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Thank you for joining. Our presentation will start soon.

***Please introduce yourself in the chat**

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Practice Transformation Webinar Series
Session 3

Care Management and Team-Based Care

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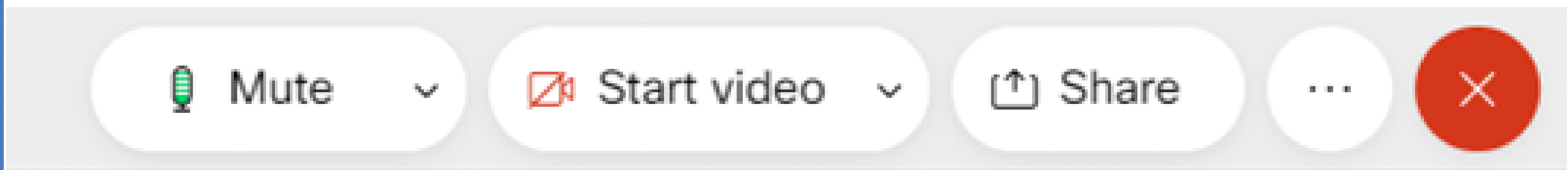
Muting and Unmuting Audio



To mute your audio, click the microphone icon at the bottom of your screen (icon will turn red).

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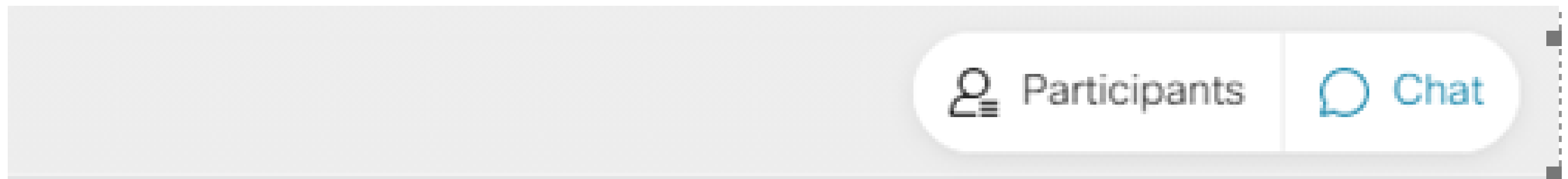
Chat Panel

Click on the "chat" icon at the bottom right of your screen to open the chat panel



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2. Click in the chat box and type a question or comment
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About this Webinar Series

- Five 30 minute sessions
- Cover 1-2 foundational elements of practice transformation in each session
- Tailored to small practices with limited resources
- Designed for you to take small steps at a time

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Steps in Practice Transformation

- Identify your patients
- Provide enhanced access to care
- ***Utilize care management services for high-risk patients***
- ***Use team-based care to improve care delivery***
- Improve collaboration with other providers
- Engage patients in their care
- Leverage data to drive improvement activities

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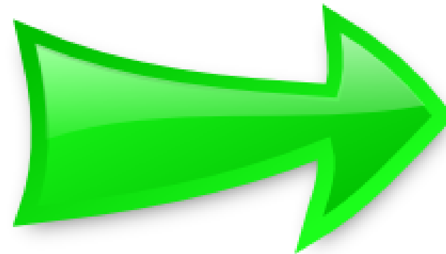
Better Outcomes



Lower Cost

While improving patient and provider experience

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Definitions

- Care management: Working with and for patients—generally outside of face-to-face office visits—to help them meet their health goals.
- Team-based care: Using the skills and abilities of everyone on the team to deliver care, instead of relying just on the provider

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Why is this important?

Care management

- Intense management of high-risk patients can prevent ED and hospital visits
- Outreach to rising-risk patients can prevent progression of their chronic condition

Team-based care

- Utilize highest skill-set of each team member
- Every team member practices to top of their license
- Improves employee and provider satisfaction

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CARE MANAGEMENT

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Poll

Does your practice currently offer care management services to your patients?

