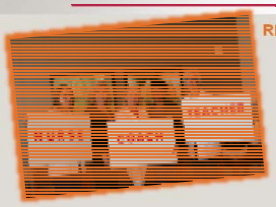
AADE7 in Practice



RN Care Managers in the Outpatient Care Setting

AADE19 National Conference
Houston, TX
August 10, 2019

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- Notice of Requirements For Successful Completion
  - Please refer to learning goals and objectives
  - Learners must attend the full activity and complete the evaluation in order to claim continuing education credit/hours
- Conflict of Interest (COI) and Financial Relationship Disclosures:
  - Presenter: Laura Smith, RN, BSN Baylor Scott and White/Health Texas Provider Network
  - Presenter: Edith Munoz, RN, BSN Baylor Scott and White/Health Texas Provider Network
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~LEARNING OBJECTIVES~

- Define the role of the RN Care Manager in the clinic setting.
- Recognize how RNs prioritize self-care behaviors using a team based care approach.
- Explain how risk stratification is used in the outpatient setting to improve individual outcomes.

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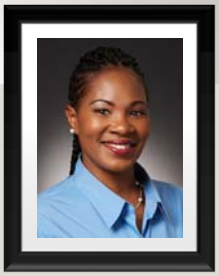
LAURA SMITH

RN, BSN

RN CARE MANAGER

BAYLOR SCOTT AND WHITE COMMUNITY CARE AT WORTH ST

DALLAS,TX



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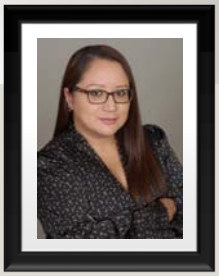
EDITH MUNOZ

RN, BSN

RN CARE MANAGER

BAYLOR SCOTT AND WHITE COMMUNITY CARE AT FORT WORTH

FORT WORTH,TX



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BAYLOR SCOTT AND WHITE
COMMUNITY CARE
CHRONIC DISEASE PROGRAM

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~HTPN/BSW RN CARE MANAGERS~

Implementation of the RN Care Managers into BSW Clinics

RN Care Manager – Registered Nurse skilled in assessment and care coordination.

- Provides chronic disease education and health management tools.
- Assists clinic care team to coordinate inpatient to outpatient transitions.
- Collaborates with high risk/complex individuals and their families to identify needs and expedite appropriate, cost-effective care.

Reference: 'Trehearne,B., Fishman, P., Lin, E.H.B.(2014). Role of the nurse in chronic illness management: Making the medical home more effective. *Nursing Economics*, 32(4), 178-184.

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RN CARE MANAGER CDM REFERRALS

Referral Workflow

Referral received from Provider via EPIC (EHR)	Receive referral via "Warm Handoff" during visit with Provider and/or other clinic staff

EPIC Referrals: Individual contacted via care call to discuss order received for Chronic Disease Management

If individual expresses interest in Chronic Disease education, appointment is scheduled for office visit with RNCM.	If individual is uninterested in receiving chronic disease education, referral is closed and Provider is notified.

"Warm Handoff" Referrals: Appointment scheduled for chronic disease management while individual is attending office visit with Provider/Social Worker/Pharmacist

Assess individual's concern about health and readiness to make behavior/lifestyle changes.	If interested, a brief intake is completed; follow up appointment is scheduled. If uninterested, document decline of service and notify Provider.

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RN CARE MANAGER CDM REFERRALS

RN Care Manager Workflow
Telephonic Appointment

Use MI techniques: reflective listening, affirmation, eliciting change talk using open-ended questions	Discuss changes in medications since last visit. Assess need for medication refills

Review Chronic Disease Self-Management Behavior Goals

Blood glucose changes; blood pressure monitoring; Heart Failure Action plan	Asthma Action plan; COPD action plan

Identify Barriers to Self Management/Problem Solving

Address any questions/concerns the individual may have. Address any health system navigation needs.	Review appointments. Document education/goals in EPIC. Communicate with Provider/Care team members as needed.

