Mentorship Webinar Series

Topic:
Strategies for Care Management - Part 1

December 12, 2017

Facilitator: Jeanene Smith

PCMH Coach

Statewide Healthcare Innovation Plan

PCMH TRANSFORMATION TEAM

Learning Objectives for the Webinar Series

- Sharing the implementation experiences and lessons learned of mentor clinic(s) with interested clinic participants around a particular topic; including key strategies and challenges
- Opportunity for the “mentee” participant clinics to ask questions in a facilitated discussion with the mentors
- Build relationships across Idaho to share lessons learned and increase knowledge of the on-the-ground steps needed to implement PCMH transformation
- Link to Statewide Healthcare Innovation Plan (SHIP) Mentorship Framework document (copy link and paste into your browser)

  http://ship.idaho.gov/Portals/93/Documents/PCMH/Idaho's%20PCMH%20Mentorship%20Framework%20DRAFT%20v7.0D_06052017.pdf?ver=2017-07-26-084527-037

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Recognition Standards on Care Management: NCQA 2017

Care Management is the focus of one of the Standards under 2017 National Committee for Quality Assurance (NCQA) PCMH Standards:

- Care Management and Support (CM)
  - Competency A
    - CM 01 **(Core)** - Identifying Patients for Care Management
    - CM 02 **(Core)** -Monitoring Patients for Care Management
    - CM 03 (Credit) -Comprehensive Risk-Stratification Process
  - Competency B –
    - CM 04 **(Core)** - Person-Centered Care Plans
    - CM 05 **(Core)** -Written Care Plans
    - CM 06 (Credit) -Patient Preferences and Goals
    - CM 07 (Credit) - Patient Barriers to Goals
    - CM 08 (Credit) - Self-Management Plans
    - CM 09 (Credit) - Care Plan Integration

Recognition under Oregon's PCPCH* Standards

PCPCH Core Attribute 5: Coordination and Integration Standard 5.C : Complex Care Coordination

- 5.C.1 PCPCH demonstrates that members of the health care team have defined roles in care coordination for patients, and tells each patient or family the name of the team member(s) responsible for coordinating his or her care.
- 5.C.2 PCPCH describes and demonstrates its process for identifying and coordinating the care of patients with complex care needs.
- 5.C.3 PCPCH develops an individualized written care plan for patients and families with complex medical or social concerns. This care plan should include at least the following: self management goals; goals of preventive and chronic illness care; and action plan for exacerbations of chronic illness.

*PCPCH: Patient-Centered Primary Care Home

Today's Mentors

Both of our Mentors Today are from Region 2 – North Central Public Health District (PHD)

St. Mary's Hospital and Clinics – Cottonwood, Idaho (ID)

Shari Kuther, Registered Nurse (RN), Physician Practice Manager

Clearwater Valley Hospital and Clinics – Orofino, ID

Vicky Peterson, RN, Clinic Manager

Guiding Questions for Mentors – Care Management Strategies

- Describe your clinical setting
- What were your goals and key strategies for developing your care management program?
- Where did you start and what were your first steps in setting up the program?
- How did you finance this effort, if needed?
- What populations did you prioritize in focusing your program? What did you use to assess risk so you could identify those patients?
- Who leads the CM effort and how do they work with the rest of the PCMH team? How does everyone communicate and share information?
- Any specific steps to gain "buy-in" from providers and staff?
- Where are you today? What are your plans going forward?
- Looking back, what were the top 2 challenges or barriers? Your best advice to overcome them?
- What were the major lessons learned from this effort?

Discussion and Sharing

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Mentors' Contact information

St Mary's

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Clearwater Valley

Vicky Peterson, RN, Clinic Manager

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Wrap-Up: Evaluation Survey & Next topics

Look for an Evaluation shortly – GoToWebinar Survey

- Will be sent out in a follow-up email
- Please provide your input on this session and ideas or suggestions for other topics/other mentors

Next Topics:

- Care Management Part 2: Care Plans – TBD January, Mentors TBD

Plan is to continue the mentorship series in 2018

You too can be a Mentor!

Contact your PHD SHIP QI Specialist or your PCMH Coach if you are interested in being a mentor on a topic. Let them know if you have questions you want answered during a future webinar.

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Mentorship Series - Contact information

In addition to your PHD SHIP QI Specialist, can reach out to your own or these PCMH Coaches directly:

- Jeanene Smith
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- Nancy Jaeckels Kamp
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