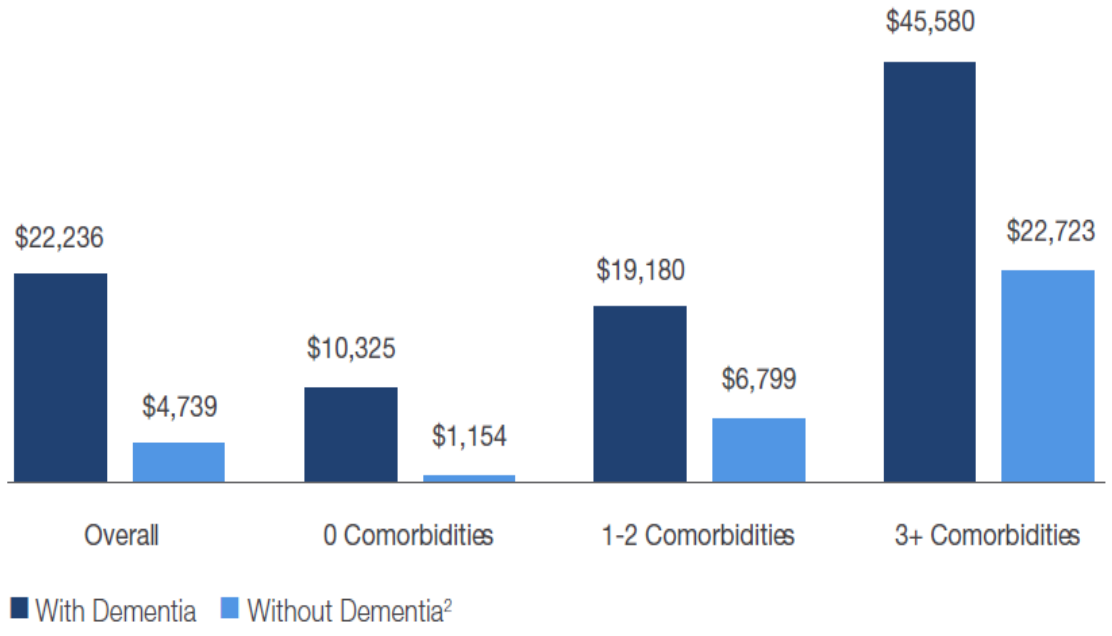
Figure 1: 2006 Per Capita Medicare Spending by Chronic Conditions and Functional Impairment



Source: Avalere Health analysis of the 2006 Medicare Standard Analytic Files.

Spending Cognitive Impairment and Comorbidities

Figure 2: Per Capita Medicare Spending By Presence of Alzheimer's/other Dementia Diagnoses and Number of Comorbidities, 2009



Source: Avalere Health analysis of the 2009 Medicare Standard Analytic Files

Non Medical Contributors of High Risk Medicare Patients

Table 2: Key Non-Medical Contributors to High Medicare Spending

NON-MEDICAL BENEFICIARY-LEVEL CHARACTERISTIC	INCREASE IN HIGH-RISK PROBABILITY[1]
Self-reported fair or poor health status	8.1%
Having moderate functional impairment[5]	6.9%
Age 85 and older	6.6%
Living in a residential setting in the prior year	4.5%
Living in a nursing home in the prior year	1.8%

MedPAC."A Data Book: Health Care Spending and the Medicare Program." June 2013. Available at: http://www.medpac.gov/documents/Jun13DataBookEntireReport.pdf.

How are Care Plans Formed?

- Assessment.
- Main challenges think about related to factors.
- Patient and families understanding the medical diagnosis.
- State the expected outcomes (Goals)
- Should include evaluation date
- Establish specific case management interventions
- Selects strategies to meet the multifactor needs of complex patients (able in interrupt data, research, literature and clinical experience to deal with patients)
- Negotiation and advocacy as needed

Coordination as Part of the Plan

Care Team:

1. Pulling it all together
2. Coordinating the delivery of care (hospitals, specialist, mental health, coordinating resources)
3. Improving and facilitating interdisciplinary communication and planning
4. Know what options are available
5. Help paint the picture for the team and patient

Anthem ACO Case Study

- Supervisor Care Manager Summary Complex Care Note:
- Home Visit made on 1/12/2016. Goal for the visit was to assess the patients' status, establish a relationship with the wife and understand the immediate management needs of the patient. The patient had no supporting agencies helping her to manage the care of her husband.
- Problem 1: RC is a 55 y.o. male CVA s/p basilar artery thrombectomy in July of 2015 with resultant quadriplegia, tracheostomy and PEG feeding, CAD, HLD, HTN, PVD, PE, gout and glaucoma. Following his initial stay at St. Mary's, he had a stay in a nursing facility, but since that time he has been at home. His trach is not ventilator dependent. He has very restricted communication. He is only able to communicate only by moving his eyes up for "yes" and down for "no". Most of this documented history comes from his wife and treating providers. He has had 2 previous admissions for increased tracheal secretions and a pulmonary embolism. The second readmission was just recently for skin breakdown and wound management.