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RN CARE MANAGER
DIABETES MANAGEMENT PROTOCOL

- Discuss Diabetes (Type 1 or Type 2) diagnosis
- Medication Reconciliation
- Provide self-management education and support based on assessment of knowledge, desire, and preference
- Facilitate setting self-management goals. Review and adjust as needed

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RN CARE MANAGER
INSULIN TITRATION PROTOCOL

RN Care Manager Basal Insulin Titration Standing Delegated Order

- RN Care Managers utilize evidence-based practice guidelines in an expanded role of intensive disease management.
- Basal insulin titration allows the RN Care Manager to facilitate high quality diabetes care through timely basal insulin adjustments.
- Optimal diabetes management requires an organized, systematic approach and the involvement of a coordinated team of dedicated health care professionals working in an environment where individualized, high quality care is a priority.

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RN CARE MANAGER
INSULIN TITRATION PROTOCOL

- Diabetes must be managed by BSW referring Provider
- Individual must be diagnosed with Type 2 Diabetes and on basal insulin ONLY (Glargine [Lantus/Toujeo/Basaglar], Detemir [Levemir] or Degludec [Tresiba]).
- Can not have hypoglycemia <70mg/dL at least 2 weeks prior to initiation of protocol
- Must have access to a blood glucose monitor and agree to engage in recording fasting blood glucose levels for seven consecutive days.
- RNCM will call to make assessments and discuss care management with Provider prior to starting the insulin titration.
- Increase dosage of insulin no more frequently than once every seven days until fasting glucose target is attained.

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RN CARE MANAGER
INSULIN TITRATION PROTOCOL

- RNCM will follow up weekly to adjust basal insulin until fasting blood glucose readings are maintained at goal.

- Once maintenance phase is attained (defined as: no change in insulin dosage for two consecutive weeks), the RN will start to taper the frequency of outreaches, starting at two weeks, then at the frequency the individual desires for disease management.

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RN CARE MANAGER
HEART FAILURE PROTOCOL

- Discuss HF diagnosis
- Review HF action plan
- Medication reconciliation
- Set and review HF goals

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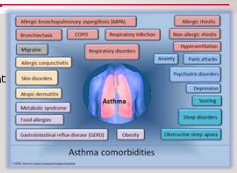
RN CARE MANAGER
ASHTMA/COPD PROTOCOL

- Discuss Asthma/COPD diagnosis
- Review Asthma/COPD action plan
- Medication reconciliation/peak flow assessment
- Set and review Asthma/COPD goals



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BAYLOR COMMUNITY CARE AT WORTH STREET
CARE TEAM

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BAYLOR COMMUNITY CARE AT FORTH WORTH
CARE TEAM

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MULTIDISCIPLINARY APPROACH TO REDUCING A1CS
AND MANAGING OTHER CHRONIC CONDITIONS

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PROVIDER FEEDBACK

"RN care managers provide an invaluable resource for our patients. They have helped identify socioeconomic barriers and given resources and encouragement to our patients to achieve optimum health".

Alexander Vilaythong, M.D.

Medical Director

Baylor Community Care at Fort Worth

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CARE TEAM ROLES
CHRONIC DISEASE MANAGEMENT

- RN Care Manager (RNCM)
  - Work closely with provider and CHW for referrals
  - Close follow up of individuals with chronic diseases (Diabetes, HF, COPD, Asthma, and HTN)
  - Review plan of care.
  - Use motivational interviewing to assist with lifestyle modifications and setting S.M.A.R.T. goals
  - Medication review / Insulin titration
  - Provider recommendations
  - Assist with & lead projects
- CHW (Community Health Worker)
  - Work with Provider and RNCM for close follow up of individuals with chronic diseases
  - Care Messages (text)
  - Home visits with CCN

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CARE TEAM ROLES
BEHAVIORAL HEALTH / CARE NAVIGATION

- Social Worker (SW)
  - Behavioral Health services
  - Resources
  - Bi-weekly or monthly group sessions
- Community Care Navigator (CCN)
  - Schedule new individuals from hospital
  - Home visit program with CHW
  - Assist with resources

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CARE TEAM ROLES PHARMACY TEAM

- Pharmacist
  - Medication review/education
  - Medication adjustments (collaboration agreement)
  - Insulin titration
- Pharmacy Tech
  - Medication education
  - Medication reconciliation

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TEAM BASED CARE HUDDLES

- RN led
- Meet weekly or every other week.
- Focus on individuals with frequent ER/hospital visits
- Goal: Reduce hospitalizations

Provider	RN Care Manager	Pharm D	Social Worker	Care Navigator
• Risk Stratification	• ED Admission and Tracking • Meeting Notes	• Medication Management • Medication Education • Cost Savings	• Behavioral Health • Barrier identification	• Home Visit • Multiple Facility Management

