# Strategies for Effective Care Management

SUPERCHARGING PRIMARY CARE

# Solutions Center Interactive Team

## Kristen A. Stine, MSOD, Learning & Diffusion Manager – HealthTeamWorks

Kristen leverages her background in training and organization development to synthesize HealthTeamWorks learnings into to actionable tools and resources to support transformation. Her primary responsibilities include developing new Training and Education programs and serving as project lead for the Solutions Center membership platform. Kristen has a Master's degree in Organization Development, is a certified Myers-Briggs practitioner, and is trained as an International Coach Federation (ICF) coach and a Clinical Health Coach from the Iowa Chronic Care Consortium (ICCC).

## Heather Walker, Learning Experience Designer – HealthTeamWorks

Heather has earned certificates in Designing Learning and Evaluating Learning Impact as well as the designation of Master Instructional Designer from the Association for Talent Development. At present, Heather is pursuing a Master's of Science in Information and Learning Technology with an emphasis in Instructional Design and Adult Learning from the University of Colorado Denver.

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# Today's Panel

## Moderator

### David Ehrenberger, MD, Chief Medical Officer - HealthTeamWorks

David has practiced family medicine since 1987, most recently at a Level III NCQA Recognized Medical Home where he worked for 17 years. Before joining HealthTeamWorks in 2017, David served in the role of CMO at Avista Adventist Hospital in Louisville, Colorado, and as Chief Executive Officer of Integrated Physician Network, a 240 provider Accountable Care Organization. He has a special interest in advanced systems of primary care and the design and development of regional collaborative and accountable care networks. He is a graduate of the University of California Berkeley, the Tufts University School of Medicine and the UCLA Family Medicine Residency in Santa Monica.

## Panelist

### Kristi Bohling-DaMetz, RN, BSN, MBA, Chief Strategy Officer – HealthTeamWorks

Kristi comes to HealthTeamWorks with more than 20 years of healthcare delivery, training, and transformation experience. Previously, Kristi was Program Director at TransforMED for CMMI's Patient-Centered Medical Neighborhood Health Care Innovation Award. She led a team to improve outcomes related to quality, cost savings, patient experience, and scalability across 15 health systems and communities. Kristi received her Bachelors of Science in Nursing from Wichita State University and her MBA from Friends University.

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# Today's Panel

Panelist

## Kelly Hubka, RN, BSN, MBA, Manager of Care Coordination, Shawnee Mission Health

Kelly Hubka is a nursing and business leader who works with primary care and specialty clinics to enhance care coordination efforts for optimal patient outcomes and payer reimbursement and incentive attainment. This includes MACRA strategy and execution, quality improvement program development and progress for NQF measures, population health, transitional care management, and oversight of primary care based social work and diabetic education programs.

She is a Certified Professional in Healthcare Quality and Certified in Care Coordination and Transitional Management. Kelly holds a BSN from University of Central Missouri and an MBA from Friends University.

Panelist

## Blake Williamson, MD, MS, FACPE Managing Partner, Healthcare Innovations Consulting Group, LLC

Dr. Blake Williamson is an experienced health care executive and physician with more than 20 years of experience creating innovative solutions to some of the toughest challenges in health care. Prior to starting a health care consulting firm in 2012, Dr. Williamson has served as the Chief Medical Officer at Blue Cross Blue Shield of Kansas City, as a consultant at Milliman USA, and was a senior executive for Asante Health System.

Based on his experiences as both a practicing physician and as a senior executive, he is able to understand all sides of the complex insurance-hospital-physician relationship to help organizations create the infrastructure to improve quality and efficiency as it carries employers, health systems and payers successfully into the future.