Case Study Continued:

- Problem 2: At this time, the patient is living at home with his wife who is attempting to manage his care at home. However, the two home health agencies that previously care for the patient in the home has closed his case. After speaking with both home health agencies the reason for closing the cases was due to the family's perceived unwillingness to follow the treatment plan, and the inability of the agencies to provide the extensive amount of care needed to manage the patient in the home. Both agencies felt the patient would be better served from long term care in a facility. However, they reported the wife is resistant to any discussion around placement according to both agencies.

- Challenges: The challenges with this patient's health are his complex conditions, limited family and financial resources to manage the patient in the home. There is extreme stress amongst the family on the management of the patient. This patient requires hourly care to manage all of his needs. The wife primarily is the sole care giver and daughters are not able to assist daily with this care hence the increase wounds we are seeing with the patient. The most recent breakdown is the wounds on his heels.

MSSP ACO Case Study

Complex Care Note:

- Start time: 1:00 pm End time: 1:45PM Total Time: 45 minutes
- CP is a 51 year old female who is being referred by Dr. McLeod to case management (by) for the following:
- **Problem 1**: complex medical problems (diabetes, COPD, Obesity, Depression, Schizophrenia, Diverticulitis, Degenerative Joint Disease, and Chronic Pain) coupled with illicit drug use and over 44 prescribed medication over the past year.
- **Problem 2**: lack of resources in managing disease processes
- **Challenges:** The challenges with this patient's health include multiple hospitalizations and ED admissions (20) with several health systems since establishing care with CIMA in 6/23/15. Patient has had a combination of 71 ED visits and hospitalizations since 3/1/2015. PMP indicates within the past year patient has received 44 prescriptions from 15 different providers, and filled at 8 different pharmacies. Patient struggles with using illicit drugs (marijuana, cocaine and opiates) as evidence by positive UDS. Patient is also a current smoker. Patient does have serious medical conditions coupled with pain management issues and multiple system usage makes her challenging to manage. This past year alone the patient has had 12 CT scans over the past 6 months at MCV, and has had 8 CT scans over the past four months at SMH, last abdominal CT scan was completed two days ago which was negative.

Continued:

- **Patient stated problem**: Patient states she is “trying to quit smoking but it is difficult” and she has trouble getting around. Patient states “I would like a rolling walker.”
- **Patient stated strength:** “Patient reports she follow up with psychiatrist, Dr Myint, regularly.” ".
- **Patient current understanding of disease:** Patient seems to have limited insight into the importance of medications in relation to treating her conditions and preventing readmissions. ".
- **Barriers to care:**

  1. Financial –Patient states she is unable to afford medication and is picking and choosing to take what she can afford.
  2. Knowledge deficit in managing conditions, restricted coping mechanisms for managing disease processes and resistant to changing current self-management plan for coping with illness.
  3. Currently patient is resistant to accepting assist from care management.

