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Enhancing Patient Access to Chronic Care Management in Brandon, VT

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2a: Barriers to Caring for Patients with Multiple Chronic Conditions

- **40%** of adults in the US have at least two chronic conditions.[3]
- Community Health Brandon has a patient population from both Addison and Rutland counties.
- **38%** of adults in Rutland County have two or more chronic conditions, which is higher than the rate for Vermont as a whole (**33%**).[4]
- Barriers to caring for patients with multiple chronic conditions include:
  - Short visits
  - Lack of communication between the multiple providers involved in a patient's care[7]
  - Difficulty achieving shared decision-making with patients[7]
- Rutland County has **-8 full time equivalent (FTE) physicians**, when compared to the national average. This shortage puts a strain on local providers' time with patients, which exacerbates challenges in caring for patients with multiple chronic conditions.[4]
- 13% of Rutland county adults do not have a primary care provider[4]

2b: Barriers to Caring for Patients with Multiple Chronic Conditions

- Other barriers to managing chronic conditions and medical care in general include social determinants of health, such as low socioeconomic status and transportation barriers.
- The following are some statistics for **Rutland County**, per the 2019 Community Health Needs Assessment:
  - 8% of families in Rutland County do not have a car[4]
  - 38% of older adults live alone[4]
  - 18% of residents report they have significant problems affording their housing[4]
  - Rutland County, overall, has the highest rate of households' receiving Public Assistance Income in all of Vermont, at 5.82%[4]
  - 12.3% live below the poverty line.[4]
  - 11% of adults in Rutland County do not have health insurance and 9% delay medical care because of financial restrictions. This is higher than the state average of 8% delaying care[4]

2c: Barriers to Caring for Patients with Multiple Chronic Conditions

- Community Health Brandon is a federally-qualified health center that is part of the Community Health Centers of the Rutland Region (CHCRR).
- CHCRR's Chronic Care Management program is available to all patients with **two or more chronic conditions.**
- Care managers help patients:
  - Comprehend information from their different providers
  - Coordinate their medical appointments
  - Manage their medications
  - Identify health goals and opportunities for shared decision-making
- Care managers also assist patients through hospital discharges and other transitions of care, a time that can be particularly confusing and overwhelming for patients, especially older adults.

The Problem: Although providers at Community Health Brandon and other CHCRR locations are enthusiastic about the Chronic Care Management program, with tight schedules and an increasing number of 15-minute visits, **it can be difficult to discuss the program with every eligible patient and find time to formally refer patients.**

3: Public Health Implications of Multiple Chronic Diseases

- Between 2007 and 2017, **58.8%** of all Medicare beneficiaries in Addison County had two or more chronic conditions.[6]
- **60.9%** of Rutland County Medicare beneficiaries during the same time period had two or more chronic conditions.[6]
- In 2014, patients with at least one or more chronic condition accounted for **90%** of total health care expenditures in the US.[1]
  - Those with three or more chronic conditions accounted for **67%** of national costs[1]
- In the US, **60% of patients over 65 have two or more chronic conditions.[9]**
- The majority of patients currently enrolled in Chronic Care Management are older than 65.
- Having multiple chronic conditions puts patients at increased risk for the following, among other adverse outcomes.
  - Death[5]
  - Loss of ADLs[1]
  - Nursing home placement[8]
  - Unnecessary hospital admissions[10]

4a: Community Perspectives

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Claudia Courcelle, RN, BSN, MSA is the Clinical Director of the Community Health Centers of the Rutland Region. She manages the care managers at all affiliated health centers, including Brandon. Claudia was one of the key figures that developed and implemented the Chronic Care Management program but recognizes that many providers still face barriers to referring patients to the program during their short visits. She provided great insight as to how care managers aim to identify a patient's specific barriers to optimal health and find solutions for such barriers.

https://www.chcrr.org/chronic-care-management/

"We recognized the fact that we had a very large population of patients that are medically complex, dealing with many social determinants of health, transportation issues, and behavioral health issues. The social determinants of health have a huge impact on medical care so if [patients] have an issue with that, it will impact their ability to take care of themselves medically. And, the more chronic diseases a patient has, the more difficult it becomes. A lot of our care managers actually interact with patients on the phone or in the doctor's office. **Some even do home visits.** The care manager can help [patients] with identifying the right provider to call. They can really be the go-to person." – *Claudia Courcelle, RN, BSN, MSA*

4b: Community Perspectives

Laurel Burns, RN, is one of the two care managers at Brandon Community Health. She helped me identify what type of project could best assist the patient population at Brandon. She also offered perspective as to how working within the context of a primary care office, and a Patient Centered Medical Home, enhances her ability to connect with the patients' that will most benefit from the Chronic Care Management services.

