# Brightspot Best Practices: Chronic Care Management

## Tri-State Memorial Hospital, Washington State and Idaho

Tri-State Memorial Hospital (TSMH) takes a unique approach with their Chronic Care Management (CCM) program. Rather than trying to enroll all patients who qualify at once, they use quality data to find areas of care where they can make the greatest impact. They started with diabetes management and built a program that enlists input from disease management experts and keeps them as part of the team. Ultimately, patients are engaged in a provider directed CCM service that maximizes the organization's expertise, programs, and community resources to help patients and better target challenging areas of care.

Population Health Nurse Nicole Louchart, RN, developed this creative approach with tremendous support from CEO Donald Wee, Chief of Clinical Operations Joleen Carper, and ACO Physician Champion Dr. John Rudolph. Louchart had been recruited for the position by Carper after working with TSMH for more than 10 years. Carper said she saw many traits in Louchart that made her a great fit in CCM, "Nicole is an excellent communicator with patients, families, and providers. She is unassuming and always there to help."

A recent SWOT analysis confirmed Carper's assessment: Louchart and the CCM program were identified as one of the organization's key strengths by TSMH's leaders and providers. Dr. Rudolph described the value she brings to the program, "Nicole has quickly become the face of CCM, the leader that helped push us into higher volumes while maintaining quality. She brings with her a self-motivated, self-starter mind frame and is able to come up with and implement new programs and policies. She has created a spark in the program that constantly pushes us all to do more for the patients."

TSMH agreed to share their experience with building a CCM program and the strategies that play a key role.

**Highlights of their program include:**

- Proximity to Providers for Engagement
- Quality Data to Determine Focus
- Providers Assisting with Enrollment Success
- Enlisting Experts to Maximize Care
- Multiple Ways to Communicate with Patients
- A Commitment to Doing Whatever Helps
- Staying in Touch with the Rules and Data
- What They'd Do Differently and Advice to Others

> *"Sometimes people will say, 'Oh, they're not compliant,' and write them off. Well, in Chronic Care Management, those are the patients you're looking for. It's not that people don't want to be compliant, they can't. They might be choosing between buying medications and paying rent."*
>
> Nicole Louchart, RN

### Starting the Program

TSMH, a critical access hospital with primary care and specialty clinics in Clarkson, Washington, and Lewiston, Idaho, started a CCM program late in 2018 with encouragement from Caravan Health. Their goals were to increase preventive services, improve disease management, and better engage patients in their own care. From the start, TSMH leaders educated the organization about CCM and explained how the program fit within overall ACO goals. When Louchart started with CCM in 2019, she took Caravan's **Health Coaching program** and the population health orientation classes to help get her up to speed. She had worked in wound and urgent care at TSMH, but population health management was new for her.

### Building Provider Trust

Provider engagement was difficult at first. The process required the provider to send a message through the EMR to Louchart. However, even if they recommended CCM to a patient, providers either forgot or didn't have the time to send a message to Louchart.

It didn't help that Louchart was in a cubicle near providers with younger patients, not the ones caring for Medicare beneficiaries. She recognized the problem and was relocated closer to the providers she needed to engage. That simple change was all she needed to build a relationship with providers. Louchart said, "I keep my door open and talk with providers frequently. I let them know what services I can provide."

The closer proximity also allows providers to bring Louchart in to meet a patient or to stop by her office after a visit to give her the referral. Providers know they can stop by anytime, and Louchart is always ready to meet patients with her card in hand. It's a quick and easy process for both providers and patients.

Louchart's efforts after patients are enrolled have paid off too, showing providers they could rely on her to go above and beyond to help. For example, Louchart frequently checks the appointment schedule to see if CCM patients are coming in. If they are, she talks with the provider to see how the patient is doing, updates them about any specialist visits or medication needs, and offers to help in any other way possible. "The most important thing is developing trust and letting them know that you're not taking over their patient," Louchart explained. "Every provider practices differently, so I just let them know I'm following their guidelines and their goals. I'm not trying to take over."

Carper helps build the program's reputation by sharing CCM success stories with the rest of the organization. All of these efforts have led to Louchart successfully working with providers at two of their three locations, with most on board and using CCM services.

## Identifying and Engaging Patients by Cohort

In the beginning, Louchart wasn't sure which patients to enroll first, but she was intrigued by the data she learned about in the **Caravan On-Demand Chronic Care Management Training**. She looked for areas where they could improve and found hemoglobin A1c levels greater than nine to be a good target. However, while she had been around patients with diabetes, she didn't feel she had enough background to address their care sufficiently. She asked Dr. Rudolph for input. He helped her develop care strategies and goals and introduced her to the diabetes educator and dietitian.

The diabetes educator and dietitian shared what worked well with patients, what didn't, and details about their programs, such as grocery store tours and cooking classes. Louchart said, "We talked about how we could work together to help patients, since they might contact a patient but not talk to them again for six months." Together, they realized that the CCM program could offer regular contact with Louchart and an ongoing link to the diabetes team. Today, Louchart follows these patients and works closely with the diabetes educator and dietitian, sending referrals as needed.

