Inclusion and Exclusion Criteria for Collaborative Care

**Objective:**
To clearly articulate a process for determining which of our patients should be considered for collaborative care visit

**Key Points:**
1. Collaborative care visits may be utilized for a. chronic disease management (*which includes chronic pain management*), b. new patient intake, c. post-discharge follow-up (ER, hospital, and skilled care/rehab), d. Medicare wellness visits, e. Pap smears, and f. acute visits (overflow)
   *NOTE: focus of collaborative visits is chronic disease mgmt, new patient intake, post discharge follow up
   ** Note: One should anticipate that the number of qualifying patients exceeds Specialty RN resources available*
2. This document will describe patient inclusion and exclusion criteria for chronic disease management visits.

Criteria for Collaborative Care (Target Audience – Providers, Population Health/Specialty RNs)

**FAQ’s**

- **What is “Collaborative Care?”**
  - Collaborative Care is a care team approach (primarily RN/Provider) that
    1) Focuses on our most Chronic patients
    2) Expands upon the traditional population health RN role
      - Patient pre visit activity (Labs, tests, telephonic support..)
      - Integrates specialty RN skills into the patient visit (RN conducts majority of patient visit)
      - Collaborates RN/MD roles during the patient visit
      - Enables RN to appropriately care (and code) for the most Chronic of our patients
    3) Enables providers:
      - To conduct more Chronic visits per hour (30 and 45 minutes visits can now be completed in 15 provider minutes)
      - To appropriately generate more RVU’s/visit
      - To spend more personal time with patients
    4) Improves all key measures
      - Quality outcomes: For collaborative care patients, 8 of 9 key diabetic measures demonstrated higher improvement vs traditional care
      - Revenue/Production: The Collaborative care model yields more
        - RVU’S/Provider than traditional office visit
        - Chronic Provider visits/hr
      - Patient Satisfaction: Patient retention in Bangor rate amongst top 3 in MPHC
      - Employee satisfaction: Staff and MD satisfaction scores of 100% in Bangor

- **What are the benefits to the provider, nurse, and patient in utilizing Collaborative Care Visits (CCV)?**
  - **Provider**
    - Utilizing Specialty RNs for collaborative visits enables providers to generate additional RVUs/hr with minimal investment in clinical time, prep time, and schedule disruption
    - assistance with time-demanding components of care such as readiness assessment and support; disease self-management teaching and between-visit support; understanding barriers and resources; coordination with family, specialty care providers, and community resources; medication and problem list reconciliation
• increased access for urgent care and annual exams
• increased patient loyalty
• increased provider satisfaction and shorter TTH
• help with chronic pain management (managed by narcotic meds)
• improved clinical quality measures
• more patient face-time with patients (while nurse scribes)

Nurse
• opportunity to engage in more direct and holistic care of patients and optimize nursing skills
• Opportunity for professional development, creativity and responsibility
• Closer one-on-one relationship with provider, patient, and their families
• Allows one to see clear alignment between day to day work efforts and MPHC, patient, personal objectives

Patient
• extra time with members of their care team focused on supporting self-management
• more opportunity to ask questions and receive complete answers
• additional contact with care team between visits

• What are inclusion criteria for chronic disease management?
  • Diabetes
    1) New diagnosis
    2) New oral medication or insulin start
    3) Poor control (identified in PopulationManager™ as having HgbA1c >8)
    4) Multiple diabetic complications
    5) Recent hospitalization for diabetes-related admission
    6) Provider or nurse recommendation
  • CHF
    1) New diagnosis
    2) EF < 50% as identified in PopulationManager™
    3) Medication starts and changes related to CHF
    4) Recent ER visit or hospitalization related to fluid overload, etc
    5) Provider or nurse recommendation
  • CAD
    1) New diagnosis
    2) New medication start
    3) Continuing smoker (identified in PopulationManager™)
    4) Poor blood pressure control (identified in PopulationManager™ as > 130/90)
    5) Recent hospitalization related to CAD-related illness
    6) Provider or nurse recommendation
  • COPD
    1) Continuing smoker (identified in PopulationManager™)
    2) Recent hospitalization for COPD-related illness
    3) Provider or nurse recommendation
  • Uncontrolled Hypertension
    1) Identified in PopulationManager™ as having BP > 160/100 despite medical management
    2) Recent ER or hospitalization related to blood pressure
    3) Provider or nurse recommendation
- Multiple Co-Morbidities
  1) Recent hospitalization related to complex medical case or social situation
  2) Provider or nurse recommendation

- **What are exclusion criteria?**
  - Age greater than 85
  - Terminal illness
  - Dementia
  - Persistent medical non-adherence
  - Provider discretion
  - Unstable mental illness
  - Patients having other case-managers as primary (ie, Home Health, Anthem, etc)