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# Provider - Health Plan Collaboration

Plan – Provider Discussion Considerations

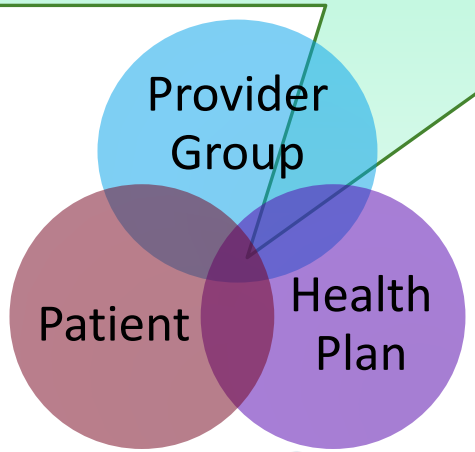
- Agree upon process flows for various programs.
  - Establish accountabilities and roles for each stakeholder.
  - Create clear & measurable goals for both plan and provider group.
- Define bi-directional information transfer for each program
  - •Include timeframe expectations.
  - •What information
  - •From who
  - •Establish reporting requirements.
- Benefit / product design
  - Reward patient for engagement in their care plan – wellness, etc..
  - Create a new product
- Reimbursement & incentive strategies.

**Example Programs**

•Care Transitions
•EBM – Closing Gaps in Care (Early detection , prenatal & chronic conditions)
•Mental Health & Substance Abuse

•ER management
•Medication Management and Reconciliation
•Shared Decision Making / Preference sensitive care / Appropriate use programs
•Referral and Specialty Network Management

•High Risk Patient Management

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# PCMH ⇔ Plan Integration

### Care Transitions:

Assess member/patient's needs pre and post transition from one level of care to another

**Benefits:** Decrease ER use, decreased inpatient readmissions, better coordination with specialist, improved appropriate utilization of care, reduced medical costs

**High Level Features:**

**Role of Plan:** Awareness of admissions, discharge, ER visits and transitions. Notification of practices

**Role of PCMH:** Follow-up and document with member and facility to manage transition. Report outcome to Plan

**Role of Patient:** Participate and engage. Follow-up as recommended

### Member Onboarding

Integrates new members into Medical Home with intention of identifying chronic conditions and initiating treatment/care plan

**Benefits:** Increased self-management, better impressions from new customers, decreased costs of new members with chronic conditions

**Features:**

**Role of Plan:** Obtain an HRA and notify practices of new members and include member risk

**Role of PCMH:** Notify Blue KC of members needing Plan Intervention

**Role of Patient:** Participate and engage. Make initial appointment as recommended.

### Closing Gaps in Care

Uses various methods of outreach to inform and coach members/ patients on chronic preventative and prenatal

**Benefits:** Improved health, reduced medical costs, appropriate utilization of care for chronic conditions and preventative screenings, improve self-management

