STATE HEALTHCARE INNOVATION PLAN, PATIENT CENTERED MEDICAL HOME
TRANSFORMATION MENTORSHIP WEBINAR: STRATEGIES FOR CARE MANAGEMENT - PART 1

Notes: December 12, 2017

Moderator: Welcome to today's webinar. This session is being recorded for the purpose of taking notes. I will now turn the presentation over to Jeanene Smith. Thank you.

Jeanene Smith: Good afternoon to everyone. Welcome to yet another Mentorship webinar series. Today's will focus on strategies for care management and we are hoping that this will be sort of part one of a couple. We have another one of these for this cohort year in January. So, we will proceed to kind of focus in on one aspect of care management today, and a little deeper diving again on the next session.

The objectives of the webinar series, as you are probably familiar with, if you've signed into these before, but it is our opportunity to have clinics share amongst themselves, kind of down in the weeds approaches and techniques to try to achieve the Patient Centered Medical Home (PCMH) model and recognition. So, this is an opportunity for all of you listening in to ask questions. You can type those in now, and then a little later, after we have our mentors talk, we will probably open up the mics and let you all ask verbally, as well.

And we want to use this opportunity to help build relationships across the clinics, because many of you are struggling with some of the same issues that our mentors have. And it is always nice to kind of compare notes on how to do this. The Mentorship program was developed out of the SHIP Mentorship Framework, and there is a document that outlines this that was developed by a group of stakeholders, and this is one aspect of trying to share knowledge across the state of Idaho.

Just to remind you guys that care management is part of several different – is pretty routinely part of any recognition program for Patient Centered [Medical] Home, whether you are using NCQA (National Committee for Quality Assurance) or Oregon's PCPCH (Patient Centered Primary Care Home), or some other recognition approach.

Under the new 2017 standards, it is under its own care management and support, and there are multiple competencies, of which are is a core ones. And I just have them outlined here for everyone to remind each other that this is what everyone is sort of striving to make sure you are doing, and fulfilling the obligations, so you can get recognition for your care management program.

Under the Oregon standards, for those of you who might have be seeking recognition that way, it is also a key part of the Core Attribute of Coordination and Integration Standard 5C, and has multiple components there as well. Very, very similar.

So, today's mentors actually come from a sort of sister organization in Region 2, the North Central Public Health District (PHD). From St. Mary's Hospital and Clinic, over in Cottonwood, we have Shari Kuther, who is a Registered Nurse, and is the Physician Practice Manager. She is joined with Vicky Peterson who is the Clinic Manager at Clearwater Valley Hospital and Clinics in Orofino.

They actually are both sitting in Orofino today. And so we are going to have them talk about their programs, which are aligned, and they do some very similar things but then they have tailored it to their individual sites in some aspects. These are our questions that I am going to turn it over to Vicky Peterson and Shari Kuther to tag-team them as they would like. If you want to, go ahead.

Vicky Peterson: All right. Hi, this is Vicky Peterson. Welcome everybody. Describing our clinical setting: St. Mary's Hospital in Clearwater and Valley Hospital and Clinics are sister organizations. We have the same upper administration. Lenny Bonner is our president over both facilities, and then a shared CAO and a CMO. And then we have multiple shared managers that go back and forth to both facilities.

We serve approximately about 28,000 people in three counties, including part of the Nez Perce Indian Reservation as well. Clearwater Valley Hospital and Clinics have three clinics associated with it. One of them is a rural health clinic in Pierce, Idaho, which is about 30 miles from Orofino. The other clinic is based in Orofino, and then we have another clinic in Kooskia, Idaho, which is about 25 to 30 miles upriver from Orofino. And then I will let Shari Kuther talk about the St. Mary's Clinic.

Shari Kuther: Hi, everyone, this is Shari Kuther. And, as Jeanene Smith said, I work for the St. Mary's Hospital side of the clinic. And so St. Mary's is similar to Clearwater Valley, except that we are on the prairie, and they are down in the valley along the river. We have five clinics. Our main clinic is in Cottonwood. And then we have another clinic in Kamiah, which is about 30 miles from the hospital and from Cottonwood. It is also about 30 miles from Orofino.

We also, then, have clinics in Grangeville, Craigmont, and Nez Perce that are smaller. All of them are owned by the hospital. We do not have any rural health clinics in our circle, if you will. I do want to mention is that we also are joined by Christine Packer. She is our Chief Transformation Officer, and so she will be sharing some information with you later in the presentation. She is kind of our guru with some of the new things that we are working on with our case managers at this time.

