

Chronic Care Management Intervention: A Qualitative Analysis of Key Informant Accounts

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Final Report
June 29, 2010

Prepared for the Washington State Department of Social and Health Services,
Health and Recovery Services Administration
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Executive Summary

The Rethinking Care Project

Rethinking Care (RTC) is a program funded by the Washington State Health and Recovery Services Administration (HRSA) within the state Department of Social and Health Services (DSHS) which began in February, 2009. The program is being carried out in collaboration with the Center for Health Care Strategies (CHCS) and King County Care Partners (KCCP), a partnership of King County Aging and Disability Services (ADS), Harborview Medical Center (HMC), and four community health center networks. Its purpose is to improve the quality and reduce expenditures for Supplemental Security Insurance (SSI) recipients with co-occurring medical and mental health/substance abuse problems by providing care management. The King County Care Partners Program (KCCP) was established in early 2007 by DSHS/HRSA as a predecessor to RTC.

The RTC Program is being carried out as a randomized control trial in order to allow a rigorous evaluation of the program's impact. Approximately 1,560 eligible individuals are expected to be randomly assigned to either the RTC intervention or to a treatment-as-usual abeyance group over a two-year period beginning February 1, 2009. As one part of this broader evaluation, a series of key informant interviews were conducted to better understand the chronic care management intervention and how it changed over time. This report summarizes the results of those interviews.

Intent of the Qualitative Analysis of Key Informant Accounts

The purpose of the analysis is to describe the RTC Program and how it has unfolded since February, 2009. Interviews were conducted with a group of RTC key informants which included program administrators, nurse care managers, social workers, and clinic care coordinators and physicians in the community health center network to inform a descriptive analysis of the intervention and engagement strategies and how these have changed over time.

Findings

- The core element of the RTC Program is nurse-led, multidisciplinary care management executed through the orientation of motivational interviewing. Clients receive a comprehensive assessment, develop self-care goals, receive the support and resources to accomplish their goals and achieve health self-management.
- Key informants identified fundamental components of the RTC intervention.
 - *Care Collaboration.* Engaging with the client's providers or potential providers to facilitate meeting the client's health care needs. This includes accompanying the client to appointments and facilitating the client/provider relationship through advocacy, coaching, modeling, and education.
 - *Care Coordination.* Gathering all of a client's providers, including primary care, specialty care, mental health, and chemical dependency, to get them talking to each other and functioning as a team. System navigation, securing health care,

and assisting clients in meeting their psychosocial needs are part of care coordination.

- *Health Education.* Providing education about specific diseases along with the skills, concrete tools, and resources for the client to self-manage their illness.
- *Central Support:* The interface between the client and nurse care manager, characterized by frequent contact, accessibility of the nurse, and access to multiple additional support people.
- Key informants described the primary benefit of the program to clients as gaining the confidence, skills, and resources to navigate the health care system and self-manage their health, as well as the individual benefits from “success stories.”
- Intended benefits to the system are cost reduction through decreased emergency department use, crime, and inpatient hospital stays; harm reduction, prevention of more serious illness; and decrease in mortality. There is also an intended benefit of incremental transformation of the health care system through program efforts.
- Key informants identified the following client characteristics as indicators for success in the RTC Program: willingness and motivation to improve health; absence of or less severe mental illness, chemical dependency, or cognitive deficits; less severe medical illness or illness for a shorter period of time; stable social support and housing.
- Physicians do not feel fully informed about the RTC Program. They most appreciate the nurse care manager accompanying their patients to clinic visits, or, “getting patients to appointments”. They expressed an understanding of the program reflecting the hierarchical culture of the medical model which diverged somewhat from the collaborative, client-centered RTC philosophy.
- Changes over the course of the initial program through to the RTC iteration include lengthening program and assessment times, adding validated instruments to the assessment, involving clinic care coordinators from the beginning of the intervention, multidisciplinary expansion through social work, bringing the initial outreach in-house, changing eligibility, increasing the focus on mental health and chemical dependency, and providing training in motivational interviewing
- Key informants identified the following challenges in the program
 - *Programmatic.* Inadequate data system and barriers to cross-institutional communication due to confidentiality significantly impede the program. Large caseloads, inconsistent work flow, lack of adequate technology (e.g. laptop computers), and hazards working in the community are challenges for the nurse care managers and social workers.

