



**WENATCHEE VALLEY  
MEDICAL CENTER**

*Physician-owned and patient-centered since 1940*

# Case Management Definition

“Case Management is a care delivery system that focuses on the improvement of patient goals within a specifically defined time frame, integrating the efforts of all healthcare team members.”

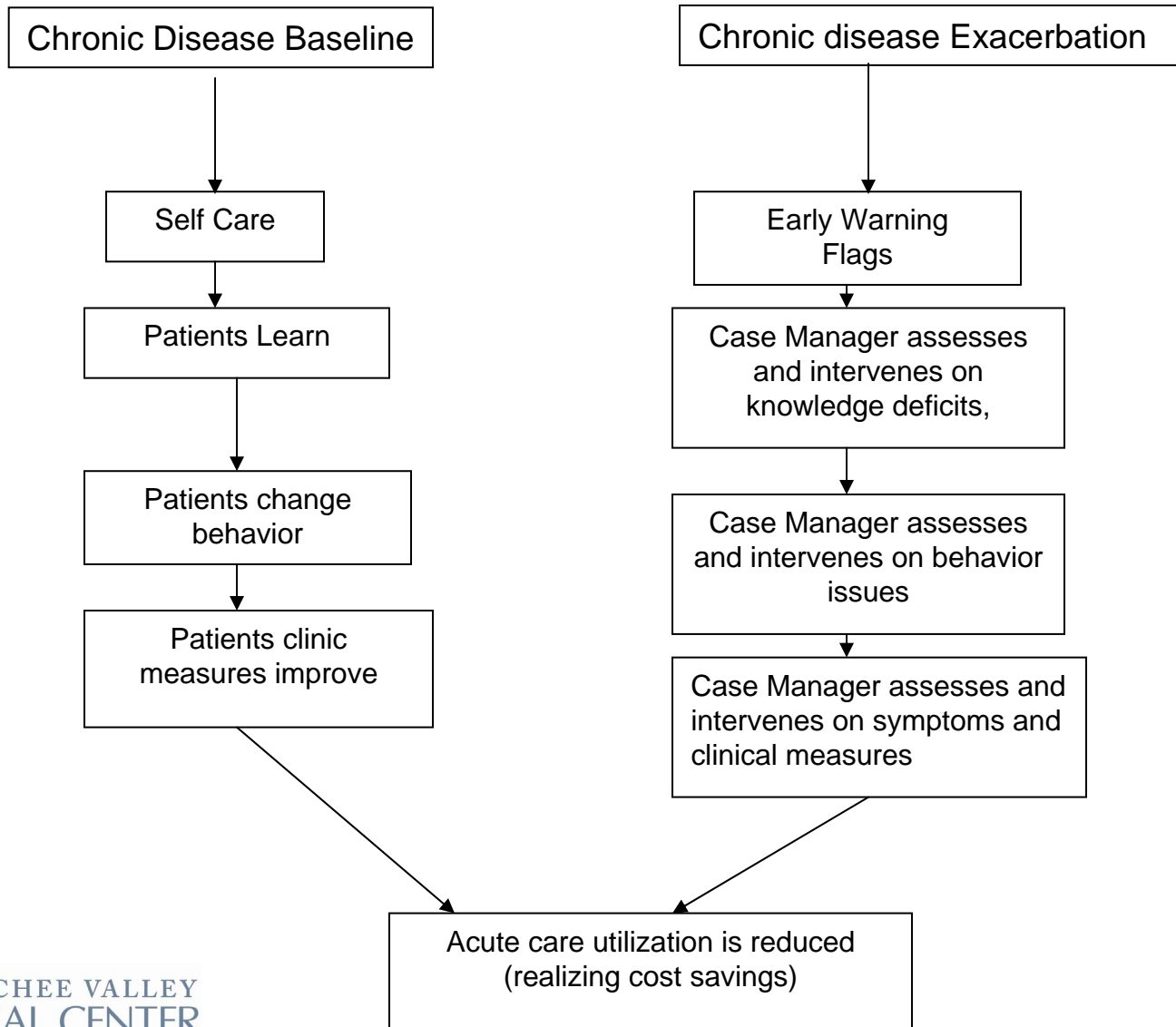
Latini, E.E., & Fotte, W. (1992). Obtaining consistent quality patient care for the trauma patient by using a critical pathway. *Critical Care Nursing Quarterly*, 15(3), 51.