Jeanene Smith: You want to talk about your goals and strategies as you guys were developing your care management program?

Vicky Peterson: Goals and strategies, I will have Shari Kuther talk first about how we financed it, because that will kind of lead into the goals and strategies of how we started our program, if that is okay.

Shari Kuther: Sure, so where we actually started with the financing, we actually reached out and we were awarded a HRSA (Health Resources & Services Administration) grant, which was a three year grant that allowed us to really build our ideas. You know, we had an idea on paper. We put it out there, and then since we were awarded the grant, it gave us some time to kind of try things without the pressure of having to succeed.

So, it was good for us in the beginning, because it really gave us the time and the resources we needed. Also, with outside resources available, too; to be able to help us create what we thought was the best program. Then as we moved into that, then I think that will help explain kind of why we did some of the things the way we did it, which may or may not work for the rest of you, as you try to work to put this together.

Vicky Peterson: When we initially got that grant, the grant allowed us to hire a nurse case manager who was able to provide extra support to our highest-risk patients. And, part of those high-risk patients that we outlined, were patients with hypertension and diabetes, smoking, opioids, and depression. They had a tough first group of folks to work with. But we were looking at the folks that needed the care the most, and the ones that were not reaching out for care, so we were going to reach out to them for care.

And along with hiring a nurse case manager, at that same time we were able to hire referral coordinators for each facility, which was amazing. They worked to create a registry. Our referral coordinators and nurses were invaluable resources in the community that we had not previously known about. So, it was having those dedicated folk to actually reach out further into our small communities and find out what resources were really out there.

Shari Kuther: That is one of the things that really we benefitted from in the beginning, because there really was nothing like that that any of us had ever one before. And so we really did, we were allowed, because of the grant, we were allowed to have that time to send those folks to the different even community resources, you know, the human needs councils, and find out who our contacts were in the community, which I think added an still adds today to the arsenal, if you will, that the case managers have, because they have that connection and that relationship with the food bank or the housing folks, or the people that can help with other social determinants of health.

So, we have got that connection in place. Where did we start? Well, we really had to start from ground zero. We had to, as Vicky Peterson said, we had to figure out who our population was, and we really had to figure out how we wanted to hone-in with those groups. And the new had to start from scratch, we got lots of job descriptions from lots of different places to see who was doing what and how were they doing it.

Then we created the job description. And then we had to try and figure out who are we going to hire. And because this program was so new, what were the patients going to think about it, and how were we going to sell it. Fortunately, we had experienced nurses in our setting already that were very interested in kind of changing their scope, if you will. And so we started with that, which that was helpful, because the relationship then was already built with the physicians, and the other providers, so that they did not have to wonder when the nurse was coming to talk to them about things that their patients might need, or different goals and plans, they had that foundation of trust already with that nursing staff.

I think that was a key element to our success; we will talk about later, some of our successes. But then, once we had the job description, then we were fortunate. There were some classes that came out and there was another project that we were part of. And, so, between Blue Cross and Regents and Pacific Source, they were also kind of starting to dip their toes into this.

And keep in mind, this started in 2012 for us. We have been at it about five years now. There were a couple [of] really good classes that were out there that we sent the three case managers to. They had to do with motivational interviewing and even all of us that are nurses, even if you went to nursing school 100 years ago, like I did, you know, care planning was a big part of what we did. But care planning on a different level. So, there were some courses for them to go back in time, if you will, to nursing school, and get those care plans kind of snuffed back up and ready to go. So, those were kind of the first steps. Vicky Peterson, do you have anything you want to add on the first step?

Vicky Peterson: I think that was it. And this might be more in the challenge piece, but it definitely took place in the first steps, is figuring out the whole documentation with the electronic medical record and how do they document in that, to get everything that they wanted to come across. So, that was actually a challenge.

Shari Kuther: You are right; more on that later, too. But along that same line, Vicky Peterson is right. Then, trying to figure out, because in the beginning, the gals actually spent hours typing all of their notes, putting all [of] the care plan in by hand, all those different pieces. And so then that is not a trackable. There was not anything trackable or their note did not flow from – nothing carried from the previous note to the next note. So, those are still some challenges that we are working on. We have got a few things in place.

Vicky Peterson: Yeah. Who leads our case management effort? It is definitely a team effort. The case managers are the lead for sure. I have got one case manager in Orofino. Shari Kuther has two in the St. Mary's system, along with the providers and the nurses and the MAs, and other team members. Christine has been an invaluable part of this whole process, as we move forward, looking at things, which we will talk about here in just a bit.