"We call our patients in transitions of care and bridge that lack of continuity. Generally speaking, people have been very receptive to knowing that their primary care office is reaching out. I maintain that people respond most to their PCP so even if they don't know me, the fact that I'm calling on behalf of Dr. Fjeld makes a huge difference for people. We've built a model that encompasses lots of care under one umbrella." – *Laurel Burns, RN*

4c: Additional Perspective

Dr. Jennifer Hall, DO, is a geriatric psychiatrist at UVM Medical Center. A significant portion of her patient population is from rural and small towns throughout Vermont. Older adults are disproportionately affected by multiple chronic conditions. I met with Dr. Hall to get a sense of the barriers to chronic care management that many older adults face, which care models work, and to think more about the specific questions to include in the screening questionnaire to identify these barriers.

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"There are a lot of stoic older rural Vermonters who may just feel like 'I need to pull myself up by my bootstraps and tough it out' so I think that's a big barrier. I think stigma is a big thing, particularly for depression and anxiety. And again, it's a very small proportion [of patients] that get to see a mental health provider. [Another] big barrier is access. So particularly thinking about how tele health and having people who can go into the home to see an elder, that's very rare. Those home visits can give you so much information. I think the collaborative care model is really critical for these folks. Collaboration with multiple specialists, but also with families, is certainly critical. Caring for these patients is difficult and if there's team-ownership it makes co-management a little bit easier." – *Dr. Jennifer Hall, DO*

My project involved implementing a pilot screening questionnaire at Community Health Brandon to address the limited time that providers have with patients and **standardize the process of referring patients to the Chronic Care Management program.**

5a: Project Intervention & Methods

Step 1: Developed a 6-part screening questionnaire by researching common barriers to obtaining health care and eliciting the input of the two care managers at Brandon, Jennifer Hall, and Claudia Courcelle. The goal of the questionnaire was to identify patients who would be candidates for the Chronic Care Management program

Step 2: Developed inclusion criteria for referral to the Chronic Care Management program (included as questions 2-6 on questionnaire)

- Having **at least 2 chronic conditions**
- **And** answering **"YES" to at least 1 of the following questions (identified barriers to optimal health care)**
  - Are you ever confused about what medications you should be taking and/or when to take them?
  - Do you ever have a difficult time paying for your medications?
  - Do you ever have a difficult time getting to your medical appointments?
  - Do you ever feel confused by the different information you are getting from your different medical providers?

Step 3: Trained the front office staff to give **a questionnaire and Chronic Care Management brochure** to all patients of my preceptor, Dr. George Fjeld, with the following exclusion criteria:

- Pediatric patients (under 18)
- Patients enrolled in Medication Assisted Treatment for substance use disorders

Step 4: Trained rooming nurses to follow the script on slide 5b to direct eligible patients to the two care managers

Step 5: Notified the two care managers at the Brandon office that the nurses would be connecting them to interested patients that meet criteria in step 2

Step 6: Documented the total number of questionnaires administered, in real time, and total number of referrals to Chronic Care Management

5b: Project Intervention & Methods

Link to an online version of the brochure that was attached to the questionnaires: https://www.chcrr.org/chronic-care-management/

Chronic Care Management Rooming Script

1. Look at the patient's answers to the chronic care management questionnaire:

   - If the patient answered NO to question 1, do not proceed
   - If the patient answered YES to question 2 **and** YES to **at least one** of questions 3-6, proceed with the script below:

2. **"I see that you've been dealing with multiple chronic conditions. Our office, as well as the other community health centers in the area have wonderful care managers, who are nurses who work with our patients to help them organize the medications, appointments, and sometimes confusing information that comes along with having multiple chronic conditions. Do you think that meeting with one of the care managers would be helpful for you?"**

   - If the patient answers NO, respond with the following: "Okay well if you ever want more information, feel free to reach out to your provider about chronic care management."
   - If the patient answers YES, proceed with the script below:

3. **"Here is some more information about our Chronic Care Management program** *[hand the patient the Chronic Care Management pamphlet]***. I will let one of our care managers know that you're interested, and she will be in to see you before you leave today."**

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Is Care Management Right for You?

