connecting dots

Closing gaps for people with chronic health issues

Diabetes has been a fact of life for 30 of Joe's 50-something years. He has lots of related complications: compromised kidney function, vision loss, and a foot wound that won't heal. He also has congestive heart failure. He lives alone, has no family locally, and works full-time because he must.

Keeping on top of Joe's health is a monumental task, just the kind of thing Community Health Innovations was designed to do. CHI, as it is known, is a subsidiary of Community Hospital Foundation that was formed to help people manage their complex healthcare needs.

When someone suffers from a single ailment, they often go to a doctor for diagnosis, treatment, and resolution. People who have multiple issues, however, may see multiple doctors and healthcare practitioners, whose individual treatments could be counterproductive unless they know what everyone else is doing. Or, those dealing with multiple conditions may simply avoid trying to get care, finding it overwhelming or too expensive. Then things just get worse, and usually more difficult and more costly to treat.

CHI tackles this with staff members called care managers, registered nurses who work closely with these patients and their care providers to help connect the dots and close gaps. Some care managers are stationed in Community Hospital's Emergency department, some are assigned to specific primary care offices, and others work with multiple physician offices.

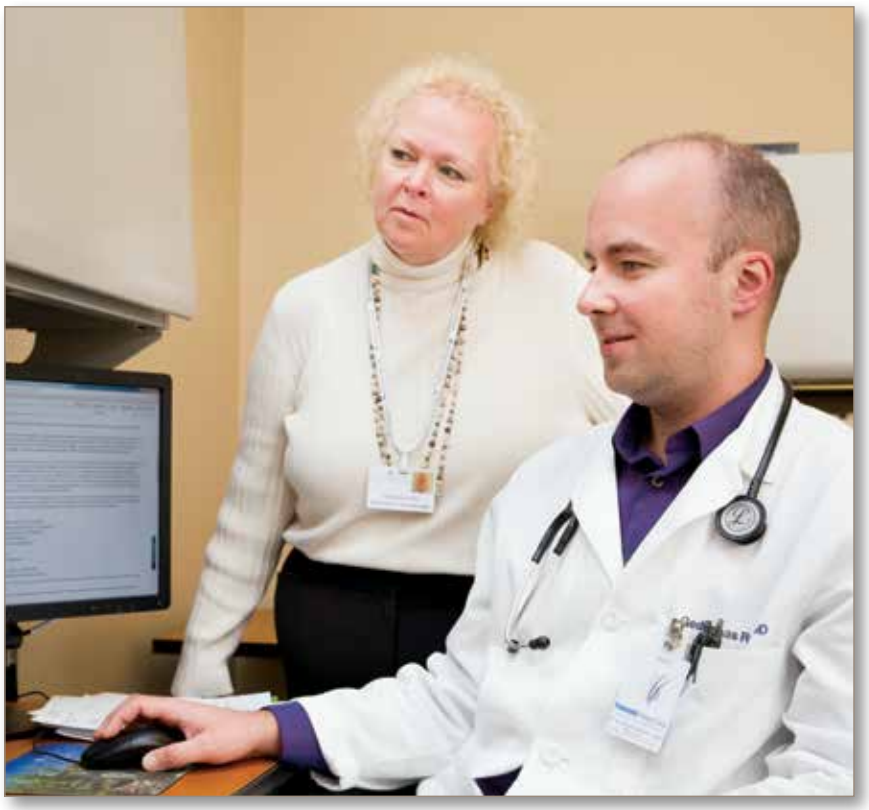
Their services are offered to patients who are identified as potentially benefiting from the approach. People like Joe. Joe was connected with Kathy Work, RN, a CHI care manager based at Peninsula Primary Care (PPC) in Carmel.

"Through coordinated care management, his blood sugar control has significantly improved," Work says. "And his healthcare providers are getting a full picture of what's going on with him and how they can help.