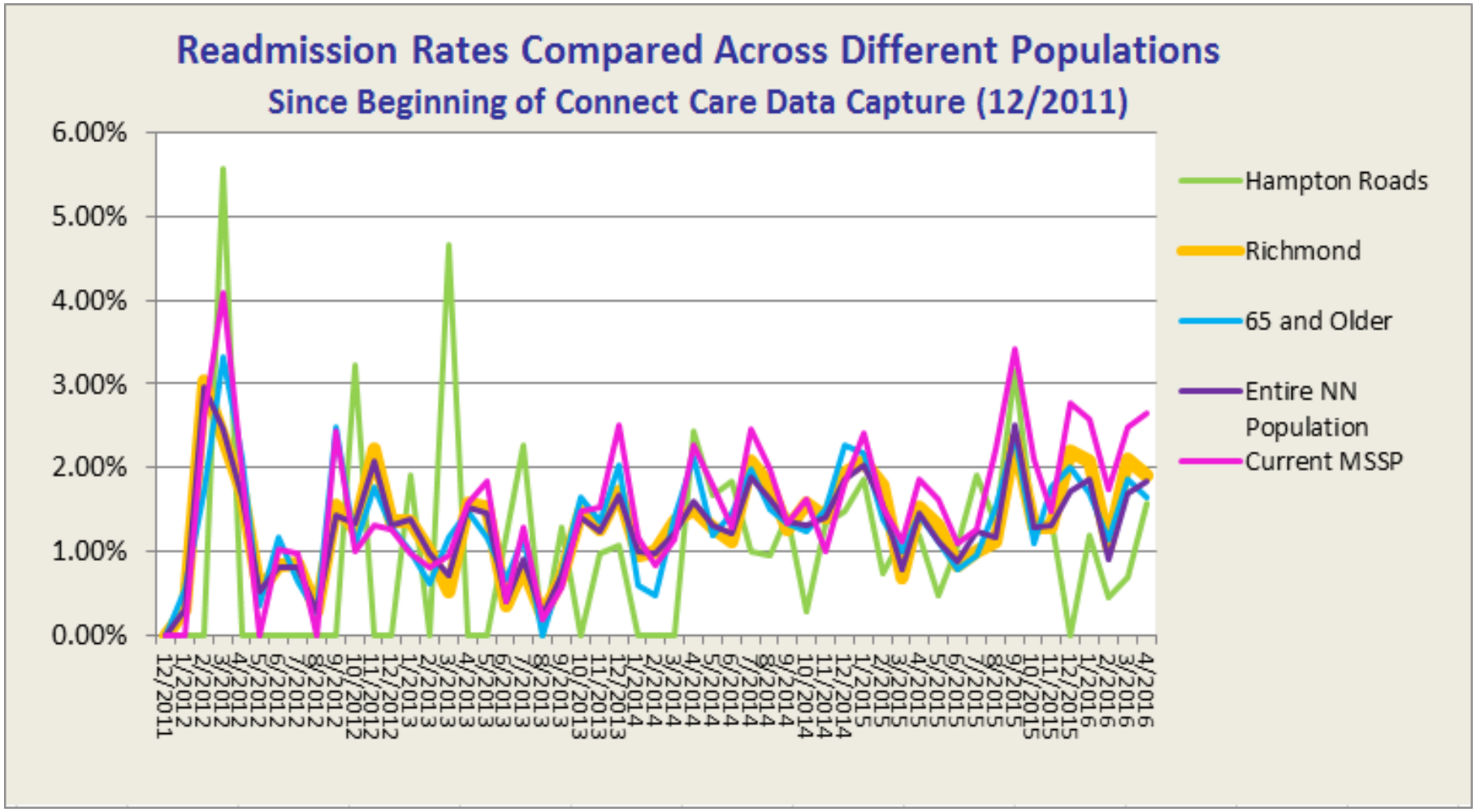
- **Advance Care Planning:** Patient does not have an AMD or Living Will currently.
- **Next scheduled follow up:** Needs to be scheduled with PCP

Care Plan:

Plan of care with patient:

- Establish communication with patient on regular basis, develop trusting relationship, and engage patient in case management to overall reduce utilization of ED and hospital for management of disease processes
- Work with PCP to improve coping and compliance with care in and assist Dr. McLeod to coordinate care with multiple specialist in community
- Assess support system
- Assess for safety in home and need for rolling walker
- Pharm D was consulted to assist with polypharmacy usage, will coordinate medication assistance programs and work in conjunction with Pharm D on self-management plan for taking critical medication
- Schedule appointment with GI, and potential pain management specialist to assist with chronic pain management
- Will begin working on smoking cessation with patient since she is motivated to start care here
- Coordinate Care with multiple providers, encompass home health nurse, mental health and social worker to help patient accept health conditions, understand effects lifestyle choices have on health, and begin to work towards healthier choices.

Outcomes:


Readmission Rates Compared Across Different Populations
Since Beginning of Connect Care Data Capture (12/2011)
6.00%
5.00%
4.00%
3.00%
2.00%
1.00%
0.00%
Hampton Roads
Richmond
65 and Older
Entire NN Population
Current MSSP

What do people think about the Program?