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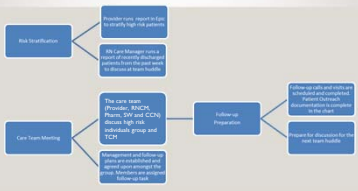
TEAM BASED CARE HUDDLES – CONTINUED



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PROVIDER FEEDBACK

RN care managers are at the core of our integrated care team. Our RN has to balance an individual's care plan while understanding their unique social determinant barriers. RN care managers and integrated team based care are the foundation for population health in the future.

Jeff Zsohar, M.D.

Internal Medicine/Pediatrics

Medical Director

BSWH Community Care Clinics

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CARE TEAM HYPERTENSION MANAGEMENT

- Individuals with current diagnosis of Hypertension
- Individuals with elevated BP without diagnosis of Hypertension
- Blood pressure checks, medication adjustments, education, and follow-up

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CASE STUDY 1

- 60-year-old H.M.
  - Initial visit: June 2017. Seen after hospital visit- seen for shortness of breath.
  - Diagnosed with: HF, Diabetes type 2, and A-fib.
  - Reviewed all HF, Diabetes, and A-fib education/ coaching.
  - During initial visits, his daughter accompanied him.
  - Monthly visits with provider.
  - Phone follow up with RNCM between provider appointments.
- Recently able to get Medicare.
  - Able to start seeing specialist: Nephrology, cardiology, and ENT for continuity of care.

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CASE STUDY 1

- A1C levels and Ejection Fraction:
  - AC = 7.8 (initial visit) June 2017
  - February 2018 = 9.3.
  - November 2018 = 5.8.
  - June 2019 = 7.5.

  - June 2017: Ejection fraction calculated at 14 %.
  - January 2018: Ejection fraction estimated in the range of 25 % to 35 %.
  - May 2018: Ejection fraction is low normal at 50%.
  - June 2019. Seen by cardiologist Heart function has recovered to an EF of 55%.

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CASE STUDY 2

- 58 year old female diagnosed with diabetes X 17 years.
- A1C at initial visit with RNCM: 11.3
- Hospitalized with e-coli/bacteremia complicated by aspiration pneumonia
- A1C improved to 7.7
- Family and work stressors led to increased A1C 9.4
- SW & RNCM followed patient closely
- She is now part of the bi-weekly SW group sessions.
- Most recent A1C: 6.2

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CASE STUDY 2

- A1C levels:
  - 8/21/17: 11.3
  - 1/11/18: 7.7
  - 710/26/18: 9.4*
  - 12/7/18: 7.5
  - 3/1/19: 6.2

