Background and Overview

- Sentara Medical Group (SMG) is comprised of more than 150 primary care and specialty practices across Hampton Roads Virginia, Northern Virginia and Northeastern North Carolina.
- In 2012, as part of primary care redesign, SMG established a comprehensive, radically-different (i.e. non-embedded, remote, or telephonic) RN Care Management model to manage the care of very important patients (VIPS) who were:
  - High risk patients (high cost and high utilizers)
  - Chronic disease patients (CHF, Diabetes, COPD/Asthma and Renal)
- VIPS were identified across 11 SMG Patient Centered Medical Home (PCMH) sites and all payers, including Sentara’s health plan (Optima). The Optima population was studied to determine if RN Care Management interventions could decrease the total cost of care in a high risk, chronic disease population.
- In 2013, the scope of work expanded to include all 30 adult SMG primary care sites. The practice of the RN Care Management was enhanced by implementing an intense 30-day transition process for all medical discharges across all venues of care and an ED “First-Call” process. Work continues to support system initiatives to:
  - Decrease 30-day all cause admissions
  - Decrease ED visits
  - Decrease total cost of care
  - Increase 7-day post-hospital follow-up with PCP
  - Increase Advanced Care Planning completion and documentation in the electronic medical record
  - Measure Quality of Life

Care Delivery Model and Interventions

- SMG Care Management Services are delivered by experienced BSN-prepared RNs who are required to have or obtain specialty certification within 2 years of hire. The RN Care Managers provide care to patients and families through a variety of modalities to include office, hospital, home and group visits, as well as telephonic and virtual visits. The SMG RN Care Managers are integral members of the interdisciplinary PCMH healthcare team. Their role is the cornerstone for:
  - Providing community-based, patient-centric complex care management
  - Managing patients across venues of care
  - Establishing long-term relationships with patients and their families/caregivers through engagement strategies
  - Safely transitioning medical discharges from the hospital and other venues to avoid unnecessary readmissions and ED visits
  - Facilitating the establishment of Advance Care Plans
  - Monitoring and improving patients’ perceptions of physical and emotional/mental health over time
  - Providing resources for improving medication adherence and self-care management
  - Participating in MD office huddles to address recent hospital and ED discharges
  - Reviewing cases at monthly PCMH meetings
  - Providing after-hours and weekend access
  - Establishing a process for patients to call their RN Care Manager before going to the ED
  - Using Lasix and Insulin Protocols to reduce unnecessary ED visits and admissions
  - Leveraging the EMR for communication with the healthcare team

Results

- Significant decreases in hospitalizations and ED visits for the VIPS population were noted. Data from June 2010-December 2011 (baseline) through December 2013 for patients being followed by SMG Care Management Services demonstrated:

  - 46% decrease in all-cause admissions
  - 27% decrease in 30-day all cause readmissions
  - 42% decrease in ED visits
  - 17% decrease in total cost of care (Optima)
  - 84% increase in 7-day hospital follow-up with PCP
  - 50% increase in completed and documented Advance Care Plans

- The SF-12 Health Survey® is a 12-question survey to measure functional health and well-being from the patient’s perspective. The SF-12 Health Survey® was administered to VIPS at the beginning of RN Care Management engagement and repeated after 6-months to determine if the patient’s perception of their physical health and emotional/mental health had improved. The results demonstrated:

  - 47% decrease in rate of patients at risk for 1st stages of positive depression
  - 43% decrease in rate of patients’ perception of physical status to be “below normal”
  - 6% decrease in rate of patients’ perception of emotional/mental status to be “below normal”

Conclusion and Implications

- The SMG RN Care Management model demonstrates the effectiveness of targeted patient population management by leveraging RN Care Managers across a large multi-specialty medical group.
- This innovative community-based care management model can serve as a guide for other medical groups interested in managing targeted populations.

Acknowledgements

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