

## EXAMPLE: Care Management Implementation Communication

### Providers:

It is an exciting time for patients at (name of Clinic). The Care Management (CM) program is ready to Kick off for all (name of clinic) .

The CARE MANAGER (CM) staff has spent time over the past 8 months completing Care Management (CM) training, in person training, weekly CM discussions and practice time on their own and with partners. This has prepared them to have the skills to identify eligible patients and engage, assess and interact on a regular basis with patients that would benefit from additional resources to improve their health.

Care Management goal: Identify and engage with patients who have more complex health problems and/or are struggling with engaging effectively in their care. Patients eligible with be identified by several approaches:

- CM Dashboard - Risk Stratification- based on chronic conditions, polypharmacy and ED/Hospital utilization; CM focus will be on patients with a risk score  $\geq 8$  at this time.
- Provider - all providers are encouraged to assist in identifying patients who would benefit from CM and discuss with the CARE MANAGER or send a CM Referral Order
- CARE MANAGER - patients who may not show a risk score of  $\geq 8$  but CARE MANAGER knowledge supports engaging the patient in CM.

### What does this mean for you as a provider?

- CARE MANAGER's may be reaching out to you to review patients who would benefit from care management and are scheduled for a PCP visit. They may have a CM value statement to review with you - a preliminary CM value statement, this may evolve as the CM approach will focus on what is a priority to the patient. This PCP visit is a great time for you to promote the value of CM for the patient and if agreeable do a warm hand-off (in person) meeting with the CARE MANAGER to discuss care management.
- CARE MANAGER's will be available to review the CM Dashboard - Risk Stratification list with you to help you understand the risk score for your patient population and CM eligible patients.
- CARE MANAGER's may be reviewing in person or during huddle time any patients identified or engaged in CM.
- CARE MANAGER's will be reviewing their weekly schedule with you so you have a clear understanding of who they are engaging in CM.

Keep in mind that the initial phase of offering Care Management at your Center will be very slow and steady. This is necessary to allow each CARE MANAGER to continue to build their skills at engaging and enrolling patients in Care Management and to manage available capacity with their current responsibilities. And to allow time to transition some of these tasks.

Please feel free to email or phone any questions to Monique Comstock.  
monique.comstock@spiracare.com (phone number)

## Care Management Communication

### Center Managers:

It is an exciting time for patients at (name of clinic). The Care Management program is ready to Kick off for all (name of clinic) Centers.

The CARE MANAGER staff has spent time over the past 8 months completing Care Management (CM) training, in person training, weekly CM discussions and practice time on their own and with partners. This has prepared them to have the skills to identify eligible patients and engage, assess, and interact on a regular basis with patients that would benefit from additional resources to improve their health.

What does this mean for you as a Center Manager?

- Care Management goal: Identify and engage with patients who have more complex health problems and/or are struggling with engaging effectively in their care. Patients eligible will be identified by several approaches:
  - CM Dashboard - Risk Stratification- based on chronic conditions, polypharmacy, and ED/Hospital utilization; CM focus will be on patients with a risk score  $\geq 8$  at this time.
  - Provider - all providers are encouraged to assist in identifying patients who would benefit from CM and discuss with the CARE MANAGER or send a CM Referral Order
  - CARE MANAGER - patients who may not show a risk score of  $\geq 8$  but CARE MANAGER knowledge supports engaging the patient in CM.
- All Staff at your Center may note the following in EHR:
  - CARE MANAGER's are added as providers with a schedule for each
  - Care Management encounters and notes in patient chart
  - Patients arriving for a CM encounter – See front desk specific communication
- CARE MANAGER's will be collaborating with the providers to review patients identified eligible and engaged in CM. This will include review of the CM Dashboard-Risk Stratification list, review of CM patients in person or during huddle, and formal notification of patients enrolled in CM by sharing their schedule with providers on a weekly basis.

Keep in mind that the initial phase of offering Care Management at your Center will be very slow and steady. This is necessary to allow each CARE MANAGER to continue to build their skills at engaging and enrolling patients in Care Management and to manage available capacity with their current responsibilities. And to allow time to transition some of these tasks.

All Center Managers will be responsible for communication to their Center team according to the Care Management Communication Plan

Please feel free to email or phone any questions to \_\_\_\_\_

## Staff Specific Care Management Communication

Front Desk Value Statement: The expansion of the Center team to include Care managers will help provide needed resources to the patients with complex health concerns. Care Managers will be available to assist identified patients with community resources to help meet their needs, this will include patients, caregivers and family members; In addition, the Care Management team will have an on call person available to take calls that come in from patients enrolled in Care Management

Front desk staff will need access and training on the following workflows:

- Scheduling a patient for Care Management
- Checking in Patients for Care Management – includes scripting for this
- Portal message management for patients enrolled in Care Management – if a message is accidentally routed to front desk

Clinical staff Value Statement: The expansion of the Center team to include Care managers will help provide needed resources to the patients with complex health concerns. Care Managers will be available to manage portal messages and phone calls from patients enrolled in Care Management. In addition, Care Managers will be working to ensure accurate Problem List, Medication List, Specialty team communication and ED/Hospital communications. Efforts will be made to ensure a CM interaction within 7 days prior to the PCP visit to ensure accurate, timely information in the EHR.

Clinical staff will need access and training on the following workflows:

- Enrolling patients in Care Management
- Care Management Initial Interaction
- Care Management ongoing Interaction
- Medication reconciliation and refill management for patients in Care Management
- Testing follow-up for patients in Care Management
- Care conference roles and responsibilities

Steering Committee:

It is an exciting time for patients at (name of clinic). The Care Management program is ready to Kick off for all (name of clinic) Centers.

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What does this mean for you as a Steering Committee member?

- Communicate the Care Management goal: Identify and engage with patients who have more complex health problems and/or are struggling with engaging effectively in their care. Think of how you can be an advocate for Care Management at Spira-Care.

Patients eligible will be identified by several approaches:

- CM Dashboard - Risk Stratification- based on chronic conditions, polypharmacy, and ED/Hospital utilization; CM focus will be on patients with a risk score  $\geq 8$  at this time.
- Provider - all providers are encouraged to assist in identifying patients who would benefit from CM and discuss with the CM or send a CM Referral Order
- CARE MANAGER - patients who may not show a risk score of  $\geq 8$  but CARE MANAGER knowledge supports engaging the patient in CM.
- Be cognizant of the impact of change on all staff and be supportive of peers and staff at your center, always keeping what is good for the patient at the center.
- CARE MANAGER's will be collaborating with the providers to review patients identified eligible and engaged in CM. This will include review of the CM Dashboard-Risk Stratification list, review of CM patients in person or during huddle, and formal notification of patients enrolled in CM by sharing their schedule with providers on a weekly basis.
- Task transition - this is in process and will occur over the next 1-2 months. Benefits management tasks are in the process of going to \_\_\_\_\_; Other tasks in process include simple referrals - mammograms/colonoscopy and prior authorizations. We will provide updates as definitive plans are in place. We recognize that this is creating angst among providers and staff and all are doing their best to make this transition seamless for patients and the team.

Keep in mind that the initial phase of offering Care Management at your Center will be very slow and steady. This is necessary to allow each CARE MANAGER to continue to build their skills at engaging and enrolling patients in Care Management and to manage available capacity with their current responsibilities. And to allow time to transition some of these tasks.

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