In the opinion of WVMC the best way to practice case management is in house with a shared medical record system and with Nurse Case Managers who have a personal relationship with the PCP



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# Case Management Effect with Home Monitoring



# Population Selection

- Costs per beneficiary 6-18 months prior to enrollment
- HCC score using ICD9/CPT codes from office visits and hospitalizations  
(lab codes initially included then excluded after refresh)
- Loyalty to Clinic Primary Care Physicians
- 75% of Medicare beneficiaries in region eligible
- Specialty loyalty
- Approach outside PCP to include their patients in study
- Costs at baseline per Medicare beneficiary 84% of national
- Resulting list was accepted as population



# Population characteristics

Average Age 75.9

52.6% Male      47.4% Female

51.7% DM

39.5% CHF

40.0% COPD

91.2% with one or more diagnosis

Baseline Total Costs \$17,958

# Patient Recruitment

- Medicare beneficiary letters were sent with a letter from the Primary Care Physician (PCP)
- PCP reviewed list of his patients prior to recruitment
- PCP discussed program with patient at office visit
- Phone contact
- Orientation/Problem list and Medication Review
- Home visits
- Provided Scales and BP cuffs



# Physician Feedback

**Health Buddy 2009 Refresh** *Instructions: These patients appear on your list because you are the PCP in the WVMC Plus system. Please review, respond/update, and return this list to Lori Smet at Quality Department ASAP. Call ext. 3442 with questions. Thank you.*

**5140 ABBOTT, MICHAEL FAMILY PRACTICE EAST WENATCHEE**

**Total # Patients: 7**

<u>Patient Demographics</u>					<u>Disease State</u>				<u>Reason for Exclusion</u>					Comments
History #	Patient Name	DOB	Gender	Not my patient Other Dr? <input type="checkbox"/>	CHF	COPD	Diabetes	None or Other	ESRD?	Hospice?	Nursing Home?	Dementia?	Deceased?	
6/20	[REDACTED]	[REDACTED]	[REDACTED]	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/> HTN	<input type="checkbox"/> Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(R) ICA stenosis
5/20	[REDACTED]	[REDACTED]	[REDACTED]	<input type="checkbox"/>	<input type="checkbox"/> CAD	<input type="checkbox"/> AFB	<input type="checkbox"/> HTN	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	↑ lipids
5/20	[REDACTED]	[REDACTED]	[REDACTED]	<input type="checkbox"/>	<input type="checkbox"/> HTN	<input checked="" type="checkbox"/> Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	hyperglycemia
5/20	[REDACTED]	[REDACTED]	[REDACTED]	<input type="checkbox"/>	<input type="checkbox"/> AFB	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	obesity
5/20	[REDACTED]	[REDACTED]	[REDACTED]	<input type="checkbox"/>	<input checked="" type="checkbox"/> CAD	<input type="checkbox"/> HTN	<input type="checkbox"/>	<input checked="" type="checkbox"/> CAD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	obesity
5/20	[REDACTED]	[REDACTED]	[REDACTED]	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/> CAD	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	



# Enrollment and Retention

Patient barriers

Currently about 50% enrollment

Why not 100%?

- Trust issues government (big brother)
- Rural location
- Patient's perception of losing contact with PCP
- Not needing intermediary
- Denial of diagnosis
- Not self activated
- Perception that I'm "too well" or "too ill"
- Program fatigue over time
- Didn't want to do it

# Physician Barriers

- Local Primary Care Physician groups
- Political issues
- Physician buy in
- PCP didn't agree with selected patient lists
- Other patients in practice who need this program
- High resource consumers in PCP practice they wanted to include but couldn't