"Medical care has become very compartmentalized," she continues. "As care managers, we work to create a bridge among different healthcare entities, so aspects of care don't fall through the cracks and get lost. Patient information moves from one provider to another, creating continuity of care." When PPC's Dr. Gediminas Ruibys sees a patient with a complex case, he turns to Work to help him provide care that is comprehensive and effective.

"The importance of having Kathy in the room is for me to see what the other part of the team is doing, to get an update on what happened since the patient's last visit — progress with treatment, appointments with specialists and their plans, and what was not done and still has to be done," Ruibys says. "This way I can assess the progress and see if we need to make any changes in management of chronic conditions. Unfortunately, I usually don't know their whole story without the help of a care manager. I have to address so many things in that brief period of time that I may not have time to find out what is going on in the patient's life, which is sometimes a critical piece of information."

While the care managers focus on healthcare, sometimes their work involves removing an obstacle to healthcare. Care managers have connected people with transportation so they can get to appointments, helped them apply for medical coverage, and identified resources for basics like food and housing.



Kathy Work, RN, and Dr. Gediminas Ruibys review a patient's records at Peninsula Primary Care in Carmel.

"Care management requires teamwork and a good support staff, so we can say 'Here's what's going on and here's what we need to do,' and the patient gets the comprehensive care they need," Ruibys says.

This model of care is part of what's called the "patient-centered medical home," where, as the name says, the patient is the focus and medical care and services align around him or her. "This means creating a highly reliable, collaborative approach to medical care, a place where people truly know their patients," says Dr. Anthony Chavis, chief medical officer of CHI. "Simply delivering care is not going to get us there. Fundamentally, the American healthcare system needs to change to a more holistic way of delivering care. From birth to death and across delivery sites, we need an integrated healthcare strategy."

Those delivery sites include emergency departments. Managing a chronic illness is not usually a job for an emergency department (ED), which is designed to treat acute illness or trauma. Yet Dr. Reb Close, who practices in Community Hospital's ED, says there's a significant need for coordinated care for patients who have come to rely on the ED for help with poorly controlled, chronic medical problems.

"The ER [emergency room] is very convenient; we are open every hour of the day," Close says. "But it is also

expensive and inefficient as far as chronic care goes. We are not equipped to provide optimal ongoing care."

Transitional care managers work with frequent ED users to identify the underlying causes of their return visits and to help resolve them.

For example, "a number of patients with diabetes were coming in regularly," Close says. "Once we got them educated, improved their access to resources, and got them on a care plan, their health improved and their care for chronic issues was transitioned to the more appropriate primary care setting."

CHI is working with physicians throughout Monterey County and has assisted hundreds of patients. Reducing reliance on emergency departments for non-emergency care is among its biggest impacts. Patients are still getting the care they need, but in more appropriate settings, Chavis says. In 2014 alone, it is estimated that transitioning patients to more appropriate care resulted in 1,100 fewer emergency department visits for medical issues and 600 fewer visits for behavioral health issues at Community Hospital, he says.

Liz Lorenzi, chief operating officer of CHI, says the approach is in keeping with the "triple aim" in healthcare: enhancing the patient-care experience, improving the health of the community, and reducing the cost of care.

Robert Quist, RN, works closely with Emergency department physician Dr. Reb Close to help patients get the care they need in the right setting.

"By integrating real-time clinical data with historical data about patients, we're able to make smarter, evidenced-based decisions, giving our patients the best possible care in the most efficient way," Lorenzi says.

Robert Quist, RN, in emergency nursing for 26 years before he got into care management, identifies people who have barriers to healthcare and tries to break down those barriers by educating and empowering patients to manage their own care.

Quist recently worked with a patient in his 40s who had lingering issues from a motorcycle accident. He had no healthcare providers, no personal support system, and no insurance. Quist arranged for him to see an orthopedist and gave him resources for dental services.

"The patient recently called to tell me he'd made an appointment to have a tooth replaced," Quist says. "That was a big step in managing his own care. We also talked about ongoing pain he has and how best to manage it. We try to follow a patient's progress, so we can graduate him or her out of our care-management program."

More information can be found at www.communityhealthinnovations.org.