But, looking at how we started with the grant, and the objectives that we were looking at in the grant, to where it has moved on to now with the chronic care management, and transitional care management pieces. Other major players in the team, and leading the effort, are our diabetic educators at both facilities, and then we are bringing on behavioral health specialists to have that integrated behavioral health specialist within the clinic system, which can help with the patient.

Shari Kuther: But, backing up to the question about how did we prioritize our, and focus our program, so in the beginning, as Vicky Peterson alluded to, we actually queried our patient database, and we looked at the four things that we felt were the most significant or put the patients at the highest risk. And that was those on chronic opioid therapy, a diagnosis of depression, hypertension, and diabetes. And then we also queried whether they were smokers or not.

And then – so, that is where started. But then after – that was only about 75 or 80 patients that, in the beginning, agreed to work with us, or work with our case managers. So, then we kind of – the next step was we branched out and we said, okay, let us look at who has had multiple re-admissions, or multiple admissions to the hospital over the past year. Who has had multiple visits to the ER? And then, and as we still were gathering names and patients to move toward, then we started looking at who were the patients that were having multiple clinic visits.

That seemed like maybe it was becoming more in the sense of the social visit. You know, they needed to come to the doctor every two weeks for something, or maybe they were coming every two weeks and then they were calling every other day. You guys, you all know we have those patients. So, we started sliding some of those folks into that case management realm as well. And, so that kind of gave us our base, if you will, to start from, and keep moving forward with.

Currently, the gals do things a little bit different. They do collaborate on a monthly basis, and they talk to each other frequently, but they do get together about once a month and just kind of go over their toughest case, and you know, or challenging cases. “I am really struggling with this guy and how to get over this hurdle. Do either of you have any ideas to help me?” And so they really spend a lot of time collaborating which each other, which is really good.

And then the next step is kind of even reaching further. You know, where else can we go? What do we do next? But, so right now, I think the Orofino case manager has about 120, 130 folks in case management. The gal in Cottonwood has about 80 folks. And then the gal in Kamiah is brand new. Our previous case manager retired. So, our gal there is brand new.

But I chuckled because she has been on the job about, what, ten days now, and she told me that she has got 30 referrals already ready to go. So, it will not be long and she will be right up there with the other gals. Jeanene Smith, I am not sure if you want to do this this way or not, but does anybody, I guess I would ask if anybody had any questions about anything that we had said so far.

Jeanene Smith: Well, I tell you, there was a question that came in about your guidelines. Are those something that you would be willing to share with others if the folks contacted you?

Shari Kuther: Guidelines as far as – we would be happy to share our job description, yeah, if that is what you mean?

Jeanene Smith: Yeah, guidelines around your care management program. It sounded – and you just went through your risk factors to develop your initial panel, which was the other question they had. So, I think you got that one covered already. I had a question is how did you, in your training, did you – and thinking about your program, a lot of challenges as people get into care management and then how do you phase them out so you can bring in enough new people? And it sounds like some of these are startup, especially that third site, but do you have a plan for how you manage people back out of care management, or do you have some criteria? And have you been thinking about that?

Vicky Peterson: You know, funny you should ask that. You know that question down here about challenges that you have?

Jeanene Smith: Well, we can wait and talk about it then.

Vicky Peterson: No, that is okay. We can talk about it now. In some ways, it has been a challenge. You know, because, and I am not sure if that is the nursing part of us, in that you want to stay engaged and nurturing, and progressing them along. But at the same time, each of the gals has had a number of folks that have been graduated. But I think really what they have used for that up to this point has been that the patient has felt that they have met the goals that they set out to meet.

And that the patient feels like they are ready to kind of take back control of their life, and they are set to launch and go out and do their thing. We do have, all of the gals have a certain number of folks that are on what they would call, like, a limited contact. So, maybe they only call them every three months, or every six months to check in with them, see how they are doing, or remind them that it is time to come and get whatever bloodwork or things like that. So, it really is very – they have moved several folks to that kind of minimal contact, minimal intervention.

Jeanene Smith: And what – what is your maximum? When do they, are they calling daily or weekly or monthly? What is the usual for the majority of them?

Vicky Peterson: Oh, probably the majority of them I would say monthly.

Shari Kuther: Yeah.

Vicky Peterson: Yeah, some of them definitely, they call more frequently. Like Shari Kuther alluded to, that was one of the more difficult things for them to do is to have a patient where they would say, “Okay, I am not going to reach out to them, you know, as often.” Yeah, probably monthly. Some of our chronic care management patients, they talk to more often. But it definitely depends on what diseases they are dealing with.