Types of Care Management

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Episodic care management

- Initiated during episode of risk (transition from hospital, ED visit)
- Opportunity to reduce cost, improve patient safety and engage patient
- Short-term
- More about coordination then disease management

Longitudinal care management

- Identify high-risk patients
- Opportunity to improve quality of life and reduce costs
- Regular, scheduled contact
- Long-term
- Can include plan of care based on patient goals and preferences

Episodic Care Management

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Patient Examples

- Patient discharged from SNF stay
- Patient discharged from hospital
- Patient had ED visit and has new oxygen
- Patient just lost their job and insurance and needs assistance with obtaining medications

Staff Considerations

- Work in the medical field
- Knowledge of resources for referrals
- Good communication skills
- Knowledge to know when patient needs more interventions

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Longitudinal Care Management

Patient Examples

- Patient has HbA1c of 13
- Patient visits ED at least weekly
- Patient with early kidney disease
- Patient with CHF with increasing number of ED visits
- Patient with newly diagnosed diabetes

Staff Considerations

- Nursing or social work discipline
- Dedicated staff member
- Clinically trained to manage patients with complex needs

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Who Should You Care Manage

Episodic care management

- Discharged from hospital with new equipment or multiple medication changes
- Discharged from ED with new high-risk med or diagnosis
- Need for food, prescription, or rent/utility assistance

Longitudinal care management

- Patients with highest HbA1c values
- Patients with multiple hospitalizations recently
- Patients with multiple chronic conditions
- Provider referrals

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Episodic Care Management

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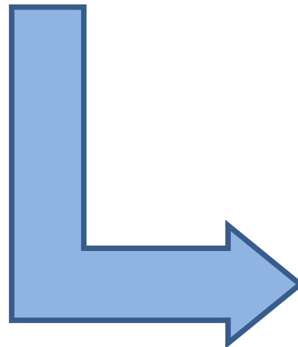
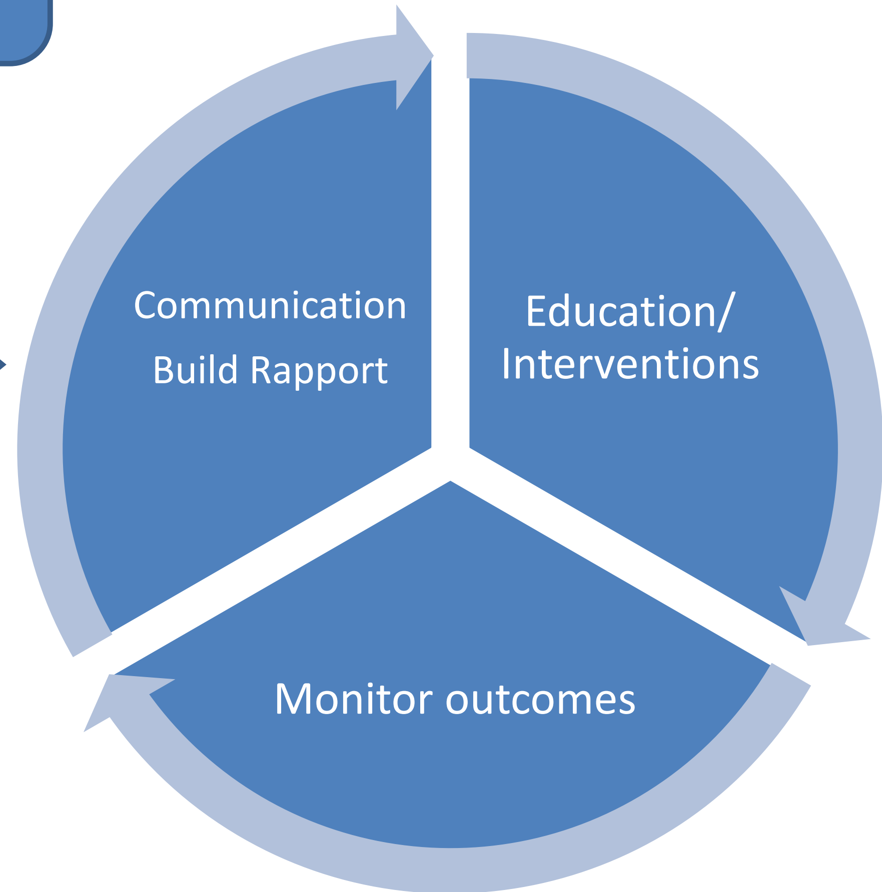
Longitudinal Care Management

Patient Identification





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Poll

Does your practice currently conduct follow-up phone calls?

