

Care Coordination Presentation Follow- Up

Questions Directed to Beth Hennessey from the Workforce Core Group

Our care delivery model has been applied to different providers groups and different locations so the answers to these questions varies depending on setting/provider/population. One example is caseload – when applied to home health patients where visits are also conducted by a case manager, the case load is 25 but caseload when applied to employees with chronic disease is targeted to 200/case manager.

The following questions will be answered based on providing this care to a home care patient.

1. What is the required background, recruitment and training of care managers?
 - Care managers are RNs or Physical Therapists with experience in home and community based care, working as a team member, communication among provider types, and accountable for clinical, functional, and service utilization outcomes. Clinicians are trained and certified in integrated chronic care management with includes 12 hours instruction, written examination, and three months demonstration in clinical practice.
2. Is there a certification of care managers?
 - Certification of providers is with the nationally recognized certification program, National Association of Home Care and Hospice.
3. How were patients assigned to care managers?
 - Patients were assigned based on care needs identified through a comprehensive holistic assessment.
 - How many patients per care manager? Twenty-five patients are assigned per case manager but they were also conducting home visits on these patients.
4. What types of providers did they work with?
 - They worked with a team that included: MDs, PCP/Specialists, RN, PT, OT, ST, MSW, Homehealth Aide, Pharmacist, Advance Practice Nurses/Specialists for Cardiac, Diabetes, Wound/Ostomy, Pulmonary, and Palliative Care.
5. What were the roles and responsibilities of care managers?
 - Care Managers were required to be knowledgeable and competent in following domains:
 - Clinical knowledge and skill (evidenced based / best practices)
 - Care resources for patients
 - Transitional planning and care
 - Management skills
 - Teaching and education skills
 - Counseling skills/ behavior change
 - Knowledge of health care financial environment
 - Performance improvement techniques
 - Information systems
 - Ethical /legal issues
 - Technical information skills
 - Outcomes management and evaluation

6. How were they reimbursed?

- They were salaried and received 2% pay increase for certification.

7. What data exist on savings, health outcomes, patient and provider satisfaction?

- Savings were realized for the healthcare plan based on decreases in avoidable hospitalizations and Emergency Room visits
- Savings were realized for the provider in terms of increased staff productivity, decreased overtime and decreased staff turnover.
- An increase in patient and staff satisfaction and engagement were realized.

8. What was the cost of establishing and maintaining the program?

- The primary cost was in the training and coaching of staff to develop and maintain new practice; the training for clinicians is offered for \$700/student; recertification offered every 3 years at cost of \$100/person; other support processes vary by where the agency is starting.
- Resources invested in technology from, EMR, telemonitoring, dashboard for patient and populations, again vary by location depending on what was in place prior to implementing the model.