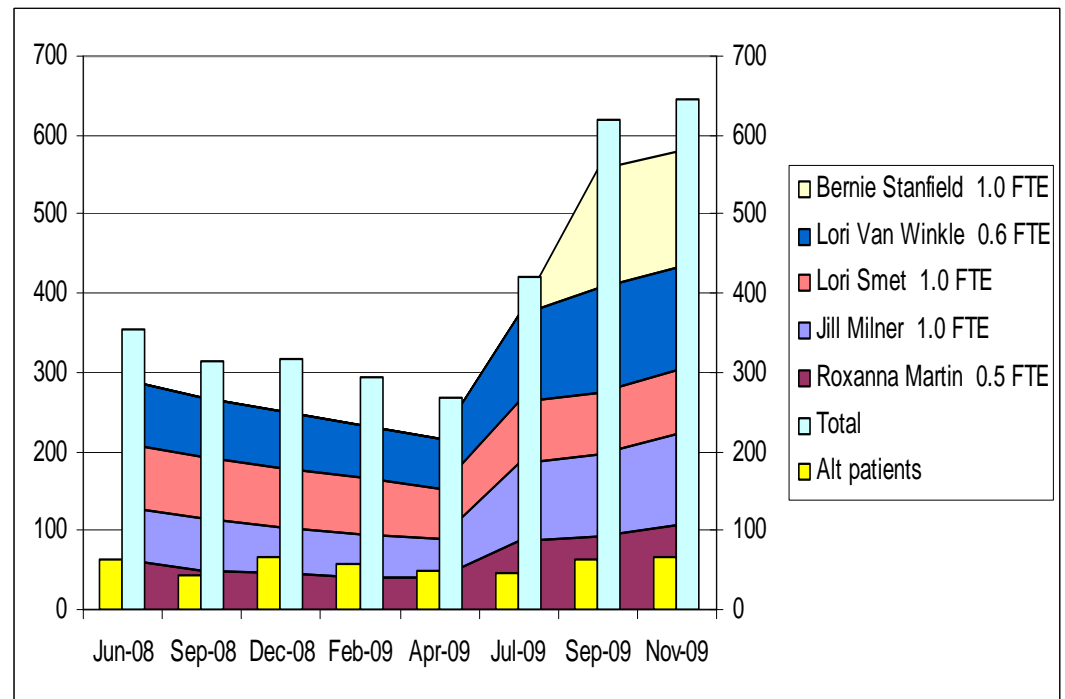
# Case Management

## How Does it All Work?

### 5 Case Managers Advance Practice Experience

- Master of Nursing
- Certified Diabetic Educators
- Health Coach training
- Motivational Interview training
- Certified Case Manager

### Case Load



# Case Manager Logistics

## Regional distribution

- Omak
- Moses Lake
- Wenatchee
- East Wenatchee
- Outside Physician groups in each region
- Internal Medicine and Family Medicine
- CM training

# Case Management

- Develop relationship with patient from beginning
- Enrollment, Wellness Days, Shared Group Appointments
- Continual phone contacts
- Develop relationship with Primary Care Provider
- Communication, credibility and trust with both patient and Primary Care Provider



# Interventions

- Protocols for diagnoses
  - CHF
  - DM
  - COPD
  - CAD
  - Generic algorithms
- CM assessment and intervention
- Notify physician, change medications, “day of” appointments, ER referral



# Electronic Medical Record Communication

Contact At:

Entered By: Smet, Lori

## Previous Details

Date/Time	Modifier	Details
10/05/09 11:24 A	Lori Smet	Called [REDACTED] this am and he was SOB on the phone and didn't recover as quickly as he usually does. Wt today was 126 and over the weekend was 125-130. He also said that he did have some SOB at noc took his inhaler x 1 and said that he was better afterwards. So I am having him take an extra 20 mg of lasix today. Also he said that he is taking 60 mg of lasix in am and 20mg in eve. this is different from his profile. I will call him tomorrow to f/u. Lori
10/05/09 03:54 P	Joan Kay-Casemier Nelson	I called him, he will come in to see me this afternoon. THANKS
10/07/09 08:17 A	Lori Smet	[Finalized]



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# Case Management

## Sentinel Event

- Discovery for QI
- Enrollment efforts
- Home/Hospital Visits
- Transition of Care
- Medication Reconciliation



# Why did this work?

## **RELATIONSHIPS**

PCP, CM, Healthcare Team, PATIENT

## **COMMUNICATION**

Shared Electronic Medical Record

Communication between Patient and Case Manager

**CREDIBILITY/TRUST** from all stakeholders

**Medical Director/Physician Champion**



# Keys to patient success

- Patient receives ongoing feedback about their health behavior
- Patient learns about diagnosis and takes ownership
- Patients begin to care about diagnosis
- Patient learns self management
- Patient learns accountability for self monitoring



# Comments on “engaged” vs “non-engaged”

## You can tell who is engaged:

- Poor control is a self- failing
- They want to learn self management
- They pay more attention to the chronic disease

## Not engaged:

- Poor control is the “system” or the Physician failing
- They do not own their disease
- Spouse does not encourage disease management
- Frequently have social/emotional distractions that are an “excuse” to not pay attention to health status
- Accountability is placed back on the physician “My doctor told me to do this”

## The reluctantly engaged:

For those that were reluctant participants initially, they have experienced growth and change in their approach to their disease.



# Results

At WVMC we have observed:

- Redistribution of services and changes in
  - Admissions decreased 14.6%
  - LOS decreased 1.6%
  - ER visits decreased 17.71%
  - SNF days decreased 41.8%
  - Outpatient increased 18.1%
- Majority of the benefit is seen with the CHF group
- Lesser benefit seen with COPD and DM