**Features:**

**Role of Plan:** Notify members and practices of gaps in care

**Role of PCMH:** Adopt and adhere to EBG's for managing gaps in care for specific issues. Report status to Plan

**Role of Patient:** Participate and engage, follow established SOC, open & honest discussion

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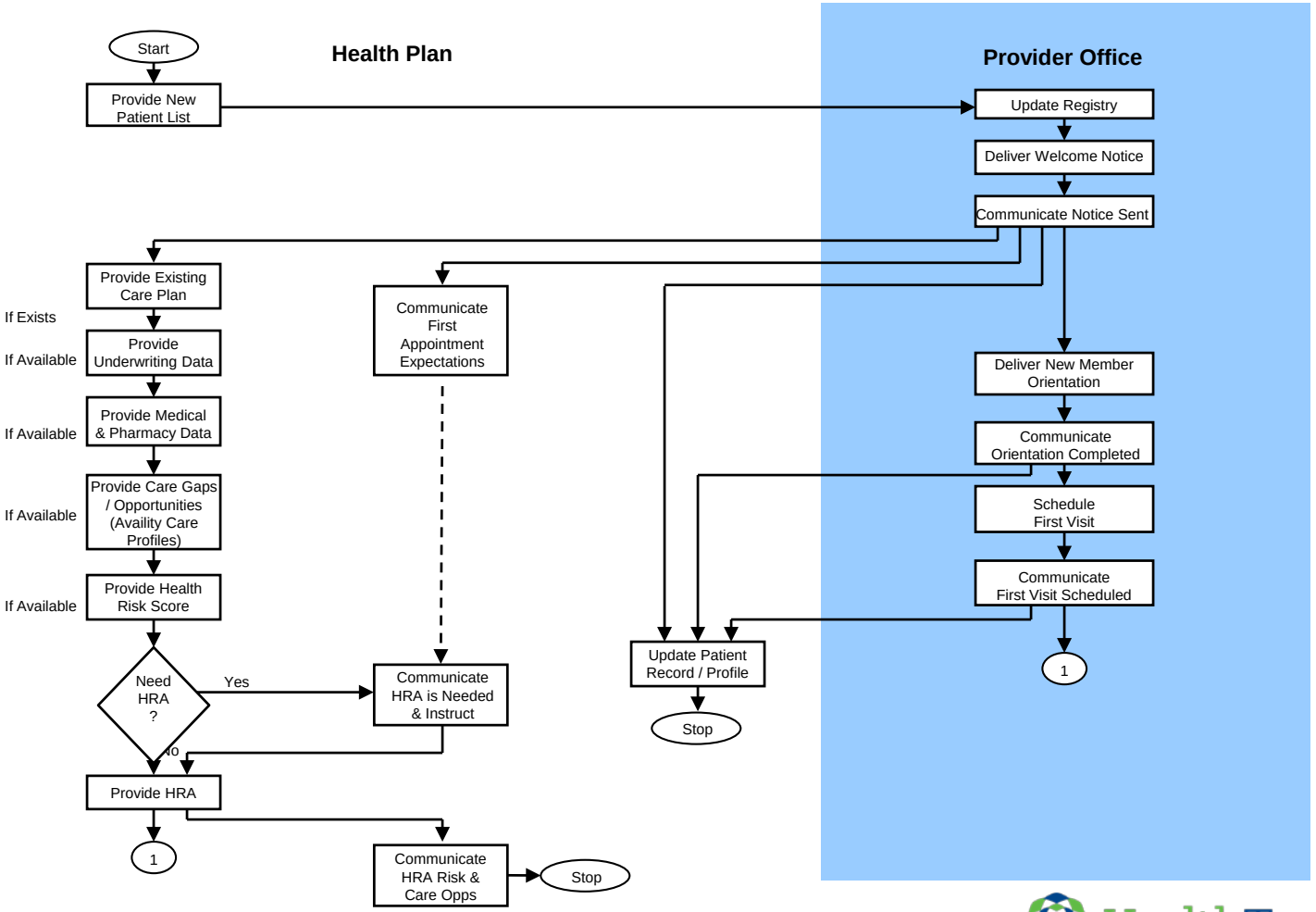
# Example Process Flow New Member Onboarding (1 of 2)

