Incorporating Community Resources

0

Into your Care Coordination Program

Building Leaders – Transforming Hospitals – Improving Care

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45 Years of Delivering Results

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HealthTechS3 is a 45 year old, award-winning healthcare consulting and strategic hospital services firm based in Brentwood, Tennessee with clients across the United States.

We are dedicated to the goal of improving performance, achieving compliance, reducing costs, and ultimately improving patient care. Leveraging consultants with deep healthcare industry experience, **HealthTechS3** provides actionable insights and guidance that supports informed decision making and drives efficiency in operational performance.

Our consultants are former hospital leaders and executives. **HealthTechS3** has the right mix of experienced professionals that service hospital clients across the nation. **HealthTechS3** offers flexible and affordable services, consulting, and technology as we focus on delivering solutions that can be implemented and provide a positive, measurable impact.

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STRATEGY – SOLUTIONS – SUPPORT

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GOVERNANCE & STRATEGY

- Affiliation Consulting
- Executive & Management Leadership Development
- Strategic Planning & Market share Analysis
- Community Health Needs Assessment
- Compliance Consulting Services

FINANCE

- Performance Optimization / Margin Improvement
- Revenue Cycle & Business Office Operations
- Productivity & Staffing Consulting - Optimum Productivity Toolkit

CLINICAL CARE & OPERATIONS

- Continuous Survey Readiness
- Quality Assurance Performance Improvement
- Lean Culture
- Customer Experience
- Clinical Resource Management
- Care Coordination – Primary Care Practice
- Physician Practice & Clinic Assessment
- Long Term Care Consulting
- Swing Bed Consulting
- Perioperative Services Consulting

RECRUITMENT

- Executive Recruitment
- Manager and Clinical Positions
- Physician / Provider Recruitment
- Information Technology Professionals
- Interim Placement

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4TH Quarter Webinars

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CMS Revises Swing Bed Standards – What's New?– What's the Same? – Are You Ready?
Host: Carolyn St.Charles, RN, BSN, MBA, Regional Chief Clinical Officer
October 5, 2018 at 12pm CST
https://bit.ly/2wJsa93

Relationship-Based Telehealth: Incorporating Telehealth into your Care Coordination Program
Hosts: Faith M Jones, MSN, RN, NEA-BC, HealthTechS3 Director of Care Coordination
October 11, 2018 at 12pm CST
https://bit.ly/2MoaGdY

Interim Leadership: Ensuring A Catalyst for Change
Host: Jennifer LeMieux, CRCR, BS, MBA, Strategy Consultant, HealthTechS3
October 25, 2018 at 12pm CST
https://bit.ly/2Q3ujoF

All Webinars are Recorded

Strategies for Meeting the Healthcare Needs of At-Risk Populations
Host: Carolyn St.Charles, RN, BSN, MBA, Regional Chief Clinical Officer
November 2, 2018 at 12pm CST
https://bit.ly/2CwrmKT

Advance Care Planning: It's about the Conversation not the Form
Host: Faith M Jones, MSN, RN, NEA-BC, HealthTechS3 Director of Care Coordination
November 15, 2018 at 12pm CST
https://bit.ly/2MPqrtB

Critical Access Hospitals - Anything New for 2019?
Host: Carolyn St.Charles, RN, BSN, MBA, Regional Chief Clinical Officer
December 7, 2018 at 12pm CST
https://bit.ly/2NPgysk

Getting Organized with Lean: 5S for the New Year!
Host: Faith M Jones, MSN, RN, NEA-BC, HealthTechS3 Director of Care Coordination and Lean Consulting
December 13, 2018 at 12pm CST
https://bit.ly/2Q5OmCU

Instructions for Today's Webinar

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- You may type a question in the text box if you have a question during the presentation
- We will try to cover all of your questions – but if we don't get to them during the webinar we will follow-up with you by e-mail
- You may also send questions after the webinar to our team (contact information is included at the end of the presentation)
- The webinar will be recorded and the recording will be available on the HealthTechS3 web site: www.healthtechs3.com

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Faith M Jones, MSN, RN, NEA-BC

Director of Care Coordination and Lean Consulting

Faith Jones began her healthcare career in the US Navy over 30 years ago. She has worked in a variety of roles in clinical practice, education, management, administration, consulting, and healthcare compliance. Her knowledge and experience spans various settings including ambulance, clinics, hospitals, home care, and long term care. In her leadership roles she has been responsible for operational leadership for all clinical functions including multiple nursing specialties, pharmacy, laboratory, imaging, nutrition, therapies, as well as administrative functions related to quality management, case management, medical staff credentialing, staff education, and corporate compliance. She currently implements care coordination programs focusing on the Medicare population and teaches care coordination concepts nationally. She also holds a Green Belt in Healthcare and is a Certified Lean Instructor.

