Title:
Development of a Nursing Scorecard to Track Metrics to Support Complex Care Management

Tierney Elizabeth Giannotti, MPA
Weitzman Institute, Community Health Center, Inc., Middletown, CT, USA
Mary L. Blankson, DNP
Administration, Community Health Center, Inc., Middletown, CT, USA
Ianita Zlateva, MPH
Research and Evaluation, IZ Research Group, LLC, Suffield, CT, USA

Session Title:
Health Information Technology Tools to Support the Implementation of a Complex Care Management Program

Slot:
F 09: Friday, 28 July 2017: 2:30 PM-3:45 PM
Scheduled Time:
2:50 PM

Keywords:
Complex Care Management, Population Metrics and Scorecard

References:


Abstract Summary:
A nursing scorecard was created to track population metrics for nurses providing Complex Care Management to high-risk patients in primary care. The monthly scorecard helps nurses track their progress and allocate resources appropriately. Nursing leadership utilizes the data to address gaps in workflow and to measure success of workflow implementation.

Learning Activity:

<table>
<thead>
<tr>
<th>LEARNING OBJECTIVES</th>
<th>EXPANDED CONTENT OUTLINE</th>
</tr>
</thead>
<tbody>
<tr>
<td>The learner will be able to describe the purpose and implementation of a nursing scorecard.</td>
<td>We will describe the need for a nursing scorecard in the primary care field and provide background on how and why a scorecard was developed for the Community Health Center, Inc.</td>
</tr>
<tr>
<td>The learner will be able to understand the importance of tracking population metrics for nurses providing complex care management</td>
<td>We will provide an example of the nursing scorecard developed at the Community Health Center, Inc. and data on how it reinforces a measurement culture in primary care.</td>
</tr>
</tbody>
</table>
The learner will be able to understand the global implications of nursing scorecards in the primary care field

We will demonstrate how the scorecard helps nurses in primary care organize their approach to managing complex patients.

Abstract Text:

Primary care nurses often need to take on the role of nurse care manager (NCM) as they support a provider’s panel of complex patients. Nurse care managers (NCMs) at the Community Health Center, Inc. (CHCI) use a clinical dashboard tool to aid in decision support to identify and manage individual patients through Complex Care Management (CCM). The NCMs identified that they needed a different tool to better support a global view of their impact as well as to identify areas needing additional focus.

A nursing scorecard was developed to track population metrics as part of the implementation of a complex care management program across 12 clinical sites of CHCI. CHCI is a statewide agency providing care to individuals with low socioeconomic status, including many that are uninsured and underinsured. It has 14 integrated patient-centered primary care sites, delivering medical, behavioral health and dental services along with other ancillary care services such as those delivered by registered dieticians, podiatrists or chiropractors to name a few. CHCI delivers care in over 200 total service delivery sites, when school based clinics and health care for the homeless sites are included in the total count.

Each CHCI nurse supports two individual primary care provider panels. CHCI’s nursing scorecard quantifies care management indicators and outcomes as part of overall nursing performance with each of those panels. It provides the NCMs with data that is updated monthly. This helps the NCMs to identify which providers may follow best practices, and the overall trends for measures such as hypertension and diabetes control for each provider’s panel of patients. The scorecard reinforces a measurement culture, which helps the NCMs to focus on specific patient populations or specific provider panels that are in need of intervention. When NCMs review the scorecard each month, they can make decisions on resource allocation to ensure they are addressing areas of greatest need. Furthermore, the scorecard provides opportunities for continuous improvement and accountability for the care management program. It supports NCMs in understanding the value of their work.

The scorecard is populated with data extracted from the electronic health records of all patients in a panel managed by an NCM and their two primary care providers. Data include the number of patients defined as eligible for care management (high emergency department utilization, recent hospital discharge, uncontrolled chronic illness, or multiple chronic illnesses), the number of those enrolled by a nurse in care management, and clinical measures such as the percentage of patients with uncontrolled hypertension and diabetes. The nursing scorecard was built through the collaboration of the NCMs, CHCI Business Intelligence, Quality Improvement Department, and Chief Nursing Officer.

Tracking population metrics for nurse-driven interventions for high-risk patients in primary care can help identify the impact of CCM on clinical measures for these patients, i.e., uncontrolled hypertension and diabetes, and re-admission to the hospital within 30 days of discharge. CHCI’s scorecard reveals how many patients a nurse in primary care could potentially support in CCM at any given time while still fulfilling other aspects of the primary care nurse role.

The scorecard was active for all sites as of 4/14/2015, post the yearlong, stepped-wedge implementation of the overall complex care management program. The first scorecard noted that, on average, NCMs were managing about 6% of their eligible panel, with a wide range of 1% to 27%. By six months, this had grown to an average of 11% of the eligible panel, ranging from 1% to 29%. As of 12/2/2016, this has grown to 14% on average, ranging from 3% to 67%. This suggests that complex care management is now actively being performed by all nurses in the program. It does however highlight potential degrees of activity in care management activities, and that more work must be done to better quantify complexity to determine an exact panel expectation for NCMs. Both hypertension and diabetes control have improved
since program and scorecard implementation by 3.7% and 2.5% respectively. CHCI’s care management scorecard ensures that NCMs are better able to make decisions on resource allocation and to focus efforts to improve complex care management operational and clinical measures. Scorecards may be a solution for other clinics, regardless of geography, implementing care coordination or complex care management to support their teams toward success.