- "Without my NN, I would not be able to provide care to my patient population, while also trying to perform an administrative role. The NN position is essential for coordinating transitions of care and managing complex patients who are often at risk for hospital admission. With our healthcare system's separation of ambulatory from inpatient care, the NN is the glue that holds those two parts together and allows the patient to make a seamless transition" David Kelly, MD
- "My Nurse Navigator has been a lifesaver for me. She has been directing me in the right direction by setting up my appointments, helping me afford my medication, trying hard to keep me on track, and being there to talk to me. She is a Guardian Angel," Patricia, Patient
- "I love coming to see my doctor at Patterson. He just introduced me to the Navigator to help me afford my medication, I miss not being able to get samples when starting a new medications, or when I can't afford a co-pay. When I did not know there was another way, Phyllis has worked out something for me. I have been able to reach her without having to wait on hold by calling directly to her office. If I leave a message she always calls back. It has been a pleasure working and talking with her," Fuhrmann, Patient
- "I don't know what I would do without my Navigator. You helped my husband so much during his last year of life and helping our family once he was ready for hospice. Now you continue to help me with my issues. I'm so appreciative of the guidance". Nancy, Patient

Continued:

- “I don’t know what I would have done if you hadn’t taken the time to talk with me. Helping me find the right help in my area, rides, and with my medicines has been such a huge blessing.” Roberta, Patient
- “No one ever cared before if I could afford my medicine. Thank you for your help with my medicines. You explained my health so well and helped me come up with a way to keep healthy.” Carl, Patient
- “My children were so appreciative of your assistance while I was hospitalized. They all live out of town and felt great relief knowing they had someone that was looking out for my medical needs and helping them make sense of it all” Gail, Patient
- “Everyone was very caring and concern about us. Our visit was unexpected and we felt like we had gone everywhere and had no other place to go. We decided to tell our provider, who told us to discuss the situation with the Nurse Navigator; she may be able to help. We are very appreciative for all the time and effort that was given to us, and the gift was very helpful, “Kristina, Patient and Kimberly, Family.
- “I have been so impressed by the communication and thoroughness of your team in helping my mother- so much so, that I am seriously considering switching to your practice in the New Year”. Janet, Daughter

Summary: Care Plans

- Partnership with patient and support family/structure
- Make sure you take the characterizes of the patient and their situation in your plan which should include (health status, beliefs, values, spiritual/health practices, preferences, choices, coping style, culture and environment.

Nurse Navigator

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"I have been so impressed by the communication and thoroughness of your team in helping my mother- so much so, that I am seriously considering switching to your practice in the New Year." – Janet, *Patient*

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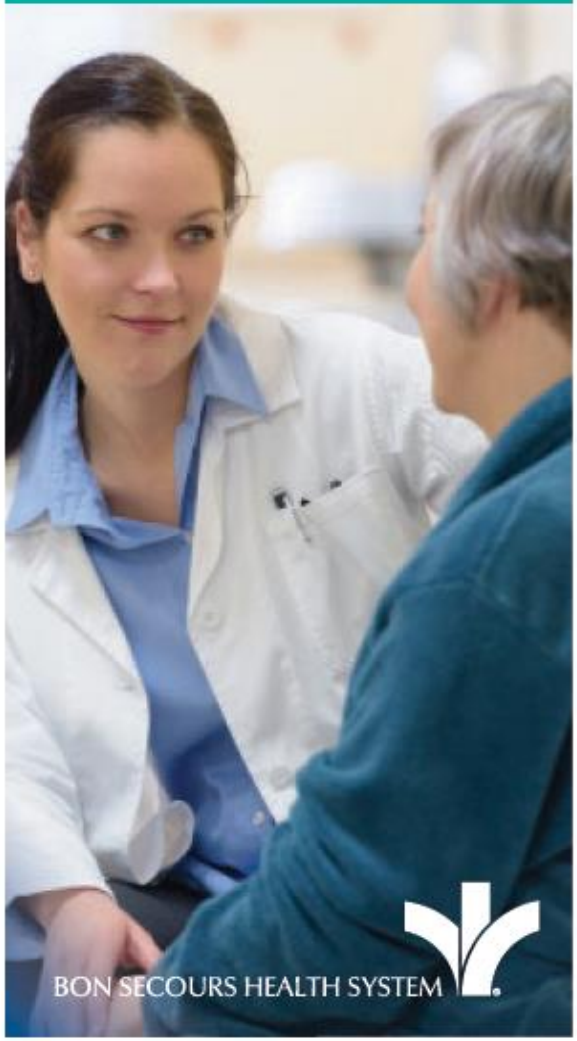
BON SECOURS HEALTH SYSTEM

Patient Navigator Program

Partners in Your Health Journey



BON SECOURS HEALTH SYSTEM

Questions

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