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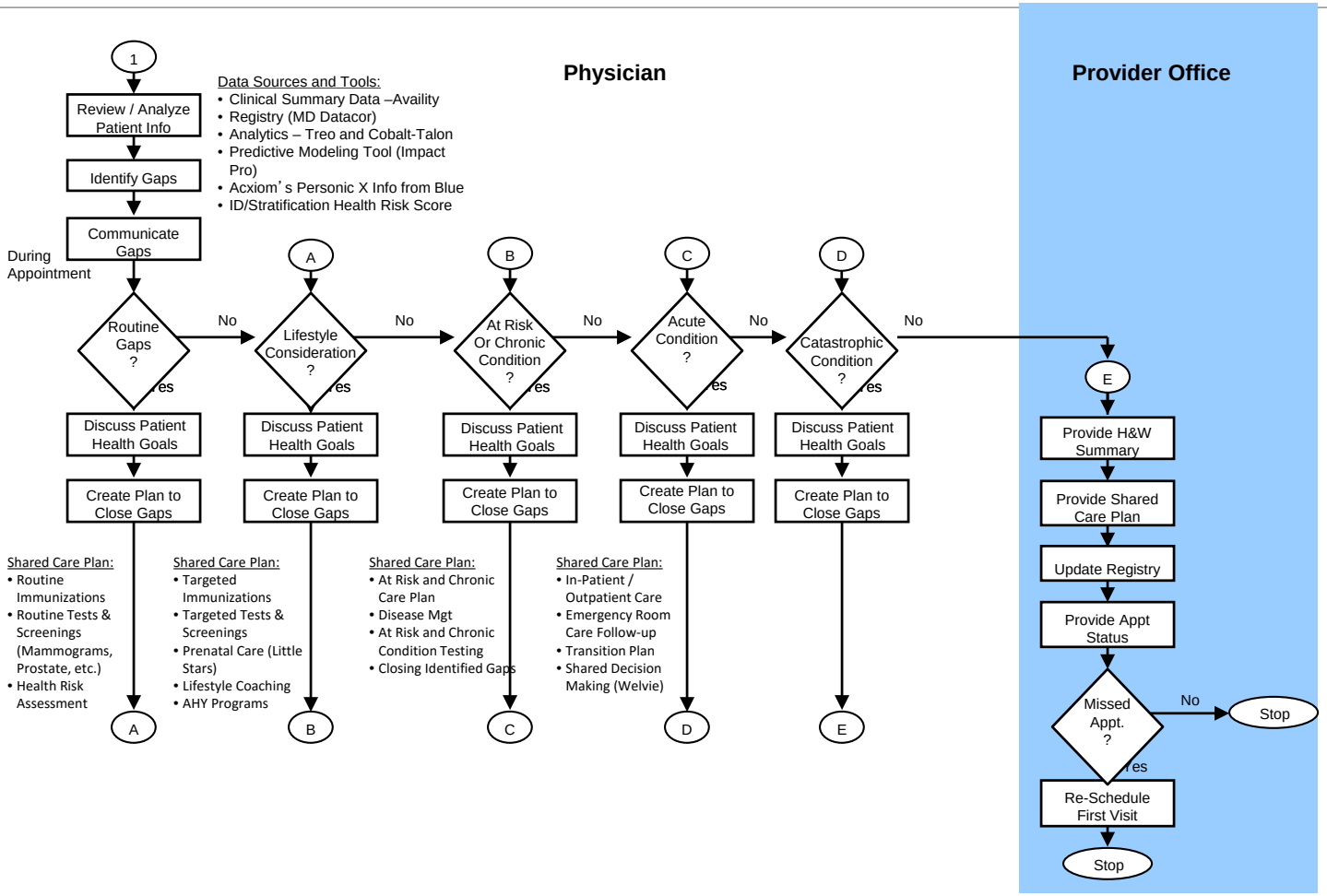
# Example Process Flow New Member Onboarding (2 of 2)

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# Workflow Overview

1. **Identify patient in need of Care Management:** Primarily via hospitalization and uncontrolled diabetes

2. **Reach out to patient and offer services:** The Care Manager (RN) will make initial contact to offer services, elicit patient engagement and set goals.

3. **Documentation:** The Care Manager will add the patient to a tracking spreadsheet and also document the phone encounter via Word template to upload as a "Care Management Plan" and route to the provider.