Shari Kuther And we had, for example, the Cottonwood case manager has one patient that he was calling his provider daily, and probably coming to the clinic requesting to be seen weekly almost. And most of the time, maybe had somewhat of a legitimate issue, needing to be seen, but not necessarily needing to see the physician each time. So, he was really a great candidate for case management. And in the beginning, she spent a lot of time, probably all, even upwards of an hour a day, talking to him on the phone.

And that was kind of one of her first targets that she set was, instead of giving him free reign to call, even three or four times a day asking her questions, that was one of her very first goals was working with him to get him comfortable to making a list of all of the things he wanted to ask, and then having a certain time of day that he could call and talk to her every day; knowing, obviously, that if he felt like there was an emergency, or something critical, he could call at any time.

That was kind of her very first step with him. And now she actually has worked with him for quite a while, probably even a couple years that she has been working with him. But she is down to talking to him, instead of three to four times a day, every day; she talks to him maybe once a week. And he is only coming in to see his provider about once every two months or so.

So, really, we have felt like that has been a pretty big win for everybody. He is much more confident, and he does have some underlying mental health issues. But he is much more confident, and he is doing much better on his own. And then obviously the doctor has much more time to take care of other patients because he and his MA (medical assistant) are not dealing with the patient and his questions, you know, continuously throughout the day. So, fortunately there are not too many of those.

Shari Kuther: But there are those few that, especially in the beginning, it might be a weekly contact, or maybe an every two week contact, and then that is one of their goals is to move that out to getting them comfortable to doing things and helping them to learn how to better care for themselves so that they can do it at home, and not to call or to reach out so frequently, to have that self-confidence.

Jeanene Smith: There was a question about limiting panel size. So, are you limiting panel sizes with your providers, and is there a correlation between your, these risk, high factors, and how you look at these patients? There is a limit to what the case manager is going to have, and then is there some way that you are distributing these with your panel as well?

Shari Kuther: What are the two top challenges or barriers? One of our biggest challenges has been panel size. You know because we have been doing this for five years, so we have been trying to search for some answers for five years, because no two programs are alike. We would talk to the case managers, for example, at Blue Cross. Well, they might have 300 patients in their panel.

The new gal that we just hired, she came to us from the VA, and she had 900 patients in her panel. And then in contrast, you talk to the public health department who is doing some new case management stuff there, and they – their nurses have a panel of 25. And so really trying to get an idea and a handle on what is the appropriate panel size, and the numbers of the red, green, and yellows, kind of classifying patients by how much time or how much risk they had.

You know, what is the right balance with that? So, we have also put that challenge out to our PCMH coaches, as we have been part of the CHIP (Children's Health Insurance Plan) cohort one and two. And they have helped us work through that on different levels as well. We did just have a conversation with Laurie, who is our coach this time, and I think that she brought in an outside contact of hers, and he had a really great tool that he shared with us.

And so we actually have rolled that out to our case managers, and are excited to kind of give that a try and work through that, and see if we can come up with some really better, concrete ideas about what panel size really should look like, and what it should be. And one of the, you know, one of the challenges to all of that, too, is that – and I had not thought about this until he presented this information to us, but, you know, if you are not graduating anybody out of your program, if you are not graduating anybody from the red to the yellow for from the yellow to the green, or even from the green out of your program, then how – how does that limit who you can bring into the program?

If you have your case manager and is maximized in their panel if you will, and you are not graduating anybody or you are not moving anybody from one level to another, you cannot keep just adding in reds, or you cannot just move them from red to yellow. If I am not ever moving them from yellow to green, or I am not ever moving the greens out, then, you know, how does that impact your ability to bring in new folks?

So, that definitely is one of our challenges to still try and figure out. The other piece that feed into that is how do you pay for this moving forward? As Vicky Peterson said, we had the grant in the beginning, and it was a three-year grant. So, then, when 2015 rolled around and the grant ended, we were forced to look at, okay, now what do we do?

Well, fortunately by then, we had joined in with the program that, like I mentioned, that Regents and Blue Cross and Pacific Source and Medicaid were all doing. So, there we were reimbursed for our work in working with those folks as well. Now, that has kind of come to an end or is working on coming to an end. I think it actually ended. But how do we move this forward with being able to re-coup, because nurses are expensive.