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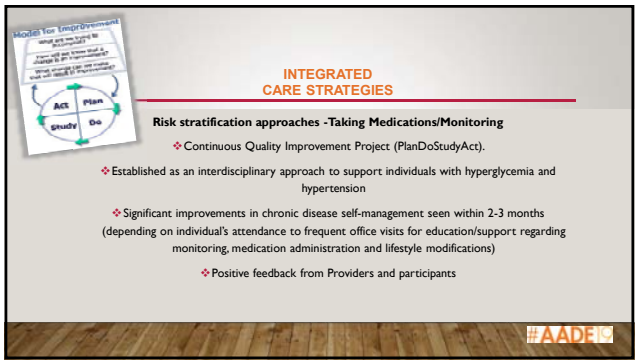
Model for Improvement
Act
Plan
Study
Do
INTEGRATED
CARE STRATEGIES
Risk stratification approaches -Taking Medications/Monitoring
Continuous Quality Improvement Project (PlanDoStudyAct).
Established as an interdisciplinary approach to support individuals with hyperglycemia and hypertension
Significant improvements in chronic disease self-management seen within 2-3 months (depending on individual's attendance to frequent office visits for education/support regarding monitoring, medication administration and lifestyle modifications)
Positive feedback from Providers and participants
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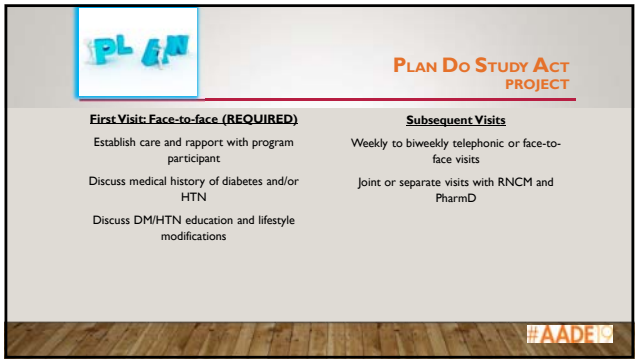
PLAN
PLAN DO STUDY ACT
PROJECT
First Visit: Face-to-face (REQUIRED)
Establish care and rapport with program participant
Discuss medical history of diabetes and/or HTN
Discuss DM/HTN education and lifestyle modifications
Subsequent Visits
Weekly to biweekly telephonic or face-to-face visits
Joint or separate visits with RNCM and PharmD
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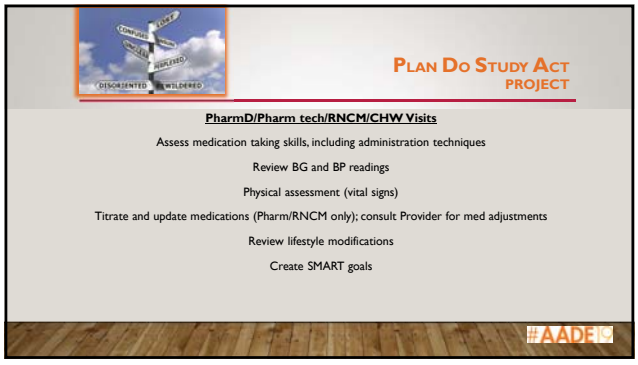
PLAN DO STUDY ACT
PROJECT
PharmD/Pharm tech/RNCM/CHW Visits
Assess medication taking skills, including administration techniques
Review BG and BP readings
Physical assessment (vital signs)
Titrate and update medications (Pharm/RNCM only); consult Provider for med adjustments
Review lifestyle modifications
Create SMART goals
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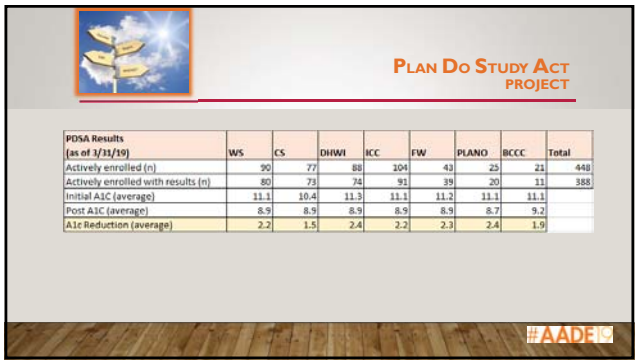
PLAN DO STUDY ACT
PROJECT
PDSA Results (as of 3/31/19)
WS CS DHWI ICC FW PLANO BCCC Total
Actively enrolled (n) 90 77 88 104 43 25 21 448
Actively enrolled with results (n) 80 73 74 91 39 20 11 388
Initial A1C (average) 11.1 10.4 11.3 11.1 11.2 11.1 11.1
Post A1C (average) 8.9 8.9 8.9 8.9 8.9 8.7 9.2
A1c Reduction (average) 2.2 1.5 2.4 2.2 2.3 2.4 1.9
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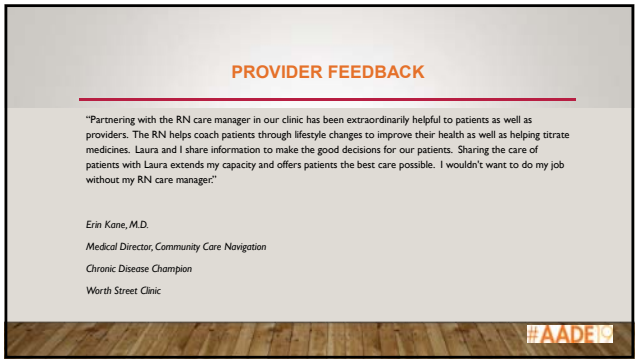
PROVIDER FEEDBACK
"Partnering with the RN care manager in our clinic has been extraordinarily helpful to patients as well as providers. The RN helps coach patients through lifestyle changes to improve their health as well as helping titrate medicines. Laura and I share information to make the good decisions for our patients. Sharing the care of patients with Laura extends my capacity and offers patients the best care possible. I wouldn't want to do my job without my RN care manager."
Erin Kane, M.D.
Medical Director, Community Care Navigation
Chronic Disease Champion
Worth Street Clinic
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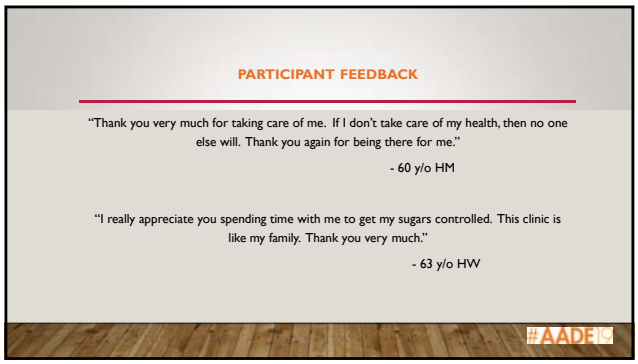
PARTICIPANT FEEDBACK
"Thank you very much for taking care of me. If I don't take care of my health, then no one else will. Thank you again for being there for me."
- 60 y/o HM
"I really appreciate you spending time with me to get my sugars controlled. This clinic is like my family. Thank you very much."
- 63 y/o HW
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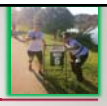
INTEGRATED CARE STRATEGIES



