

# NURSE CASE MANAGEMENT REDESIGN PROJECT: LOS ANGELES COUNTY CALIFORNIA CHILDREN'S SERVICES (CCS)

PRESENTER: MARY DOYLE, MD, FAAP

SEPTEMBER 10, 2014

FAMILY VOICES WEBINAR: NUTS AND BOLTS OF CCS

# BACKGROUND

## **CCS Program:**

Covers a diverse set of medical conditions

## **CCS Patients/Families:**

Need care coordination on a care continuum spectrum

## **CCS Care Coordination Model:**

Traditionally, the same for everyone

## **Problem:**

The most needy are underserved

# LA COUNTY CCS EXPERIENCE

- **Serving:** 45,000 clients in the general program; 5,000 in the MTP
- **Processing:** 2500 new referrals a month
- **Case load/mix:** average of 650 cases/nurse; random assortment
- **Analysis of a sample of 2000 patients in April 2013:**
  - ~60% - acute and likely to resolve in 1 year or less  
or chronic but straightforward to manage
  - ~40% - chronic and complicated
- **Conclusion:** one case management model does NOT fit all!

# THE IDEA

- Sort by complexity of the CCS condition
- Assign complex cases to one group of nurses and non-complex ones to another
- Adjust the case loads: nurses with the complex cases would carry less; nurses with the non-complex cases would carry more
- Assign each case a health status group: takes into account all of needs of the patient and his or her family
- Match level of care coordination to complexity of need
- Track meaningful data

# **EXPECTED OUTCOMES**

## **Overall and In General:**

Improved case management for all patients in the CCS program

## **Long term and Specifically:**

Answers to these questions

1. Which interventions help? Which don't?
2. Where are the inefficiencies in our systems?
3. Is CCS meeting the needs of our patients, families, providers and staff?

# THE PILOT

- **Launched:** February 10, 2014
- **Target group:** 4000 CCS patients – mix of new & existing cases
- **Sorted by complexity:** non-complex versus complex
- **Assigned to one of 8 nurses:**
  - 4 nurses with 250 complex cases each
  - 4 nurses with 750 non-complex cases
- **Assigned a health status group:** ranges from 2 to 9
- **Intervened:** case management activities differed depending on complexity and health status group

# THE PILOT ACTIVITIES

- **Case Management Activities: Non-complex Cases**
  1. Introductory letter
  2. Authorizations
  3. Responses to inquiries
  4. Case closure after one year if the condition resolves

# THE PILOT ACTIVITIES

- **Case Management Activities: Complex Cases**
  1. Introductory call with a detailed needs assessment
  2. Authorizations and referrals, including care of the whole child
  3. Ongoing interventions according to need
  4. Quarterly review
  5. Annual review with an objective analysis of the success of the interventions and overall health of the patient

# SO FAR, HERE'S WHAT WE'VE FOUND

- Pre-pilot satisfaction surveys of families: N=331
- ▶ Overall: 89-97% need to connect with at least 1 person at CCS  
56-60% reported either never or rarely speaking with their nurse
- ▶ Overall greatest service needs from CCS:  
medications; transportation; medical appointments
- ▶ For families with complex cases: needs
  - More education on services for them/their child
  - Understanding their/their child's insurance
  - Understanding their/their child's medical condition
  - Authorizing CCS specialty doctors to care for them/their child

# SO FAR, HERE'S WHAT WE'VE FOUND

- **Pre-pilot satisfaction surveys of staff:** N=67
  - ▶ 75% were not satisfied with their caseloads
  - ▶ The most satisfied overall were on specialty teams
- **Pre-pilot health status of our complex patients:**  
Parental report in the year prior to the pilot for complex cases
  1. Days of school missed: 1248
  2. Days of hospitalization: 154
  3. ER visits: 208
  4. Illness visits: 183

# SO FAR, HERE'S WHAT WE'VE FOUND

- During the pilot: initial data through June
  - ▶ Total cases handled: 1060 – complex; 2247 – non-complex
  - ▶ Case loads: 205 – complex; 472 – non-complex
  - ▶ Total number of complaints/inquiries:
    - 6 - non-complex
    - 0 – complex

# SO FAR, HERE'S WHAT WE'VE FOUND

- During the pilot: initial data through June

- Pilot team nurses:

- Spending 60% of their day collecting and entering data
- All very satisfied with the model
- Quality of care coordination is improving

# SO FAR, HERE'S WHAT WE'VE FOUND

- During the pilot: initial data through June

*"I Love the Pilot Case Management Model because it allows me to be more comfortable, more satisfied because I have more time with my patients."*

*"A positive effect of the model is that every three months the families are expecting a phone call, which enables the families to feel more comfortable getting a hold of us to prevent minor issues from escalating."*

*"I am satisfied because I am able to spend more time with them, I am able to learn more about them and their needs and they contact me when they have a challenge."*

# A LOT MORE TO DO!

- **Now:** study the care coordination interventions
  - Who needs them
  - How often
  - Which ones work
- **February 2015:** data collection and analysis
  - Surveys: patients, families and staff
  - Health status
  - Effectiveness of care coordination interventions
- **Ongoing:** share data and our experience
  - With who: all working toward improving the CCS program
  - Why: to better serve **all** children and families with special health care needs