Shari Kuther: And so that is where Christine comes into play, with as we have looked at moving our organizations towards a pre-ACO (Accountable Care Organization) and now moving towards talking about ACO stuff; what could we do and how could we do [it]. And so Christine got on board and really dug in and helped Julie and Shawna with the chronic care management and then also the transitional care management that they are doing at Clearwater Valley. I will let Vicky Peterson talk more about those.

Jeanene Smith: Before we go there, we have one question. And I think Michael Ryan, I think your phone is unmuted, if you want to go ahead and ask your question related to sort of this risk stratification approach.

Michael: Yeah, sure. It would probably be easier to ask it than to type it out. I have just heard different philosophies about care management. One philosophy is kind of an escalating tier approach where the bulk of your care management effort and time is spent on the sickest patients you have in the toughest social situations, and you work with those patients. Another approach that I have heard is do what you can to help those patients, but to focus the bulk of your care management efforts on kind of the in-between patients, where maybe they have a couple of chronic conditions, and they are on track to be in really bad shape in five years, or, you know, down the road.

But, they are at kind of a pivot point where if they got some extra attention, that you could really move the needle for them and, you know, make a bigger difference in some people that just are in really bad; bad, dire straits kind of. So, I have heard those different philosophies. I was just curious what your thoughts are since, you know, you are further on in care management than we are. Thank you.

Vicky Peterson: I appreciate your question. I think one of the challenges is when you have those people that are kind of at that very far end, that first group that you talked about, that really high risk, the really sick – all of those pieces, and the case managers and even the providers do ask, "Are we going to be able to even make a difference, and is there going to be a value? Are they – have that missed that pivotal moment, that we cannot make them, we cannot help them turn that corner back around?" I would say that probably we do spend some time with those folks, on one hand, because we have the grant and because our philosophy is not always about what makes the most financial sense, which probably that should be what it is, but it is not always.

Anybody who wants to participate in case management, we will bring them in and work with them. I think what we found in some of those folks that are the sickest ones; they are not really interested in making changes. And so sometimes, and we have had this happen at both places, the case managers have met with the patient, they have talked with them, they brought in the families, talked with them, and they have tried to set some goals. "So, what is important to you," or whatever that may be.

Vicky Peterson: Sometimes they will hit an impasse, and that really, their hands are kind of tied. The patient really is not interested in changing anything, or, you know, the patient who has the horrible COPD (chronic obstructive pulmonary disease) and is on home oxygen and cannot even leave home, and you know, and they are not interested in even cutting down their number of cigarettes. It is probably pointless at this point to try and get them to stop smoking.

But they are not interested in hearing about that. They are not interested in changing their nutrition, whatever it may be. So, we do have some of those folks that we have tried and we have reached out to them, but for whatever reason, they have just decided that they do not want to participate, or that we try and set goals that what do you want your care plan to look like?

I would say that probably overall, we have the biggest impact with those folks that are in the middle of the road, if you will, there is potential here that if we could get them steered in the right direction that we could make a difference. One of the things that was really interesting, when we came up with the top four diagnoses, and then added in even the smoking status to that, and we worked through the grant, we looked at their quality marker.

So, we looked at their A1C, we looked at their blood pressure, we looked at their smoking status, we looked at their PHQ9 values, we looked at their use of narcotics, and looked at their LDLs – I am trying to think what other quality ones we did.

Anyway, when we ran that case managed population against their counterparts, so for example, when we ran the case managed ones against the general diabetic population, or against the general hypertension population, we found that those folks in case management, actually all of them, had higher scores or better scores, if you will, than the general population. So, that was really – on average, there was about 10 percent higher meeting the measure than in our general population.

So, hemoglobin less than nine, and actually I think maybe we looked at less than eight, was what we actually looked at was less than eight in that population. So, 75 percent of those in case management were at less than eight as opposed to 64 percent of our general population of diabetics. So, and then our number – I think one of the things that we saw another dramatic increase in was the number of smokers converted to non-smokers, which was really kind of exciting for the team, the gals, that was probably one of the first noticeable things.

It kind of became a little bit of a contest between the three of them. It was, "Well, I got another one to quit smoking this week." "Yeah, well I got another one, he is about there." And so, but yeah, that is a good question, and it is hard to know what the right approach is, exactly.

Michael: Thank you.

Jeanene Smith: You guys want to move on then to the financials, what you were going to lead into there, Shari Kuther, with Christine?

Shari Kuther: Sure. So, as far as the buy-in from them, you know the question about any specific steps to gain buy-in from providers and staff, I think both of us would agree that buy-in is very important, because the referrals to case management are going to come from your providers. I think one of the reasons that we were successful with the buy-in, is because we did have the luxury of having nurses from our current staff move into those roles, so those nurses were known.