Risk stratification approaches: Healthy Eating/Being Active

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CASE STUDY 3

~49 year old female with Heart Failure/COPD/Type 2 DM~

- Diagnosed with Heart failure and COPD in November 2016; Type 2 Diabetes x 10+ years; Smoker-1/2 pack per day
- Ejection fraction 60%; A1C 13.2% at initial visit with RNCM; BP ranging 130s/100s
- History of frequent ED/inpatient admissions due to difficulty accessing health care. 2016: 7 ED/hospital visits; 2017: 4 ED/hospital visits; 2018: 2 ED/hospital visits
- Re-established care with clinic June 2018. Referred to clinic care team (RNCM, Pharm, SW and CCN). Assistance with transportation provided.
- Barriers: lack of transportation, unable to afford medications, inability to plan meals, decreased physical activity due to chronic back and knee pain
- Pharm visits: discussed medication education and reconciliation, possible initiation of new DM meds, BG monitoring (fasting and post-prandial readings); smoking cessation

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CASE STUDY 3

- RNCM interventions: HF action plan/smoking cessation, discussed BG monitoring, reviewed meal planning/food resources and encouraged meeting with social worker for behavioral health (PHQ 2 positive), SMART goal setting.
- 3 month follow up: decreased hospitalizations for HF/COPD exacerbations and infections; A1C 13%; meeting with Provider and/or care team monthly.
- 6 months follow up: 1 hospitalization due to infection; A1C 13.3%; reports increased feelings of depression due to living situation; continuing to engage with Provider and care team every 1-2 months
- 9 months follow up: no ED/hospital visits for acute care; A1C decreased to 10.1%; reports she stopped smoking; continues meeting with care team every 1-2 months
- 12 month follow up: no ED/hospitalizations in 2019; A1C decreased to 8.1%; continues to engage with Provider and care team

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CASE STUDY 4

~60 year old male with Type 2~

- Diagnosed with Type 2 x 20 years
- A1C 14% at initial visit with RNCM
- Referred to PDSA program due to needing assistance with taking medications and lifestyle modifications
- DM Medications: Metformin 1000 mg twice daily; Novolog 70/30 20 units twice daily
- Medical History: Bipolar disorder-going to outpatient mental health facility for treatment; hyperlipidemia
- Barriers: limited support system, mental illness, no medications x 3 years; limited insight regarding medication and lifestyle management

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CASE STUDY 4

- Pharm visits: insulin titration (if applicable), BG monitoring and smoking cessation. 1st visit average FBG: 350 mg/dL average PP: 258 mg/dL.
- RNCM interventions: lifestyle modifications, discuss barriers, SMART goal setting.
- Follow up A1C 1st 3 months A1C decreased to 7.5%
- A1C increased back to 14% due to stressors, poor medication taking skills and unhealthy meal choices; re-introduced to program.
- After 6 months with program A1C decreased to 6.7%. FBG average: 129 mg/dL PP average: 145 mg/dL

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