1. Are you currently working with a Care Manager at Brandon Medical Center?

   YES NO

2. Do you currently have **two or more** chronic conditions?

   YES NO

Circle any of the following that apply to you:

Diabetes	Mental Health Condition	Multiple Sclerosis
High Blood Pressure	Cancer	Thyroid Disease
Heart Disease	Arthritis	Chronic Kidney Disease
COPD	Osteoporosis	Dementia
Asthma	Fibromyalgia	Post-Stroke Disability

3. Are you ever confused about what medications you should be taking and/or when to take them?

   YES NO

4. Do you ever have a difficult time paying for your medications?

   YES NO

5. Do you ever have a difficult time getting to your medical appointments?

   YES NO

6. Do you ever feel confused by the different information you are getting from your different medical providers?

   YES NO

6a: Results and Responses to the Questionnaire

- Administered questionnaires to **35 patients**
- Led to the direct connection of **1 patient with Chronic Care Management**
- The percentage of referrals to Chronic Care Management out of the total questionnaires distributed so far is low, at **2.86%**
- Preliminary findings show that based on patient answers to questions 3-6 (barriers to care), most patients surveyed do not qualify for Chronic Care Management based on the **questionnaire's inclusion criteria** *(note that the Chronic Care Management program only requires that you have two or more chronic conditions)*
- Of the 19 questionnaires that I physically saw after the patients completed them, only **15.79% answered "YES"** to one or more of questions 3-6
  - This may be due to the subjective nature of the questions
  - This may also be due to stigma surrounding the questions
  - This finding may offer an opportunity for expanding the inclusion criteria of the questionnaire to any patient with two or more chronic conditions, irrespective of perceived barriers to access

6b: Results and Responses to the Questionnaire

- Patients were able to complete the questionnaires in less than 5 minutes
- Front office staff initially found it difficult to instruct patients to bring the questionnaire into the room with them after completing it in the lobby, but did not find this to be an issue beyond the first day
- Front office staff reported that multiple patients expressed that they did not know what the Chronic Care Management program was
- Many patients also expressed confusion about the Chronic Care Management program to the nurses involved in the pilot. One patient thought that it was a program through his insurance company and intended to take his money.
- This confusion, brought to light by the questionnaire, led to opportunities for clarification and education about the program, on the part of the nurses.
  - "Any exposure is progress" – *Laurel Burns, RN*
- Nurses did not find that the script disrupted the rooming process

7: Evaluation of Effectiveness and Limitations

Future evaluation measures may include the following:

- Quantify the number of patients who are referred to Chronic Care Management from the questionnaires by having care managers continue to document referral method
  - Compare this number to the number that are referred directly by providers to see if there is a significant difference between the two groups
- Evaluate for any changes in care manager patient loads before and after implementation of the questionnaire (i.e. see if the program leads to a significant increase in patients enrolled in Chronic Care Management overall)
- Conduct a patient focus group to assess perspectives about the questionnaire and suggestions for quality improvement
- Conduct a separate focus group for involved staff (nurses, care managers, and front office staff) to obtain qualitative data about the intervention's ease of administration and any challenges faced
- After a 6-month pilot of this questionnaire at Brandon, administer a survey to all patients to assess awareness of the Chronic Care Management program and see if there is a significant difference in accurate understanding of what the program is, between patients who had been given the questionnaire, and those who had not. Ideally, we would control for outside variables such as age and sex and match patients in each group

8: Future Directions

- Coordinate a formal teaching session for all rooming nurses and front office staff to standardize the process of administering the questionnaire and referring patients to care managers
- Expand implementation of the questionnaire to the patients of the four other providers at Brandon
- Develop Chronic Care Management posters for the Community Health Brandon **waiting room and exam rooms** to increase exposure to the program
- Expand the questionnaire to other CHCRR practices, with associated training of nurses and front office staff
- Use the answers to these questionnaires to evaluate the barriers to care that patients at Community Health Brandon, rather than Rutland County at large, are identifying, and utilize that information to best target Chronic Care Management services to address those specific barriers

9: References

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