CMHC HCH Patient Process Narrative[1]

Hypothetical Health Care Home Patient Scenario

Patient Background: "Howard": Howard is unmarried, age 40, 5'9" tall and 250 lbs. He smokes 2 packs of cigarettes a day. At age 25, he was diagnosed as having schizophrenia. At age 37, he was diagnosed as having hypertension. A year ago, he was diagnosed with adult onset diabetes. He was just admitted for the 3rd time in the last 12 months to general medicine at his local community hospital after coming to the ER for feeling weak, thirsty, and light-headed. His blood sugar in the ER was 470. After his last previous discharge from the General Hospital for hyperglycemia 6 weeks ago, he did not follow through with the hospital's recommendation to schedule a primary care visit to manage his diabetes.

Engagement and Health Care Home: There are 2 pathways to initial engagement with the CMHC health care home:

1) The General Hospital Social Worker's resource manual indicates that persons with severe mental illness may be referred to Wellsville CMHC if they need care coordination and disease management services provided by a health care home. This information is in the resource manual as a result of a MOU covering referral and transitions of care between General Hospital and Wellsville CMHC (TC). General Hospital has also been informed by Medicaid that Wellsville CMHC is providing treatment and care coordination on behalf of Medicaid and therefore may be provided with Medicaid recipient PHI. The social worker at General Hospital calls the Wellsville CMHC nurse coordinator in an effort to make sure Howard receives the continued care that he needs.

2) Shortly following Howard's second hospitalization 6 weeks ago, Howard was added to a list of persons to be actively sought for engagement by CMHC health care homes because he had more than one avoidable hospitalization in a 12 month period. The CMHC had been unable to locate Howard because they did not have an accurate address for him. When General Hospital called the Medicaid hospital's concurrent utilization management phone line to obtain initial authorization for the hospital admission (which is required within 24 hours of admission) Howard was entered as a current admission in the concurrent utilization management system.

> ***Behind the Scenes –***
> - At 12:00 a.m. daily, a list of new hospital admissions and discharges is transferred to CMT, the disease management analytics contractor for CMHC health care homes.
> - Then, CMT cross-matches the list and compares it to a list of persons identified as currently having a health care home or being sought for engagement to health care home.
> - Wellsville CMHC receives its updated list each morning from CMT that shows which people are newly hospitalized and in need of outreach or transitional care.

The CMHC nurse coordinator (or other CMHC staff) notices that either the hospital has called regarding Howard or that they have been notified of his admission on the overnight new admissions updated list. The CMHC assigns a nurse care manager to contact the hospital that day and visit Howard on-site as soon as his clinical condition permits personal interaction.

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[1] Key for data for health care home services

1) comprehensive care management = (CM)
2) comprehensive care coordination = (CC)
3) health promotion = (HP)
4) comprehensive transitional care = (TC)
5) individual and family support services = (SS)
6) referral to community and social support services = (RC)

Once assigned, the CMHC nurse care manager takes the following steps:

- Uses Cyber Access to review and print Howard's 3-year history of care provided by Medicaid (CM);

> *Cyber Access reports on all of Howard's medications prescribed in 3 years. Includes medication, dosage, pharmacy, prescriber, medication possession ration (a measure of adherence to medication over time) and potential medication interactions. It also includes all clinical episodes of both inpatient and outpatient including date, provider, diagnosis and procedure.*

- Contacts Howard's hospital ward and provides outpatient medication reconciliation to Howard's hospital nurse using the cyber access report; and
- Provides a copy of the Cyber Access history via fax to the hospital to be used in treatment planning while Howard is hospitalized (CC).

The Cyber Access pharmacy section indicates that Howard has been regularly filling prescriptions for his antipsychotic and antidepressant medication, but he has only filled a prescription for his prescribed oral diabetic medication (i.e., Metformin) one time more than 3 months ago. According to the report, he does not have any prescriptions for his hypertension. He has seen 6 different primary care physicians over the last 3 years, but he has not seen any of them more than twice. Two of the doctor's visits were for his diabetes, and one was for hypertension. Most of his outpatient visits were for simple acute complaints-- including upper respiratory infection and a sprained ankle.

When Howard is well enough for visitors, General Hospital notifies the CMHC nurse coordinator. Then, Wellsville CMHC sends a case manager/community support worker to the hospital to visit Howard and assist him in getting and keeping his appointments and avoid unnecessary hospital visits in the future. Howard agrees to accept this assistance. The case manager sets up an appointment for him with Wellsville CMHC the following week and tells him that they will contact and visit him as soon as he is discharged.

Subsequent to this visit, the CMHC nurse coordinator calls Howard's hospital unit nurse regularly to track his progress and to be updated regarding his discharge plans (TP). Prior to his discharge, the hospital faxes Howard's after-care plan to the Wellsville CMHC care nurse coordinator (TC). Howard is finally discharged from General Hospital.

Two days after his discharge, the Wellsville CMHC nurse coordinator checks Howard's record on Cyber Access and sees that no prescriptions have been filled since his discharge. This causes concern, therefore the CMHC contacts Howard and a community case manager/support worker goes to Howard's home. Together, Howard and the case manager go to the pharmacy to fill his discharge medication orders (SS) and then stop back at the CMHC where the nurse coordinator reviews the purpose of each medication (HP) with Howard. The nurse coordinator assists in filling a daily medication administration box for him to use at home (SS).

