More Effective Case Management: Using the "Acuity Tier Model" to Create More Equitable PHN Caseloads and Improve Client Health Outcomes

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BACKGROUND

- FCPH administers the Children with Medical Handicaps (CMH) program which boasts a caseload of over 6,000 clients between the ages of 0-22.
- PHNs provide comprehensive case management to children with various medical needs and their families.
- Each FCPH PHN currently maintains a caseload of roughly 1,500 clients.
- PHN client caseloads were previously assigned based solely upon zip codes and geographical region of the county.

PURPOSE

- The "Acuity Tier Model" has been implemented to create more equitable caseloads.
- The use of this model will also ensure that the needs of the children and their families are addressed in an efficient and purposeful manner.

METHOD

- The Acuity Tier Model was implemented at FCPH in April 2019.
- Once the PHN has a conversation with a family and/or conducts a home visit, the PHN assigns the family to an appropriate tier (Tiers 1-4).
- The assignment to a tier is based upon specific criteria and the expressed and/or observed needs of the family:
  - **Tier 1:** assigned to families who can independently navigate the program and do not require much extra support.
  - **Tiers 2 and 3:** assigned to families that require moderate support and intermittent contact from their PHN.
  - **Tier 4:** assigned to families that require the most extensive PHN case management services.
- Tiers can be reassigned at any time, per PHN discretion.

ACUITY TIER MODEL

CMH Acuity Tier Model

Client name: _____ Date: _____
CMH #: _____ PHN: _____

Tier 1	Contact	Tier 2	Contact
☐ CMH Treatment program Renewal ☐ Child has been enrolled on CMH program for more than 24 months ☐ "Medically stable" ☐ Family manages medical condition with minimal or no assistance ☐ Understands and accesses needed resources ☐ Able to navigate CMH program independently ☐ Family advocates for client independently	**Phone/email contact** – At least 1 time per year and as needed **Home Visit:** 1 per year	☐ New to the CMH Treatment program ☐ Family/client understand and manage client's health condition(s) but may need more regular reminders and support from PHN ☐ May have questions regarding CMH program or difficulty/frustration navigating the program at times ☐ Inconsistent related to follow up ☐ Need encouragement to carry out recommendations ☐ Needs some encouragement or direction to advocate for the client independently	**Phone/email contact:** 1-2 times a year and as needed **Home Visit:** 1 per year
Tier 3	**Contact**	**Tier 4**	**Contact**
☐ One or more chronic health condition(s) that need improvement in management ☐ Management by more than 2 subspecialists ☐ Difficulty navigating and frequent questions regarding CMH program ☐ Family unable to cope ☐ Financial concerns/job loss ☐ Unable to recognize problems or identify solutions ☐ May appear unwilling to use resources ☐ May require involvement from multiple community agencies (PFK, HMG etc.) ☐ Requires frequent assistance from PHN in seeking resources/assistance ☐ Transitioning to adult services ☐ May have multiple concerns regarding client's environment but may not necessarily pose a threat to health/welfare ☐ English is the family's second language	**Phone/email contact:** At least 2 times per year and as needed **Home Visit:** May require more than 1 home visit per year	☐ Client has multiple medical diagnoses ☐ Potential for/or actual CPS involvement ☐ May be homeless ☐ Limited understanding of BCMH program or other community resources despite education ☐ Requires extensive education related to child's medical condition, treatments and needs ☐ Requires involvement of multiple community agencies ☐ Dependent on others to seek resources/assistance ☐ Safety concerns in the client's environment ☐ Unable to meet financial needs ☐ Non–English speaking, requires interpreter services	**Phone/email contact:** Frequent contact between home visits (more than 3 times a year) **Home Visits:** May require at least 2-3 home visits per year

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STANDARD WORKFLOW

PHN receives client's CMH Letter of Approval and contacts the family.

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PHN explains the CMH program, addresses any questions or concerns.

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PHN offers a home visit.

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After telephone, email, and/or home visit contact with family, PHN assigns the client to the appropriate tier.

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PHN will contact family as needed or according to the recommended contact schedule per tier assignment.

RESULTS

- The Acuity Tier Model is an ongoing project that is currently implemented into the daily workflow of FCPH PHNs.
- Currently, 904 individual, unduplicated clients have been assigned to Acuity Tiers:
  - **Tier 1:** 393 clients (**44%**)
  - **Tier 2:** 344 clients (**38%**)
  - **Tier 3:** 127 clients (**14%**)
  - **Tier 4:** 40 clients (**4%**)
- Through assigning tiers, hotspot areas of need are being identified within the community so that more focused services can be provided to the families with the highest needs:
  - **31%** of currently assigned clients reside in high-risk zip codes (high rates of infant mortality, high crime, etc.).
  - **43%** of clients currently assigned to Tier 3 have had a home visit.
  - **68%** of clients currently assigned to Tier 4 have had a home visit.
- Current efforts around creating equitable caseloads:
  - Revise current community resources based on areas of need.
  - Increase home visits-specifically with Tier 3 and Tier 4 clients.
  - Goal is to contact all clients at least once per year.

NEXT STEPS

- FCPH PHNs will continue to assign clients to tiers as they establish contact.
- Contact families based on recommended Acuity Tier contact schedule.
- Future caseload redistribution based on acuity.
- Administer client satisfaction surveys based on PHN services.

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ACKNOWLEDGMENTS (The "Acuity Tier Model" has been adapted from a recommendation contained within a 2015 assessment report conducted by an independent consultant).