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Steps to Implementation

Episodic Care Management (ECM)

- Establish a process for identifying patients that need hospital or ED follow-up
  - Only follow-up with those on your active patient lists
  - Follow-up on all hospitalizations
  - Prioritize ED follow-up to high-risk diagnosis
- Assign care team members to follow-up with those patients
  - Spreadsheets/shared folder
  - Scripts/templates

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Steps to Implementation

Longitudinal Care Management (LCM)

- Identify what patients need LCM
- Ask your providers
  - Who do you think will be hospitalized in the next 6 months
- Conduct outreach to patients to help them better manage their chronic condition
  - Education
  - Resources
  - Referrals

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Measuring Success

- Rate of ED and hospital follow-up calls
- Rate of patients who receive a call who are readmitted
- Quality measures for patients in LCM
- Avoidance of hospital or ED visit for patients in LCM

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TEAM-BASED CARE

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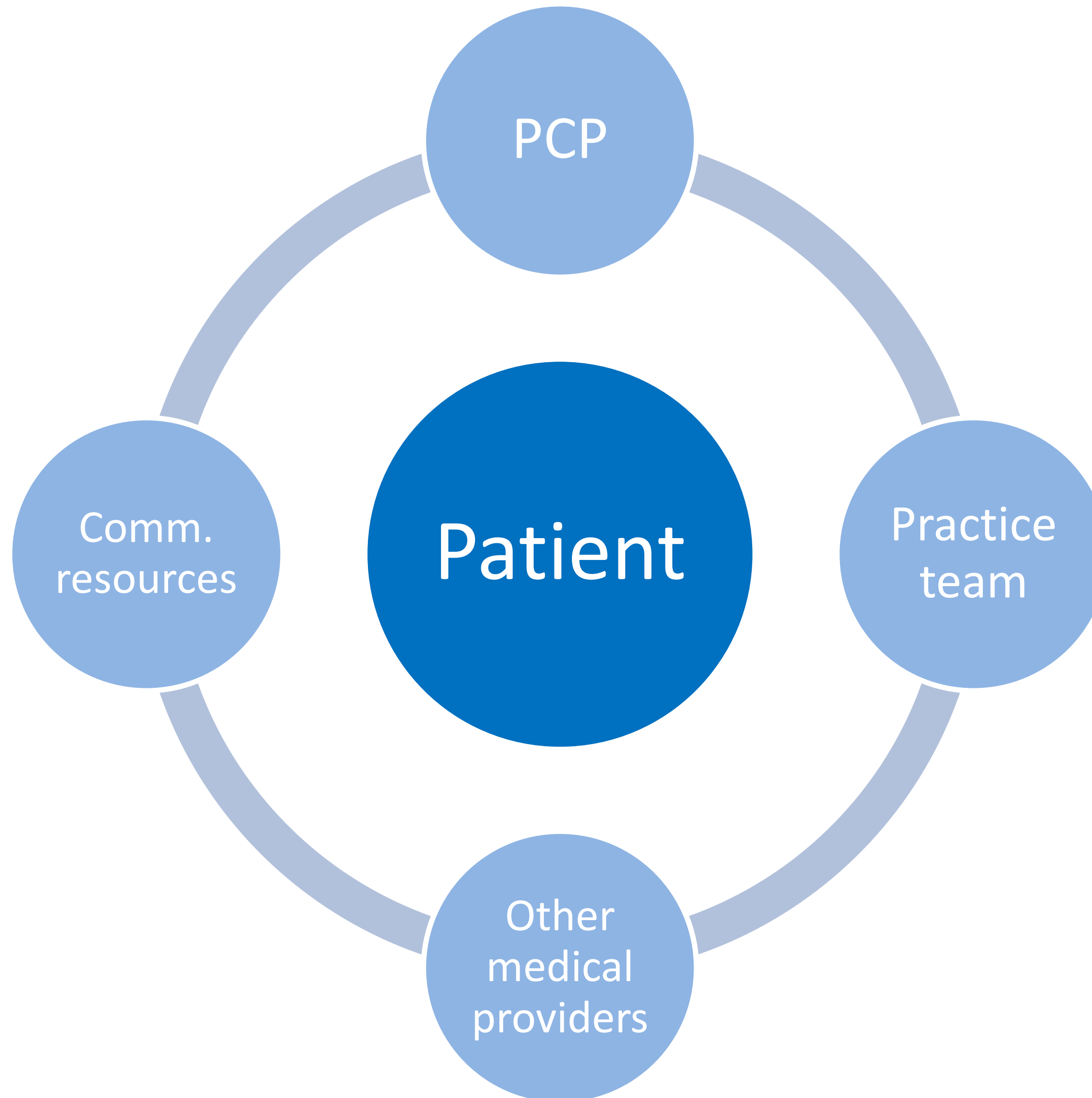
Team-Based Care



