**Advanced Care Management: Q and A:**

\*This document reflects discussions during the NRHI SAN Advanced Care Management Events. We will continue to update this document as we progress through this webinar series.

**Advanced Care Management Model 1: Care Management Through Registries  
Launched December 7th, 2017**

**Panelists Include:**  
Jeyn Monkman, MA, BSN, NE-BC, Institute for Clinical Systems Improvement  
Medley Shamp, RN, Tri-County Health Care  
  
**What happens when patients are also going to other healthcare organizations:**  
  
Medley Shamp shared that the Tri County Health-Care facility in Minnesota that services a town of roughly 4,000 patients, Tri-County Health Care has an agreement to lease Epic EHR software from a larger organization known as Centra Care in Saint Cloud, MN. There are many small organizations in rural Minnesota that have bought into the same system. These organizations who have bought into the same system with Centra Care have their patient data pooled, and their info appears on Tri County’s registry. Additionally, the state of Minnesota produces a set of standard quality reporting measures practices are encouraged to use which promotes consistency amount reporting.  
  
*Example given:* If Tri County Health-Care refers a patient 90 miles south to an endocrinologist, they know that the facility will be checking for the same community measures (A1C levels, tobacco cession, etc.).  
  
**In addition to contacting high risk patients, do you also conduct home visits between medical appointments?**

Medley shared that the care coordination team does not provide home visits between medical appointments, but they do have community paramedics, who are trained medical personnel, who go into homes on non-emergency situations. Community paramedics are only used on certain matters. For routine matters, they ask the patient to come into their facility.

*Example given:* A patient who was trying to get onto the lung transplant list, had oral thrush due to a medication he was taking. He called into the clinic, and due to a storm outside the patient was unable to get to the facility for evaluation. They sent community paramedics to the patient’s home to conduct the evaluation, and that evaluation was relayed to the patient’s physician.  
  
**Could you talk about the pros and cons of using single disease registries, rather than using a multi disease registries? Do you see a practical way of managing patients with a multi-disease registries?**  
  
The Tri-County Health Care care coordination team would like to be working with a multi-disease registry, but they lease their EHR system from a larger healthcare organization. They have found work-arounds by using sticky-notes on charts, and since their population is so small, they know a majority the patients they see. They do believe a multi-disease registry would be beneficial, when compared to a single disease registry.   
  
**Would sharing registry data directly into other programs (Like MIPPS or MACRA) be beneficial?**  
  
The scope of this question is large, and could be delved upon deeper. This is a piece that is defined by the requirements of MACRA and MIPPS to get payment, and implement quality measures. Additionally, it puts pressure on the organizations current registries and EHR to see if they can support the integration of data.   
  
Tri County Health Care has joined an ACO, which has opened their patient data to more organizations. Medley stressed that organizations would benefit by getting data pullers, front end staff, and decision makers, to work together to accommodate the goals of the programs. In their region this collaboration has been very helpful.   
  
**Does your registry have the capability to automatically feed into the health maintenance, to automate tasks that need to be addressed during a patient encounter?**  
  
Specific to EPIC, you can print specific documents that remind physicians to do certain tasks during an exam through a pre-visit planning tool. Physicians who use electronic records can access this through the health maintenance tool. Tri-County Health Care’s registry can automatically update items like lab exams in the health maintenance tool.

**Advanced Care Management Model 2: Powering Up for Managing a Population  
Launched December 13th, 2017**

**Panelists Include:  
Tani Hemmila, MS, BSW, Director, Institute for Clinical Systems Improvement (Minneapolis MN)  
Todd Hinnenkamp, BA, RN, RN Ambulatory Supervisor and Depression Care Management, Essentia Health**

**In the Compass model are the psychiatrists on-site?**

This varied based on the organization and the system. Many times, the psychiatrist was off-site (very few were co-located). They could also be in the same building, or conducting psychiatric consults virtually.

**What training do the care managers need? Do they usually have the skills needed or do the practices conduct the training?**  
Be intentional and thoughtful about the model of care that you are going to use, and the characteristics that are needed to succeed in that role. For example,if you are going to provide depression care, you need to hire someone who is interested in a long-term relationship with a patient; regardless of credentials. Some nurses who joined the COMPASS team decided early on that depression care wasn’t for them, and returned to a more acute setting. Similarly, some social workers who worked in the program, were attached to a 45-50-minute therapy-type visit, and had difficulty seeing the value shorter visits focused on behavioral activation in a primary care setting. Some skills that care managers need to have are:

* + Understanding of diseases, multiple condition implications and behavior change
  + Laser focus on treat-to-target
  + Interpersonal skills, engaging and trust-building
  + Use of registry and planning contacts
  + Flexibility and adaptability
  + Taking the long view; therapeutic relationship
  + Respecting patient autonomy, strengths, and supporting their self-management
  + Creative and tenacious problem-solving, with patients and team

[The Compass Guide offers some additional training resources.](https://www.icsi.org/dissemination__implementation/compass/compass_intervention_guide/)

**What are some of the best ways to communicate with providers?**

* Internal messaging between providers (secure email).
* Ability to pick up the phone and call providers.
* Electronically through EMR.

**How often do the care managers reach out to patients?**

It varies based on their activity level in the program. If a patient is in an active phase of their program, they could be contacted at least once per week. Once the patient has come close to meeting their targets and isn’t in an active phase of the program, the communications can be less.

For more information on this question, check out the [COMPASS Intervention Guide](https://www.icsi.org/dissemination__implementation/compass/compass_intervention_guide/)

**How do you encourage the providers to use the care plan?**

There is not an easy answer for this question. You need to build a relationship with the provider, and ask them what they need. During the Compass Project, the Care Management teams noticed that the providers are more likely to buy in to using the care plan if they can see the value of how it and the care management team will be used.

**If a specialist asks for a change to the care plan, how do you handle that?**

There are some teams that had specialists involved. In those teams, their recommendations were handled like any other recommendation, and through the SCR team channels. Specialists’ roles varied. There are specialists who are doing a quick consult, or there are specialists who are working with a patient with a complex medical need, and are asked to take a managerial role in that patient’s care.

**How does the COMPASS approach differ from standard approaches to care?**

It differs based on the themes of the program, the COMPASS program focuses on “treating to target”. Additionally, the COMPASS program is a collaborative approach, that takes advantage of the different perspective and skills on the team. Lastly, it engages patients who were previous disengaged in the healthcare system for various reasons, in part because of their depression symptoms and also, largely, because the health system has not traditionally been well equipped to effectively support their complex needs.

**What’s the typical caseload for a care manager using the Compass model?**

A typical caseload is between 60-100 patients based on the type of support the care manager has to track the patient list, do outreach, and phase a patient out of the active phase.

**How do I get started? What are some good first steps?**

One of the ways to get started is to do some discovery, and engage others on what they are seeing a need for. Find existing workflows that could be adapted, and what doesn’t exist that would need to be added. Clarify myths on what care management is an isn’t. Care management isn’t patient stealing, its patient sharing. Care management is a value add, not a value take-away.