To ensure providers approved of her outreach to their patients, Louchart created a list for each provider showing the identified patients' last A1c level and blood pressure. Louchart and Rudolph met with providers in person and asked which patients on the list could use extra assistance. Providers made their recommendations and Louchart used the opportunity to remind them about the types of services she offers.

The next cohort, COPD, followed the same process. The pulmonologist group gathered, patient lists were pulled, and providers selected patients to contact for CCM. Following COPD was uncontrolled hypertension, and TSMH added to improvement efforts by having staff meetings to cover organizational expectations for hypertension care.

## Enrollment

As in other organizations, Louchart found that enrolling patients is much easier if the provider speaks with the patient about CCM first or introduces the patient to her. She explained, "People just get nervous about who you are, why you're calling, and why you're so nosy about this information. Even just saying 'hi' to them in the office will help." The one request she makes of providers is to tell patients, "Nicole, the CCM care coordinator, will be calling to help you out." Her success rate for enrollment is good, with 60 patients in the CCM program so far. While potential CCM patients are identified by cohort, Louchart welcomes all qualifying patients referred by providers too.

## Multiple Ways to Connect with Patients

Louchart uses every opportunity to connect with patients, and all contact is recorded in an EMR template. She checks if they have an appointment so she can touch base, and patients know they can call her too. Patients reach out to Louchart to proudly report on their self-care activities or ask questions, like what she thinks of their blood pressure levels. "Patients are more aware of their health and where they need to be. They no longer wait to reach out if there's a problem. I feel like that's a win," said Louchart.

Conversations during monthly calls depend on the patient's specific needs. For example, if the issue is diabetes management, Louchart will check if they've had their eye exam and hemoglobin A1c testing; refilling medications; have seen the PCP or nephrologist; how their kidneys are doing; and any other issue that is affecting their health. Recent calls have included discussions about COVID-19 and how they're handling it. Louchart stated, "They're thankful for the call and somebody to talk to. They say, 'Thanks for caring and thanks for checking up on me.' That that makes me feel good."

It's important for her to know the whole picture of the patient and not dismiss some as non-compliant. "Sometimes people will say, 'Oh, they're not compliant' and write them off. Well, in Chronic Care Management, that's the patients you're looking for," explained Louchart. "It's not that people don't want to be compliant – they can't. They might be choosing between buying medications and paying rent." The goal is to develop a relationship, discover a patient's needs, and do what you can to help, like assisting patients with paperwork for needed services.

### Success Story

A patient with atrial fibrillation and uncontrolled hypertension had a bad experience with a new cardiologist that left him devastated and ready to give up. Louchart wasn't going to let that happen. She kept calling the patient to stay in touch and worked with his physician to get the AFib and hypertension under control. Their relationship and improved condition gave him the help and hope he desperately needed.

He's now doing better and is one of many patients that tell Louchart, "It means a lot that somebody cares about me." When he doesn't know what to do, he reaches out to her, like the time he missed his blood pressure medication and wondered if he should double up. Louchart said CCM works because of the relationship that's developed and the constant contact. She explained, "The problem is providers are seeing them, but they don't see them for three months and a lot can happen in three months."

## Working with the Billing Department

Louchart learned quickly how important billing staff are for CCM success. A glitch in the EMR was causing problems with the billing process. Months into the program, Louchart discovered that patients she had billed for weren't showing up in the claims data. The problem was a coding issue in the EMR and Louchart and the billing department needed to work out a new process. Now, she provides a monthly list of patients with the codes used to coders/billers, and they confirm the list or note problems. The billing team also checks on patients' secondary insurance so patients know in advance what the CCM cost will be. TSMH has not waived co-insurance during the COVID-19 pandemic.

## Striving for Continuous Quality Improvement

Rudolph and Louchart communicate regularly in person and via email. They meet with Carper at least quarterly to review data and goals. When Carper or Wee meet with providers, they constantly discuss CCM, the ACO, and the benefits. Louchart said, "It's important that everybody involved talks about CCM and not just me." She also stays in touch with her Caravan team to understand their current data and where they can improve. Louchart also admits to being a strict rule follower and reaches out to Caravan to stay on top of any policy changes. She said, "I want to do the best I can do for my patients and for myself. I set high expectations for myself, so I want to know the why of what we're doing and make sure I'm doing it correctly."

## What They'd Do Differently and Advice for Others

Louchart knows there are always areas to improve and would like to have a time tracker and more marketing of the program. A time tracker would be helpful so others, like the diabetic educator, could easily track time with patients. Increased marketing would help raise awareness about the program.

For advice to others, Louchart said it's important to realize CCM is a team effort and all participants must be on board. Patience is required as the program takes time to grow. Reevaluate processes often and talk with the staff to find out what's working well and what needs to be changed. She emphasized digging in to understand obstacles and said, "If I would have just said 'Oh, the providers don't want to do it,' I would have given up. I would still have five patients. You have to ask why they aren't giving you more patients. It wasn't because they didn't want to. They were busy and didn't have time to send the task. You have to make sure you're asking those questions and seeing what you can do to help."

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