Kristie Bennardi
Chief Executive Officer
& Chief Financial Officer

Care Management
Field Example:

Keystone Rural Health Consortia

Care Management

WHAT?

WHY?

HOW?

WHAT
is care management at Keystone Rural?

CMS Care Management Services Keystone offers:

- Complex Chronic Care Management
- Chronic Care Management (~180 patients/month)
- Principal Care Management
- Transitional Care Management (~20-30/month)
- Behavioral Health Integration

Other CMS reimbursable services

- Initial Preventive Physical Exams (IPPEs)/Annual Wellness Visits (AWVs)

WHAT
is care management team?

RN Care Managers

- Caseloads = one case manager per site and discipline regardless of numbers
- Case manager in each primary care location, pediatric, behavioral health, and new dental care manager

Electronic Health Record is Athenahealth formerly known as GE Centricity
Population health software is I2i and will be using Azara as well
Care management services (e.g., what was done and time spent) is documented in EHR system

Key Areas of Focus for our Care Managers

- TCM visits
  - medication reconciliation before patient comes into the office
  - Making sure all discharge needs are met
- Medicare Annual Wellness Visits
  - Address preventive needs (e.g., colonoscopy screening) are addressed prior to provider contact
- Diabetic Eye Exams
- Hypertension Follow-up calls
- Other telephone communication and follow-up

Care Management

WHY
care management is essential to Keystone Rural and our patients

- **Quality Care**: offering care management services is the ‘right’ thing to do for our patients.
- **Value-based care**: offering care management services is an important condition of participation in value-based payment models; it is an expectation in the accountable care organization (ACO) we participate in.
- **Revenue**: care management services provide a critical revenue source outside of the FQHC Prospective Payment System (PPS)
- **Reduced Hospitalizations and Readmissions:** < 3% with our RN Case Managers, CCM, and internal 24/7 RN Triage on call system

Institutionalization of Quality as Culture

Care Managers - true champions of the Quality Team and the beating heart of the clinic

- **Start of Day**. Care Managers create huddle sheets, facilitate daily huddles, review quality metrics on huddle sheets
- **Throughout the Day**. Care Managers follow-up with providers and care team on items from the huddle sheet.

Care Management

Step 1
Hire Care Managers

- We made an important and impactful decision to hire Care Managers in 2016 in our efforts to transition to Value Base Care models.

- Currently employ 5 Care Managers
- Case manager in each primary care location, pediatric, behavioral health, and new dental care manager
- All of the Care Managers focus on TCM

Step 2
Identify Patients for Care Management

Patients identified for overall care management services through the following :

- Risk Stratification – Using I2i and Aledade App, we identify those that are high risk including those with recent hospitalization/ER visits, uncontrolled diabetes and hypertension, etc.

Patients identified for TCM via:

- Discharge data
  - Skilled nursing facility (SNF) or hospital fax
  - SNF or hospital email
  - Aledade App
- Care Manager reaches out to patient within 2 business days of discharge using patient script

Step 3
Define Care Manager – Care Team Interface

- Keystone Care Manager job description
- Keystone Nurse Care Manager TCM script

Care Managers connect regularly with the care team

- Prepare daily huddle sheets
- Lead daily huddles
- Review and monitor quality metrics

Step 4
Services Provided as Part of TCM:
Care Manager

Prior to TCM visit (via phone), Care Manager:

- Reviews discharge instructions and any outstanding questions
- Determines whether symptoms have improved or worsened
- Determine whether patient has started/stopped any medications.
- Assess whether patient has picked up any new medications at pharmacy.
- Address social risks that could prevent patient from attending TCM visit (e.g., financial, transportation, scheduling, etc.)
- Remind patient to bring all pill bottles and medications
- Provide instructions for seeking after-hours access and same day access, if needed, prior to appointment

Step 4 (cont'd)
Services Provided as Part of TCM:
CM/RN/Provider

During the TCM visit (in-person), Provider:

- Perform full medication reconciliation, pre-post hospitalization
- Discuss Advance Directives
- Document any hospital administered vaccines or any outstanding vaccines
- Review symptom response plan with patient including any emergent vs. primary-care treatable symptoms
- Provide instructions for seeking emergency care, same day access, and after-hours care
- Perform Fall Risk Assessment
- Assess for social needs including food, housing, and transportation
- Assess patient goals for visit and perceived factors leading to hospitalization
- Determine if medication adjustments needed or follow up on test results, imaging, or discharge instructions
- Determine need for referrals including Chronic Care Management and additional social support services
- If patient agrees to receive Chronic Care Management, it must be documented by the provider in the note and Case Management must be notified
- Determine follow up plan.

Pre-visit CM followed by provider in person
Rooming RN
Provider

Step 5
Enroll Patients in Care Management

During TCM Visit

- Determine need for referrals including Chronic Care Management and additional social support services.
    - If patient agrees to receive Chronic Care Management, informed consent must be documented by the provider in the note and Case Management must be notified
- Determine follow-up plan
- Enroll in Care Management – warm hand-off, if possible

Post TCM Visit

- Provide patient or patient representative with dated and reconciled active medication list and clinical visit summary
- Communicate follow up plan to patient/patient representative
- Ensure that any follow-up appointments are scheduled including care management

Step 6 - 10
Care Management

Care Managers take it from here…

- **STEP 6** Create Individualized Care Plans
- **STEP 7** Enhance and Expand Partnerships
- **STEP 8** Document and Bill for Care Management
- **STEP 9** Graduate Patients from Care Management
- **STEP 10** Measure Outcomes