- *Participation.* Unmet basic needs, language/cultural barriers, mental illness, and chemical dependency hinder clients' participation. Finding and contacting clients is difficult.
- *Providers.* Judgmental attitudes discourage clients. The medical residents and new professionals who care for clients do not have enough experience for their complexities. Appointments are too short. Waiting periods for appointments are too long. The nurses and care managers and social workers experience professional territorialism in the clinics.
- *Systems.* Lack of access to chemical dependency treatment and the bureaucracy of the mental health system keep clients from progressing.
- Key informants expressed appreciation for the innovative nature of the program, their talented, committed colleagues, strong leadership, successful community partnerships

Recommendations

- ***Multidisciplinary Refinement.*** The program has become increasingly multidisciplinary in its execution, with increased focus on psychosocial issues, mental health, and chemical dependency. The nurses and social workers at times work outside their core competencies; nurses address psychosocial, mental health or chemical dependency issues, and social workers perform clerical duties. Providing a framework in which these staff members practice primarily within their professional roles would increase productivity and efficiency. Clerical support is needed. Retaining the central support and leadership of the nurse care manager is important; key informants identified this “go to” person as an essential ingredient of the intervention.
- ***Caseload and Work Flow.*** Nurse care managers gave suggestions of maintaining caseloads between 35 and 50 clients. Consistent, steady case flow and weekly meeting schedule would improve the nurse care managers' and social workers' ability to execute the program efficiently.
- ***Technology***
 - Laptops the nurse care managers and social workers could take with them in the community, as well as cell phones, would save much time. Global Positioning System (GPS) devices would also help in navigating across the county when they visit clients. These are relatively inexpensive items that could make a significant difference in staff productivity, efficiency, and morale.
 - Given the challenges in cross-institutional information exchange it would be important to identify ways to share such information. One possibility is to assign client numbers so they do not have to be identified by name in emails.
 - Clients often lack consistent phone contact due to homelessness, finances, or lifestyle. It would be reasonable to consider the option of giving them disposable

cell phones at any period during which lack of contact would impede successful participation in the program.

- **Data System**

- Because the intervention has become increasingly multidisciplinary, equal and flexible access to the initial assessment additional information would help streamline the combined efforts of the nurse care managers and social workers in the most efficient way possible.
- Partner clinic physicians indicated that they would like updates on clients. Developing a standard format for client updates as well as a protocol for transmitting this information to physicians and possibly other providers such as mental health and specialists should be considered as an important element of the new data system.
- Clinic care coordinators indicated that they would like client summaries at the transition. Developing a standard format for a transition summary should also be considered as a component.
- Considering that cross-institutional communication by email is a challenge, creating a data system that allows extensive enough documentation and updates that need for email communication about clients is minimized would cut down on the time and complex strategies nurse care managers, and clinic care coordinators are currently using.
- For information and records in which detailed narrative is not necessary or standardization is optimal, providing several options requiring minimal data entry would save time and increase efficiency.

- **Assessment and Evaluation.** Investigating whether there are validated instruments for other languages and populations for the Patient Activation Measure (PAM) and the other assessment instruments and fortifying clinical evaluation by standardizing it would strengthen assessment and evaluation as a whole.

- **Education and Marketing.** More consistent education and marketing about the program, particularly the underlying core concepts of care management and motivational interviewing, would clear up misunderstandings, allowing providers to work in concert with the program and mitigating the professional territorialism the nurse care managers and social workers say they encounter in the clinics.

- **Transition.** Consider standardizing the transition procedure, including provision of formal client summaries for the clinic care coordinators. Given the variability in client needs and the concern of client dependence on the program, consider customizing a protracted transition option that would provide clients who have less social support, or other factors that complicate transition, with incremental steps that more slowly taper

contact while helping to increase the resources or skills they are lacking for successful transition.

- **Provider Clinics.** Consider adding the primary care clinics that already see many program clients to the partnership. This would ease burden on the partner clinics and provide more timely service for clients. Consider developing a strategy for accommodating the reality of short provider appointments such as more frequent visits. Provide regular client updates to providers. Developing a standard format as well as a protocol for transmitting this information to providers should be considered as an important element of the new data system.

- **Future Study and Focus**
 - The program intervention is slowly transforming the system as it makes small incremental adaptations in response to the RTC Program and brings together parties from all parts of the health care system for collaboration. It would be fruitful to study this system change and how it is evolving, as it is an essential element of the impact of the intervention and on the cutting edge of health care delivery.

 - Considering the difficulties in the mental health system, focus on building mental health integration to reduce some significant client barriers to participation.

 - Emergency departments are a significant element of this client population's care. Collaborating and coordinating with emergency departments in a similar way as the program currently collaborates with clinics could add another beneficial layer to the intervention.

 - Key informants emphasized the individual nature of clients' accomplishments in the program and spoke about wonderful success stories they hear. Consider collecting and compiling client success stories in a format that can be easily shared with others. Such stories have the potential to powerfully communicate the impact of the program to a broad range of stakeholders.