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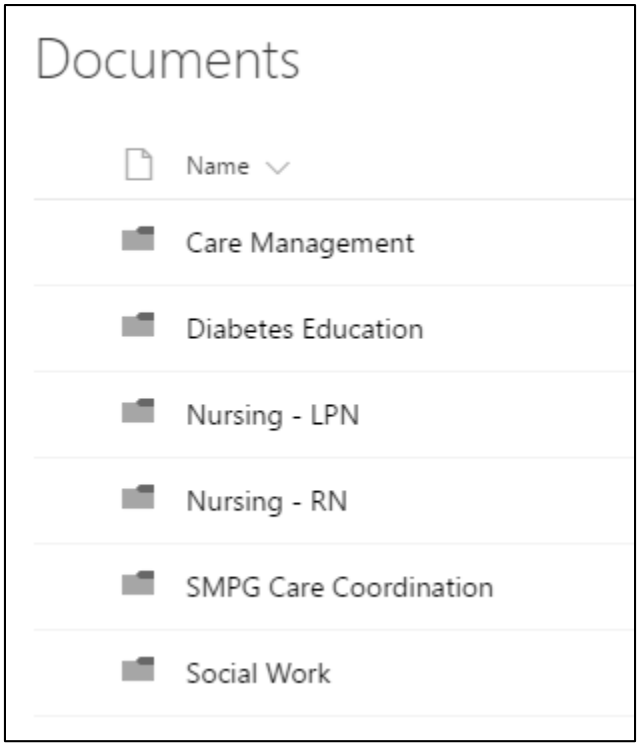
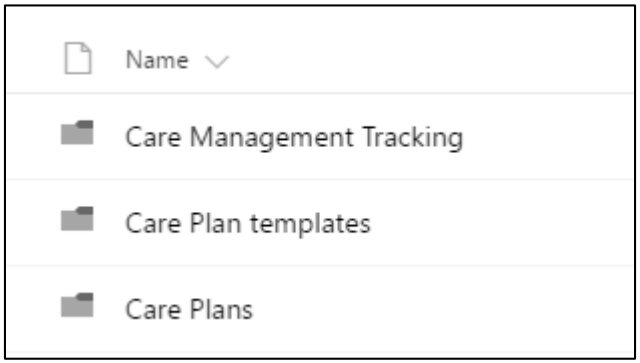
# Care Coordination SharePoint Site




We keep the tracking spreadsheet, care plan templates, and active care plans on a secure SharePoint site.

This allows the care plans to be “living documents“ and able to be updated easily without retyping all of the base information.

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| CARE MANAGEMENT<br>NURSE TELEPHONE ENCOUNTER | |
|---|---|
| Contact attempt #1 | |
| Contact attempt #2 | |
| | |
| Date of last care management contact | Date of last phone call from Care Coordination |
| Date of last hospitalization | Date of last time in hospital for overnight stay |
| Readmissions and/or ED visits since last contact | Patient reported hospital and/or ED visits since last time Care Coordination talked to patient |
| Patient's chronic conditions | List of chronic conditions in Athena (remember depression/dementia) |
| | |
| Patient reported status | How does patient feel they are doing? |
| Medication status | Is patient taking medications as prescribed? Are there any questions or areas of confusion, med changes, side effects, polypharmacy, etc? |
| Are there any barriers to medication adherence? | Are any barriers identified (cost, cognition, polypharmacy, etc)? What are they? |
| Transportation adequate? | Does patient have access to transportation? |
| Able to complete ADLs? | Can patient complete ADLs with or without assistance? |
| | |
| Patient driven goals? | What are patient's goals to optimize health state? Remember SMART goals are specific, measurable, agreed upon, realistic, time-based. |
| Follow-up plan | Would patient like Care Coordination to check in in two or four weeks? |
| | |
| Care Coordinator | Care Coordinator name and extension |

# Care Management Plan Template

A Word document is used for the Care Plan template that is uploaded to Athena as a PDF "Care Management Plan" and routed to the provider.

The Word document is saved on a secure Share Point site for future updates.