A week after filling his prescriptions, Howard goes to the Wellsville CMHC for his scheduled appointment (*he received a reminder phone call from the CMHC to keep the appointment the previous day* (SS)). At this appointment, Howard is given the usual comprehensive evaluation regarding his behavioral health. He also receives a health risk evaluation from the nurse care manager that includes screening for BMI (height/weight), blood pressure, cholesterol, triglycerides, and glucose intolerance. This information is entered into a disease registry maintained on Cyber Access (CM). The nurse care coordinator notes the following healthcare problems by a combined review of the Cyber Access history, health risk assessment and metabolic screening:

✓ Howard does not have an ongoing relationship with any primary care physician.
✓ He has a diagnosis of hypertension, but has not been prescribed any medication for hypertension in the past 2 years, and his current blood pressure is elevated above normal range.
✓ He was diagnosed with diabetes year ago, but he has never been given diabetic education except for brief discussions while in the hospital. He does not really think he has diabetes because they are not giving him

insulin. He does not understand the use of oral medications to control of high blood sugar so he does not get the prescriptions filled.

✓Howard smokes 2 packs a day, but wants to quit. He is also obese but does not like the idea of dieting.

The CMHC's nurse care manager and mental health professional review their evaluations of Howard with the psychiatrist. Before Howard leaves the CMHC that day, he engages in a group discussion with the nurse care manager, the mental health professional who conducted his behavioral health evaluation, and his community support worker. Together, they agree on initial treatment plan (CM) that includes:

HOWARD'S INITIAL TREATMENT PLAN:

Howard's Recovery Goal: I will get an immediate appointment and maintain regular appointments with the same primary care physician who will manage my hypertension & diabetes. Of all of the doctors I've seen in the last year, I liked Dr. Lee the best & want him to be my primary care doctor.

Howard's Outcome: I will stay in touch with my community support worker & doctor and will take my medication. I want to do a better job of taking care of myself.

CMHC Action Plan: A community support worker will visit Howard at least once weekly & check his medication plan & whether he is taking medication as prescribed.

Howard's Recovery Goal: I agree that it is important to stop smoking & will attend the Wellsville CMHC smoking cessation support group 2 days a week (HP). I will work with my case manager to choose a Medicare Part D plan that covers smoking cessation medications since my current plan does not cover this (RC).

Howard's Outcome: I understand that smoking is not good for me & I need to try to quit. I also understand that this will be hard & need support from others.

CMHC Action Plan: Howard's case manager will schedule a time to go over his Medicare Part B options for smoking cessation medications & let him know when support groups meet.

Howard's Recovery Goal: I would like to get a job in the community; preferably working with cars. I know that I may need to go to a trade school to learn how to do auto body work.

Howard's Outcome: Getting a job may help me be motivated to take better care of myself & to get out of the house & meet more people.

CMHC Action Plan: The community support worker will help Howard get in touch with vocational rehab services in his community (RC) so he can pursue his desire to do auto body work & be employed.

Per the treatment plan, the nurse care manager calls Dr. Lee's office to arrange an appointment for Howard for the following week (RC). The case manager calls Howard to notify him about the appointment and also calls as a reminder to him the day before the appointment (SS).

Despite the care manager's efforts to remind Howard, he fails to keep his 9 AM appointment with Dr. Lee the next day. When the case manager inquires about why the appointment was missed, Howard says that he rarely wakes up before 11 AM. The nurse manager tries again and calls Dr. Lee's office to arrange another appointment for Howard. Initially, Dr. Lee is reluctant to reschedule since Howard missed his first appointment, but he agrees when the nurse care manager assures Dr. Lee that Wellsville CMHC will ensure that Howard keeps his appointment (RC). The appointment is set for 2 PM the following Wednesday.

Howard's case manager calls Howard's the day before and goes to Howard's house at 1 PM the following day to accompany him to his 2 PM appointment (SS). Howard's case manager provides Dr. Lee a copy of the Cyber Access 3-year summary report of Howard's previous medical history, the nurse coordinator's health risk assessment, and Howard's initial treatment plan (CC). Dr. Lee examines Howard, prescribes a different dosage of Metformin for his diabetes and starts him on antihypertensive medication. Dr. Lee amends Howard's treatment plan as follows (CM):

DR. LEE'S ADDITIONS TO HOWARD'S TREATMENT PLAN:

☑ Antihypertensive medication added

☑ Reflects different dosage of Metformin for diabetes

☑ Psychiatrist(s) may want to consider switching Howard's antipsychotic medication to one less likely to cause weight gain.

☑ Get flu vaccine in the fall

At his next visit to the Wellsville CMHC, Howard is shown how to log on to the patient version of Cyber Access (called Direct Inform). Direct Inform provides Howard with the same 3-year history of his past medical care, but in simplified layman's terms. It identifies specific questions or preventative care that he may need and allows him to print the questions he selects off as a "to do" list of things to talk about with his doctors and his next appointments. Training on how to login to Direct Inform is provided by either a Peer Specialist or his community case manager (HP or SS). The nurse coordinator is available to discuss any questions Howard has about his record of past medical care or the recommended questions to go over with his doctor (CC or HP).