But we also had some early-on successes, and they jumped in and they tackled those difficult patients that the docs were really kind of at the point of, you know, "I do not know what else to do. I am talking to this guy until I am blue in the face, and he just is not going to do X, Y, or Z." And so then getting those case managers involved, you know, like, say, with that early success.

One of my favorite success stories is in Cottonwood; the gal was working with this fellow who was really having some issues with chronic pain. And there were other, you know, obviously he met all the criteria. But anyway, as they were going through this, one day he came into the office for he was having some issues, whatever.

So, she went in to the visit with the provider and was there and just kind of listened to everything. And then after the provider left, she started talking to the patient about, you know, the depression. And at that point in time, we were not screening everyone with PHQ2s or nines or anything. But, she started talking to the patient about, you know, "Gosh, if I was having all these issues with pain and I was having as much trouble and struggles with this as you were, I think I might be getting a little bit depressed about things."

And, obviously, there was a reason she is a case manager, not a practice manager. She is much better at the conversation than I am. But, anyway, he actually admitted to her that he was, indeed, very depressed, and he actually had suicidal ideations, he had a plan. He had everything except he had not picked the date. He did not know when he was going to do it yet.

But he had everything else figured out. And he actually admitted that to her. And so she was, you know, like, "Okay, well, let us get the doctor back in here. 'Let us see what we need to do to get you at a safe place today.' They went through a bunch of different things, they got a bunch of different things put in place, got him some counseling set up for that afternoon, you know. And there was a lot of other dynamics that all went into this.

Five years later, that man is doing very, very well, and he is alive, and even very early on, after he had admitted that to her, we saw some very good, initial success. It does not take many success stories like that to know that you are doing the right thing, and that other providers hear about what happened, and so then they start sending those patients as well.

Vicky Peterson: That is a huge piece of how we got some of the provider buy-in was them hearing those stories and seeing how some of the other patients responded to the case management. Communication was huge. I know when we first started, we had the care managers meet with the providers at a med staff meeting, or, you know, and say, "These are what I have to offer. These are the services that we can do." And then being very transparent with what we were trying to accomplish with the patients with the providers.

Shari Kuther: Yeah.

Jeanene Smith: So, do you guys have routinely these kind of story sharing still? Or, how do you sort of keep the link between the providers and the care managers? Are they presenting regularly? What kind of structure, if any?

Vicky Peterson: I do not think that they necessarily present their success stories to anybody. But, you know, the care managers or case managers are embedded right in the clinics. If the patient comes in to see the provider, they accompany the patient to the appointment. They might actually be part of the appointment as they – so they will meet with the doc ahead of time and say, "Hey, here is the care plan. Here is the things we have been working on."

And then the provider will see the patient, and they may have a conversation about, "Okay, well, what do you think about changing this goal, or what do you think about making this next step?" So, there is still a lot of interaction between that case manager and the providers.

Vicky Peterson: The provider-identifies a new issue, so he will say to the case manager, you know, "Hey, I think this is an issue. Can you add this to your list?" And then the case manager can talk to the patient about their perception of it, and what steps they want to take to try and rectify the, you know, solve the problem, if you will."

Jeanene Smith: Great.

Shari Kuther: The next one on where are we today, and where are we going, plans going forward. So, this is where Christine, we can have her add in here. We are still dealing with the patients that the care managers have been dealing with, but in addition we have implemented the chronic care management program and the transitional care management. And Christine has been a huge driving effort in that. So, Christine, if you want –

Jeanene Smith: Clarifying: These are for billing Medicare right?

Shari Kuther: Right, right. Yeah.

Vicky Peterson: However, we also have learned that there are some of the insurance companies that will also pay for case management services, so it is not a free program any longer. Christine, do you have anything that – maybe for the folks, so that if they want to look into it, even some of the billing codes or some of the, quickly, some of the different pieces around CCM (Chronic Care Management)?

Christine: Thank you. So, chronic care management, or CCM, as we call it, has been a bit of a journey for us. And transitional care management has also been a journey for us. We had kind of a unique situation, as I have talked to other practices who are rolling out these programs in that we already had a program set up. A lot of people were starting from scratch. And so it was a little bit of a blessing and in some ways a challenge to already to have a program set up.

