MVMC WAS ONE OF THE FIRST CAH'S IN THE STATE TO INITIATE THE CARE COORDINATION MODEL

What We Were Looking For:

- MVMC was looking for a way to improve patient satisfaction
- Decrease Readmissions by improving Discharge Planning
- Patient Contact Person
- Improve Patient Care and Disease Control
  - Patients are being seen in the Primary Care Setting rather than as in-patient
- Improved access for the patient
- Timely notifications for "normal" result tests
- As a means to improve patient centeredness
- Improve "Transitions in Care"

DISCHARGE PLANNING:

I currently do most of the discharge planning for Swing Bed patients and conduct most of the care conferences. All OBS, In-Patient and Swing Bed discharges are followed up with at least one telephone call to make sure the patient/family has everything they need, even with a Hospice or Home Health discharge.

Discharge Planning was not practical for In-Patients and Observation Patients. Nursing Staff conduct and complete these discharges unless they are complicated or need special services. These discharged patients are still followed up with by phone.

Care Coordination around the state is changing. CMS has added new programs to assist Medicare Patients on the road to "Wellness" and "Preventative Care".

CMS has added Chronic Care Management, Million Hearts and the National Rural Accountable Care Consortium.

IT IS AN EXCITING TIME TO BE WORKING IN CARE COORDINATION!

Chronic Care Management:

Chronic Care Management looks at those Medicare Patients that have 2 or more of diagnosed chronic conditions and provides 20 or more minutes of non-face-to-face services. This is a chargeable service with 80% covered by Medicare.

It gives facilities an opportunity to assist our patients in monitoring and assisting the patient in their condition management.

It will Reduce costs, increase patient engagement, change disease management.

1/3 of the population suffers from at least 1 Chronic Condition

70% of all deaths result from Chronic Disease

85% of healthcare dollars go to the treatment of Chronic Diseases

2/3 of Medicare dollars are spent on patients with 5 or more chronic diseases

National Rural Accountable Care Consortium

Provides Quality Improvement Workshops, Assessments, Care Coordination Newsletter, Specialist Roles, Educational Portals and Program Training.

Gives us the tools needed for Provider those Medicare Wellness Exams, Patient Care Planning - which can also be used as the base for Chronic Care Management.

Million Hearts is also a part of this and will also become part of the Patient Care Planning

As a Care Coordinator, I am very excited about these programs – we'll see if patients will also be excited about these – soon!

We, as well as other CAH's throughout the state are getting ready to unroll these care coordination programs to our patients!

PATIENT ASSISTANCE DRUG PROGRAMS:

-These are assistance programs directly from the drug companies
Currently working on expanding this program and we are in the information gathering phase
-We also have the 340B drug program set-up for our patients

DISEASE CONTROL PROGRAM:

Letters go out to our patients as "reminders" for the following diseases or scheduled health maintenance:

-Diabetes
-Hypertension
-Thyroid
-PAP Smears
-Mammograms
-Hyperlipidemia
-Routine Wellness Exams

Letters have also been sent to patients regarding repeat influenza vaccines for children, allergy injections, health fair tests that were not completed that the patient had paid for.

We used National Standards of Practice in addressing the frequency of exams and tests for these letters to our patients.
As patients contact us for appointments after receiving their letters, labs or other testing is entered as a pending order so the results will be back in time for their exam.

CONDITION OR TREATMENT	TEST	TESTING FREQUENCY	CLINIC VISIT FREQUENCY	TRACKING METHOD
Diabetes	A1C	6 Months	6 Months	Crystal Report
	Microalbumin	Annually		
	Lipids	Annually		
Prediabetes			Annually	Crystal Report
Hyperlipidemia	Lipids	Annually	Annually	Crystal Report
Hypertension	Basic U/A	Annually	Annually	Crystal Report
CHF	CBC, COMP, MG, TSH	Initially	6 Months	Crystal Report
	EKG	Initially		
	Cardiac Echo	Initially		
Medication Refills			Annually	Per Patient Basis
Patients on Digoxin	Dig level	6 Months	Annually	Crystal Report
Patient on Testosterone	PSA, CBC, Free and Total Testosterone	6 Months	Annually	Unknown
Thyroid	TSH	Annually	Bi-Annually	Crystal Report
Elevated PSA	PSA	6 Months	Annually	Crystal Report
Women of MBT			Annually	Unknown
Mammography	Mammogram	Routine screening should begin at age 40 and continue as long as the patient is in good health		Scanning Report
Colonoscopy	Colonoscopy	Routine screening should start at age 50 and then every 10 years unless problems		Unknown - Per patient basis by Chart review
Wellness Routine Exams			<50 every 5 years - 50 65 Every 3 Years - >65 Annually	Crystal Report
Women's Health	Pap Test	Routine First PAP test at age 21 - Women ages 21 - 29 should be screened every 3 years - Women ages 30 - 65 can be screened every 5 years		Scanning Report
Patient on Antidepressants		Every 3 months		Unknown
Well Child			As per attached schedule	Per Patient Basis

PRIOR AUTHORIZATIONS:

-Prior Authorizations for Drugs
  This is at times a *process* with forms sent through "Cover My Med"
  Supplying the insurance company with additional information
  "Appeal" process
  Can at times be completed by telephone call
  Becoming more difficult since 2015 changes - Sending PA's through 2 3 times for drugs patients have taken for years. This includes insulins (this is becoming more and more time consuming)
-Prior Authorizations for Procedures
  PET scans, MRI's, Radiographically guided procedures, etc.
-Prior Authorizations for Workman's Compensation (additional testing or need to send the patient for a specialty referral)

OTHER DUTIES AS ASSIGNED:

-Contact with normal result patients for mammograms, imaging studies, ect.
-Assist with giving Influenza Vaccines, TB skin tests, MA duties
-Track patients who have been referred to Physical Therapy
-Placing "Pending Orders" for patients that come in following a letter reminder for needed appointment
-Answering patient questions requiring a Registered Nurse
-Setting-Up multiple meetings for Community Needs Assessment
-Assisting with the Healthfair

As with other small CAH's I, like others wear multiple hats including:
  -Clinical Care Coordinator/Discharge Planner/QA/Risk/Safety Coordinator - Attendance at BOD meetings for Quality Reporting
  -Attendance to multiple departmental meetings

QUALIFICATIONS:

-A Registered Nurse - experienced in many areas of healthcare, especially facility practices, Standards of Practice, Referral Practices
-Good communication skills - must communicate with providers, internal and external departments and patients
-Ability to get along well with others
-Must be determined - do not let patient needs fall through the cracks
-Strong patient advocate
-Strong computer skills, experienced excel user
-Familiarity with current EMR and all modules

QUESTIONS?

If you are interested in setting up a Clinical Care Coordinator program at your facility, please feel free to contact me. I can give you information to get you started.

Janine Clavadetscher, RN
Madison Valley Medical Center
305 N. Main
Ennis, Montana 59729
406-682-6606
406-682-3874 Fax
janinec@mvmedcenter.org