

# Team Care and Case Management

Connie Davis, MN, ARNP

MacColl Institute for Healthcare Innovation  
Group Health Cooperative of Puget Sound

Part 5

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# Video presentation

Improving Chronic Illness Care  
A Planned Care Visit  
The Patient Experience

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# Chronic Care Model



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## Step 1: Determine what to do

←————→  
...start with decision support

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## Stepped Care From a Guideline

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- Often begins with lifestyle change or adaptation (eliminate triggers, lose weight, exercise more)
  - First-choice medication
  - Either increase dose or add second medication, and so on
  - Includes referral criteria

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## Step 2: Define roles and tasks

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Distribute them among the team members

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## Care Is a Team Sport

- Team development
- Review process for care from guideline
- Assign tasks, matching licensure and skills
- Cross-train staff
- Use protocols and standing orders

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## Example of Task Distribution

- Microalbuminuria testing
- Receptionist recognizes patient has diabetes, attaches req. to chart
  - MA collects specimen
  - RN reviews slip, recognizes out-of-range tests, orders confirmatory test, discusses possible need for ACE inhibitor
  - MD discusses and prescribes ACE inhibitor
  - RN calls pt. to check on med. adherence and side effects

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## Roles in Team Care

Role	Primary Care Provider	Primary Care Nursing Staff	Medical Specialist	Clinical Care Manager	Resource Coordinator	Clerical Staff

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### Step 3: Integrate specialists

←————→  
Clarifying roles and working together

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### Definitions

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- Referral: transfer of care
  - Consultation: one-time or limited time
  - Collaboration: on-going co-management

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### Effective Interactions Rely on Agreement

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- When to consult
    - driven by the guideline
    - trouble making a diagnosis
    - specialized treatment
    - goals of therapy not met

Adapted from material by Steve Simpson, MD,  
Kansas University

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## Using Consultants Effectively

Make your consultants partners

- 1st principle of partnership - communication
- communication begins with you
- ask a specific question
- specify type of consult: ongoing (referral), one time only, duration of specific problem

Steve Simpson, MD, Kansas University

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## Communicating

- Telephone or in person
- Letter with supporting objective data
- Secure e-mail
- Shared EHR

Steve Simpson, MD, Kansas University

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## Example of an Agreement in Place

### Primary Care

1. State that you are requesting a consultation
2. The reason for the consultation and/or question(s) you would like answered
3. List of any current or past pertinent medications
4. Any work-up and results that have been done so far
5. Your thought process in deciding to request a consult
6. What you would like the specialist to do

Source: HealthPartners, MN

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## The Agreement in Place

### Specialty Care

1. State that you are returning the patient to primary care for follow-up in response to their consult request
2. What you did for the patient and the results
3. Answers to primary care physicians questions in their consult request
4. Your thought process in arriving at your answers
5. Recommendations for the primary care physician and educational notes as appropriate
6. When or under what circumstances the primary care physician should consider sending the patient back to you

Source: HealthPartners, MN <sup>16</sup>

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## Examples of integration

- Shared care agreements
- Alternating primary-specialty visits
- Joint visits
- Roving expert teams
- On-call specialist
- Via nurse case manager

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## Step 4: A key task for the team...

Ensuring follow-up

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## Effective Follow-up Includes:

- Developing a process for follow-up
- Tailoring follow-up to patient and provider needs
- Eliminating unnecessary follow-ups
- Scheduling follow-up
- Monitoring for missed follow-up
- Reaching out to those not attending follow-ups

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## Follow-up could be...

- Face-to-face
- Clinical case manager
- Outreach worker
- In groups
- Phone
- E-mail

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## Step 5: Clinical case management

Meeting the needs of complex  
patients

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## What is case management?

- Many different things to different people
- Resource coordination
- Utilization management
- Follow-up
- Patient education
- Clinical management

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## Positive Clinical Trials

- Clinically skilled case manager using protocols
- Close linkages to primary care and specialty expertise
- Close follow-up and strong self-management support

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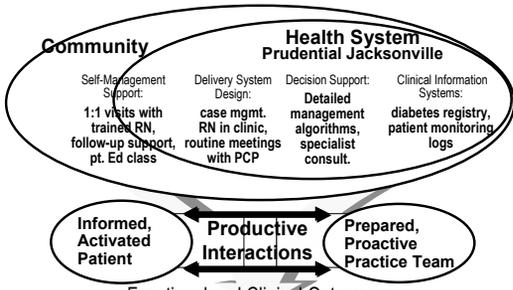
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## Diabetes Nurse Case Management



Functional and Clinical Outcomes:

decreased HbA1c, no increase in adverse events,  
improved self-reported health status

Aubert et al Ann Int Med  
1998;129:605

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## Negative Clinical Trials

- Nurse or social worker without specific clinical experience or training
- No clear goals or protocols
- Limited connection to primary care

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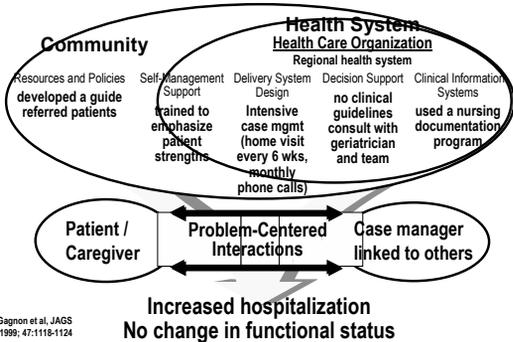
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## Non-specific Nurse Case Management



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## Principles for Case Management

- Develop patient selection criteria
- Determine needed services and availability of services
- If available, work together
- If not, review team roles and tasks and fill in gaps
- Assure that patients receive CM services

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## Features of Effective Programs

- Regularly assess disease control, adherence and self-management status
- Either adjust treatment or communicate need to physician immediately
- Provide self-management support
- Provide more intense follow-up
- Assist with navigation through the health care process

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## What if you don't have a case manager?

- Evidence suggests that non-professionals can be trained to perform follow-up and assessment
- That alone when linked to a physician or nurse case manager has improved outcomes in depression and arthritis
- Automatic Voice Response telephone systems can perform this function

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