One of the cultural things that we have kind of had to overcome internally and with our patients is that now we are going to bill for this when we can because it makes sense to do so. But we have been doing it for no charge for so long. That took a little bit of time to kind of, to move that perspective if you will. I think that the great thing about having this opportunity to bill for these services is that Medicare is, and other payers, are – as we are kind of moving from this volume to this value and quality arena around healthcare, they realized that if they realized that if they want to have us do things differently, they are going to have to pay us differently.

It is a very slow trajectory for all of us, but it is really great that they see that and they are doing that for us. We learned a lot over the course of a year. I think one of the challenges we have is that the guidelines are not always crystal clear. They can often be a little bit grey.

We have had to translate things along the way. It seems really simple to implement something like this, because we already had it going, so it should just be exactly the same. But, it is a little bit harder to do than it looks on paper. I think we have been really successful.

We have found that Blue Cross will cover chronic care management. There are three separate codes of chronic care management. And the basic one is 99490. You guys could just Google 'chronic care management' and you could find all of these. And that is a 20 minute code. And depending on the payer, they reimburse you a certain amount. Medicare reimburses us around $43. There is another code, 99487, which allows you to spend 60 with a patient.

So, thinking about the gentleman's question earlier, how do we decide who we are going to work with? It is nice that we have different codes for different kinds of people and different needs that they may have. In some cases, we may just spend 20 minutes talking to a patient in a calendar month, and then other times we may spend 60 minutes. And then there is another code where you can get up to 90 minutes. Actually, it is for an additional 30 minutes. For every additional 30 minutes you spend on top of 60, you would add this other code. We have not done that very often. We are mostly doing the 20 minute and the 60 minute.

There are some requirements, which some of them are a little bit new to us, or just were a change to us. We had to add some pieces to our care plans, we had to make sure we had a solid way, 24 hours, 24/7 access. We had a few things we had to have documented, if you will. They existed, but they were not always completely documented. We had to do some of that. We are having a good amount of success on chronic care management.

I think one of our challenges with it, and some of you may find this as well, is that there is kind of a difference between chronic care management and case management. In order to be eligible for chronic care management, you have to have two or more chronic conditions that put you at significant risk. You expect those conditions to last more than 12 months, and maybe even a lifetime. And so just because a patient is in case management does not necessarily mean they qualify for chronic care management.

It has been a bit of a journey to kind of parse that out and figure out what does what look like. When do we bill and when do we not bill. That has been a little bit of a challenge. However, it has really made a big difference in our preparation to entering into an ACO. That is something our organization feels like we are ready to do, and we are going to do that in January.

I think that if would not have been doing some of this work in advance, we would not have had quite – we would not have quite felt that we were ready to go with that. Let me just stop there and see if there are any questions around the chronic management.

Jeanene Smith: Yeah. Question for you: One: is it would be good to explain how you are tracking the time? Because, I know that is a big issue. And then one of the questions that came in is whether FQHCs (Federally Qualified Health Centers) – you guys are not – you have a rural health center at one of your sites, I believe?

Christine: Right.

Jeanene Smith: Do you guys know the relationship of – I think these codes are now available to be billed by FQHCs and RHCs (Rural Health Clinics). Is that your understanding as well?

Christine: I think they will be ready to be billed in January.

Jeanene Smith: Yeah, that is right.

Christine: I believe that is when the switch comes. The FQHCs and RHCs will be able to bill for them. We have not performed this service at our RHC, necessarily, but we can do it for – it is mostly a telephonic intervention. You can do face-to-face, but it is designed to be done mostly over the phone. And so that comes the first of January. Ask the first question again. I am sorry, I forgot what you said.

Jeanene Smith: Oh, it was how you track the time so that in case you are audited or whatever.

Christine: Yeah. Yeah, I cannot believe I forgot that, because that was really a big deal for us. What we ended up doing, we have GE Centricity, and we had our IT (information technology) group add a calculator to our care plan, because the care plan is really the document that the case manager spends most of their time in, adding goals and doing the problem list, and documenting on all the different problems. And all of that stuff that they are doing mostly happens there.

We had them add a little calculator to that where they can add time. There is a little button that says "Add previous," so all the previous time for that calendar month loads into there, and then they add their time. That works for us. It is a little bit of a manual process, and we are actually looking at some other options that may help us collect this time better. We also have the opportunity, and everybody would have the opportunity, to count time by other clinical people in your clinic. If an MA or a nurse is talking to this same patient that is in chronic care management and taking care of something for them, or giving them advice, or doing something for them, you could count their time.

