Improving Care Management to High Risk Populations at BSHC

The Problem

- A complex care management program has been in place at Bowdoin Street Health Center (BSHC) since March 2012.
- The Care Coordination Resource Team (CCRT) uses a team of nurses, social workers, and a data manager to identify high risk patients and allocate resources.
- To date, there has not been a comprehensive assessment of the complex care management program at BSHC.
- Our initial review identified 1) referral appropriateness/timeliness and 2) care manager resources as two priority areas for process improvement.

Aim/Goal

- To characterize existing referral processes and to improve their accuracy and efficiency based on best practices identified in the literature.
- To identify barriers experienced by nurses to performing effective care management.

The Team

BIDMC and BSHC physicians, nursing and administrative staff including: Talya Salant, MD, PhD, Amber Moore, MD, MPH, Fran Azzara, RN, Adela Margules

The Interventions

We performed a **literature review** to identify recommended techniques for capturing high-risk populations. Using **observations of existing processes and interviews and surveys of key stakeholders**, we 1) developed a process map to describe current referral practices and 2) identified sources of inappropriate or low yield referrals. We developed a hybrid approach to identifying high-risk patients that relies on both PCP input and defined parameters to minimize time spent on low risk patients. Using a **time-motion study**, we evaluated nursing time spent on care management tasks to better understand how nursing time could be better prioritized.
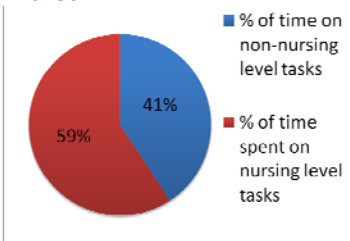
Results/Progress to Date:

Nurses spent up to 64% of their time on non-nursing level tasks. Frequent distractions and interruptions were also barriers to effective work.
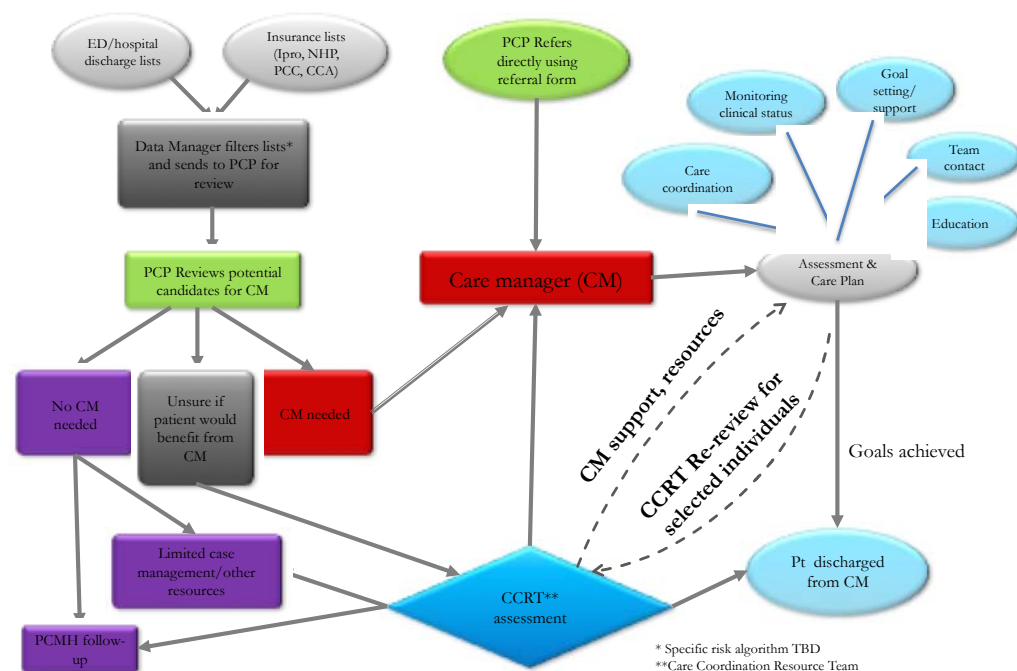
Nurse 1.

Nurse 2.

- % of time on non-nursing level tasks
- % of time spent on nursing level tasks

Nurse 1: 36%, 64%
Nurse 2: 41%, 59%
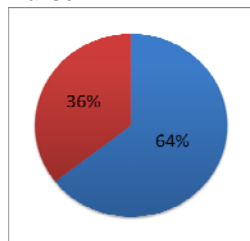
BSHC Revised Complex Care Management Process Map

* Specific risk algorithm TBD
**Care Coordination Resource Team

Lessons Learned

1) Referrals into the care management program can be streamlined to increase efficiency of care management time and better identify highest need populations quickly.

2) Nurse care managers spend a significant amount of time on tasks that do not require nursing-level skills and detract from effective care management.

Next Steps/What Should Happen Next

We are currently implementing the revised referral process and are re-structuring nurse care manager time to minimize distractions from tasks that could be performed by staff with a lower level of training. Eventually we hope to be able to hire additional staff to off-load these tasks from nursing staff. As a next step we have defined process and outcome variables (such as average frequency of nursing contacts and number of hospital and ED admissions) to better measure the effectiveness of the above interventions and also to allow for better evaluation of future quality improvement initiatives directed towards high risk populations.

For more information, contact:
Amber Moore, MD, MPH, Hospitalist,
abmoore@bidmc.harvard.edu