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Team-Based Care

- Multiple key players treating a patient
- Must all work together to achieve the best outcomes
- Included both clinical and non-clinical team members

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Team-Based Care

- Utilize highest skill-set of each team member
- Every team member practices to top of their license

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Examples

Current Workflow	Ideal Workflow
RNs or LPN run list of patients with care gaps and calls patients.	Designated staff member runs list of patients with care gaps and MA or office staff call patients.
RN does all follow-up phone calls for ED and hospital visits.	RN or LPN does follow-up calls for ED patients with high-risk diagnosis and all hospital patients. MA or other staff call all other ED patients.

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Examples

Current Workflow	Ideal Workflow
Provider conducts all aspects of the Annual Wellness Visit.	Nurse or MA conducts the Health Risk Assessment (HRA) portion of AWV and provider reviews and conducts the advice/education and advance care planning.
Provider's nurse conducts all follow-up with provider's patients, including ED and in-patient follow-up, care gaps	Devote provider nurse to office visit and lab follow-up. Designate other staff to do routine ED follow-up calls and close care gaps.

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Steps to Implementation

- Evaluate tasks assigned to each task member.
- Look objectively at workflows to identify opportunities for non-licensed staff to pick up licensed staff duties.
- Decide on one small change.
- Trial change with one provider.

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Measuring Success

- Care gap reports
- Staff and provider feedback
- AWV evaluation

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Next Steps

- Evaluate how your practice can implement care management.
- Analyze role-based workflows in your clinic for opportunities to better leverage your staff resources.
- Take one action to implement team-based care.

Reach out to Tammy and Gary for assistance!

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Questions?

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Consultation Services

- We can assist you on your Practice Transformation Journey.
  - Tailored support from KFMC consultants
  - Workflow and process analysis services
  - Data analysis
  - HIT consultation
- *Free for eligible practices*

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Learn More

- Email practices@kfmc.org
- Visit our webpage https://www.kfmc.org/practice-transformation

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Next Session-November 17

- Identify your patients
- Provide enhanced access to care
- Utilize care management services for high-risk patients
- Use team-based care to improve care delivery
- ***Improve collaboration with other providers***
- ***Engage patients in their care***
- Leverage data to drive improvement activities

Our Team

Tammy Elliott, RN, BSN, CPHQ

Practice Transformation Manager

telliott@kfmc.org

785-271-4152

Gary Carder, BA CIT, RRT

Health IT Consultant

gcarder@kfmc.org

785-271-4175

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Post-Event Survey

Please take a few minutes to provide **feedback and ideas.**

We **value your input**, and use this data to plan future events.

The survey will **be sent by email following the event.**