We are trying to figure out how to make it easy to count that time; where else we need to put our little calculator, because that is acceptable to do. It does need to be clinical people. That is our understanding. We have asked this question numerous times. So, like for example, we would like to be able to count our referral coordinator's time, because they are taking care of referral patients.

Because they are not a clinical person, we cannot count their time. There is some rules around that. But we have a little calculator we created to help us calculate that and keep track of it. We would like to figure out a way to capture more time, because we know that this work is being done by other people. And, again, the intention is to try to capture this time and get reimbursed for the time that we are spending that helps these patients and keeps them possibly even out of the hospital.

Jeanene Smith: Great. Did you guys want to talk a little bit about your challenges or barriers? Shari Kuther and Vicky Peterson, do you want to kind of start to make your major lessons and issues?

Shari Kuther: I think we have kind of identified basically the challenges and the barriers. We have talked about the ways that we are working on overcoming them: with the panel size as one of the challenges, and then the documentation and then moving on to the how do we track the minutes. There is actually a software that we are looking at implementing as well that will help with some of that time tracking. It is through Enli, and it connects with our CPS or EMR. And so it can do some of those kind of things.

Hopefully you have heard what some of our major lessons learned have been. It has been an exciting time to see how things have evolved and changed, and I think all of us would agree that bringing case managers into our system was a very positive move. Patients like it, the nursing staff really like it, the providers like it. There is not anybody that has not seen the value and the benefit of having those case managers there.

Certainly, if you have more questions, we would be happy to share any of the information that we have. Or if you have specific questions that you want to reach out to us, or want to have a conversation with us after we are finished here, we are, each of us is more than happy to do so.

Vicky Peterson: Yeah, and our case managers would be as well, if you have a staff that would want to talk directly with them, they would be more than happy to talk as well.

Shari Kuther: Absolutely.

Jeanene Smith: Christine, that is great information about the billing codes, and I am sure you have more information about trying to do the transitional care codes as well, which are probably equally challenging.

Christine: Yes. I would be happy to share it with anybody who would like to hear how we did it. I would consider us to be pretty successful at it, so I would be happy to share.

Jeanene Smith: Great, great. Shari Kuther and Vicky Peterson's contact information are up here, and I am sure you could work through them to get Christine's. But feel free to contact them. They are great mentors. If anyone has a question or a comment, please go ahead and speak up. I know it seems like we had about 40 of you out there at one point, so it seems to be a hot topic. Anybody interested in asking these guys a question in the time we have remaining?

Female 1: I have a quick question.

Jeanene Smith: Sure.

Female 2: Can you give us the difference between your care manager and your case managers? What their roles are and what their qualifications are?

Vicky Peterson: I guess they are one in the same. I probably mentioned care or case, but we have case managers, which are registered nurses, which is what we are using.

Shari Kuther: Yes. Oh, we do not, yeah, like Vicky Peterson said, it is all one in the same. Once in a while, one of the products that goes with our EMR is called Care Manager. So, case manager, care manager, we end up using them interchangeably. Sorry about that. All of them are RN case managers.

Jeanene Smith: Okay.

Shari Kuther: Thank you – this is Shari Kuther – thank you for giving us the opportunity to share about our program and our challenges and what we have learned. And I just really appreciate everybody joining today, and hearing what we had to say.

Jeanene Smith: Yeah, it is great. We will be putting up the slide deck with your contact information. It will be available on the portal for others to track you guys down. I think there is a couple slides here just to remind people about the evaluation that is going to come out.

Everyone on the line will be getting an evaluation, and we really look to that as a way to think about how to target these mentorship webinars to your needs. Please fill that out. It will be shortly generated out to you. And you, too, can be a mentor. Please let your PCMH coach or your SHIPQI specialist or – and my contact information is also in here – to let one of us know that you would like to talk about something that you really think that you are doing, or get some input; or people who really would like somebody to mentor them, and be a sort of basically a mentee.

If there are ideas of what would really help you be successful in your clinics, we want to hear from you. As I said, there will a Part II. We wanted to kind of get some examples of how people are dealing with care plans, because I know that is a big challenge, and these guys touched on it a little bit. And we are going to do that one in January.

Still tracking down mentors, so if anybody has some good experience on doing care plans well, and how they communicate across their clinic, please reach out to us. That is how you can reach me. If people have ideas for more of these.

So, with that, I want to really thank Shari Kuther and Vicky Peterson and Christine and all of you for participating today, and I look forward to more of these going forward. So, thank you guys.

Shari Kuther: Thank you.

Christine: Thank you

Moderator: Thank you, everyone: This concludes today's call.