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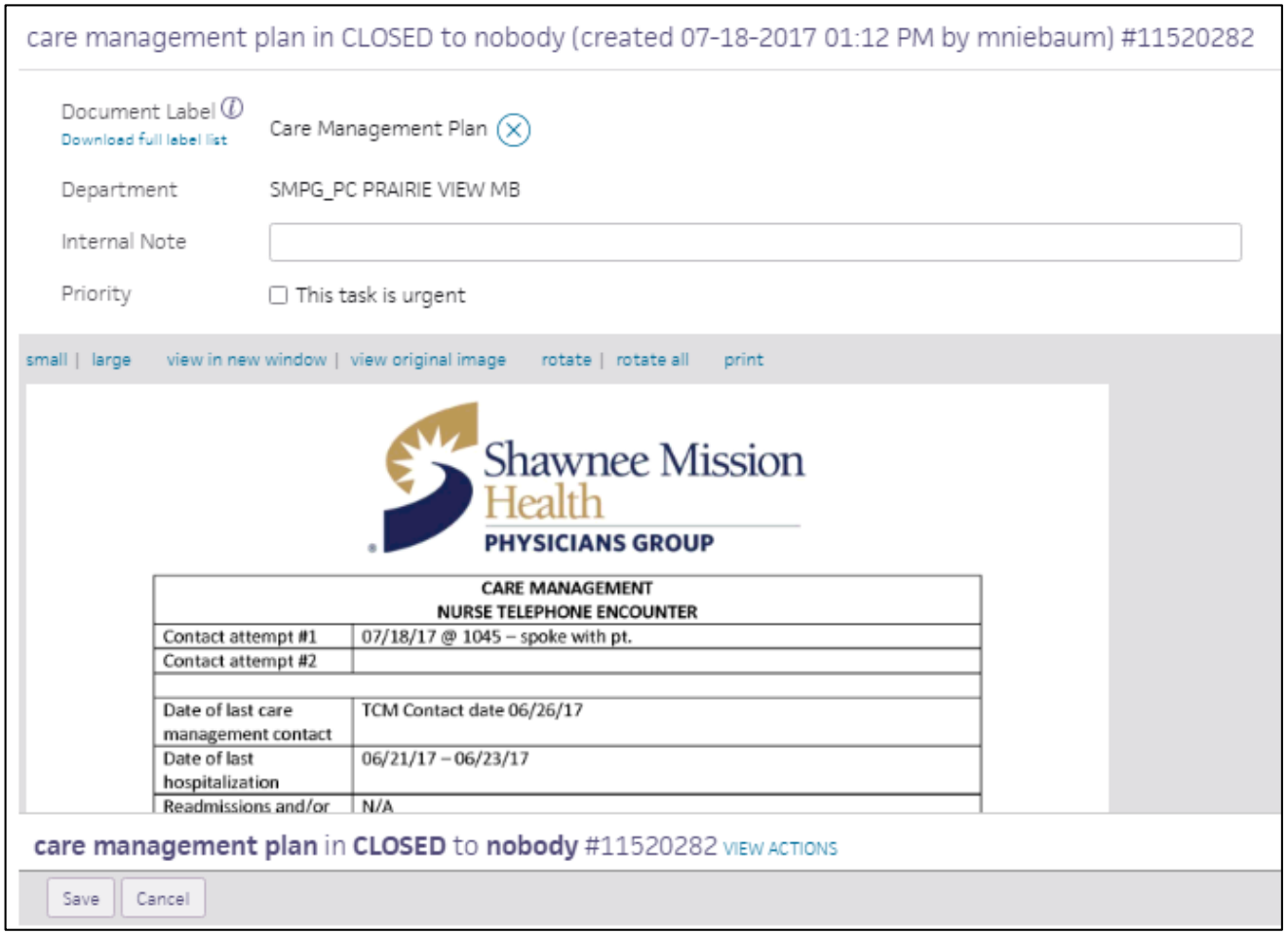
# Care Management Plan

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# CARE MANAGER TRAINING

## Solutions. Strategies. Success.

Effective care management is a key driver to increased care quality, lower costs, and increased patient and provider satisfaction. With over 20 years of practice transformation experience, we know that a dedicated resource for care management allows for targeted interventions to accelerate cost and quality objectives. In this training, Care Managers will acquire skills for integrating into the care team, establishing and implementing care management processes, tools, and resources, and educating and activating patients to adequately address their health care needs.

Take Care Manager Program Assessement

https://www.healthteamworks.org/Training-and-Education/care-manager-training/

https://www.healthteamworks.org/Solutions-Center-Dashboard/

## What Works in High Performing Networks Part 2:

## Building Vision and Strategy

March 28, 2018

11:00 a.m. MST/12:00 p.m. CST

Open to the Public

## Beyond QI:

## Why "Learning Organization" Competencies Matter

April 18, 2018

11:00 a.m. MST/12:00 p.m. CST

Open to the Public

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