Healthcare Focus | 45 Year Company History | Experienced Consultants | Technology Partnerships

Objectives

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Upon completion of the webinar, the participant will understand:

- The community resource requirements for Chronic Care Management
- How to identify community resources
- How to invite community resources into the patient's care

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Elements of Chronic Care Management

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Practice Eligibility	Patient Eligibility
• Qualified EMR • Availability of electronic communication with patient and care giver • **Collaboration and communication with community resources & referrals** • After hours coverage • Care Plan Access • Primary Care Provider supervision of clinical staff	• Medicare Patient • Two or more chronic conditions expected to last at least 12 months or until the death of the patient • At significant risk of death, acute exacerbation, decompensation, or functional decline without management • Patient Consent • CCM initiated by the primary care provider • Documentation of at least 20 minutes per calendar month spent coordinating care

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Productivity of Care Coordinator

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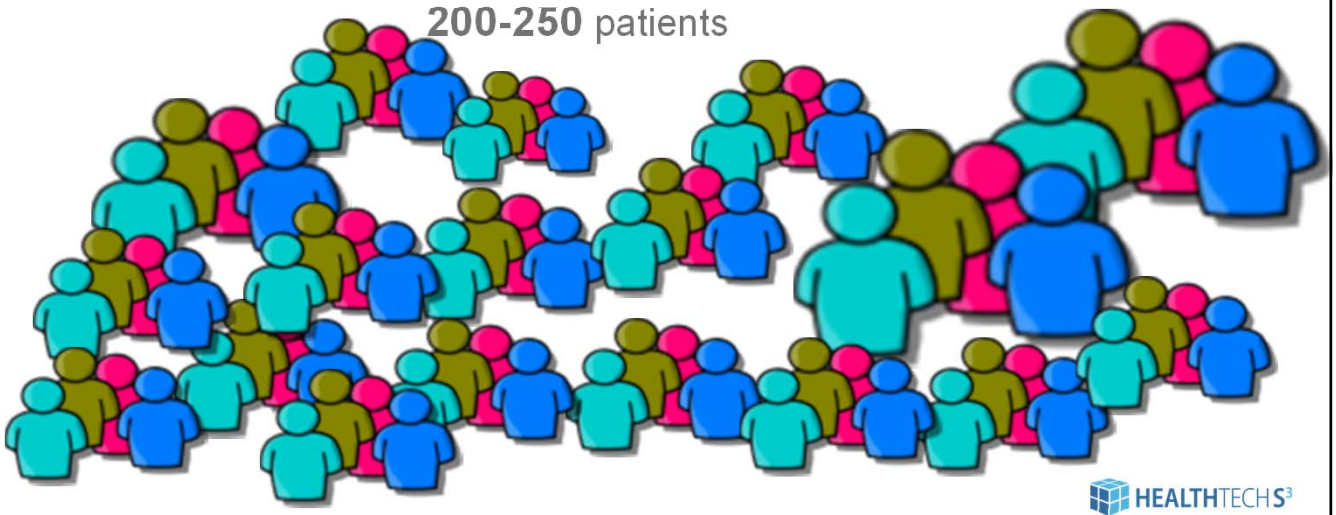
Overall a care coordinator should be able to do care coordination on **200-250** patients



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Productivity of Care Coordinator

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Let's do the Math…

225 patients x 20 min/month = 4500min/60 = 75 hours x 12 = 900 hours/year

25 patients x 60min/month = 1500min/60 = 25 hours x 12 = 300 hours/year

250 annual wellness visits x 1 hour each = 250 hours

250 ACP visits x 1 hour each = 250 hours

Direct care coordination time total of **1700 hours per year**

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Productivity of Care Coordinator

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Full time = **2080 hours per year…**

Direct care coordination time total of **1700 hours per year**

Community Resource interaction and recruitment 4 hours per week x 50 weeks time total of **200 hours per year**

Vacation, Holidays, Education time **180 hours per year**

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Skill Translation

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Learned Care Coordination

- Education
- Experience
- Terminology
- Structure

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The voyage of discovery
is not in seeking new landscapes
but in having new eyes.

Marcel Proust

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The Entire Care Team

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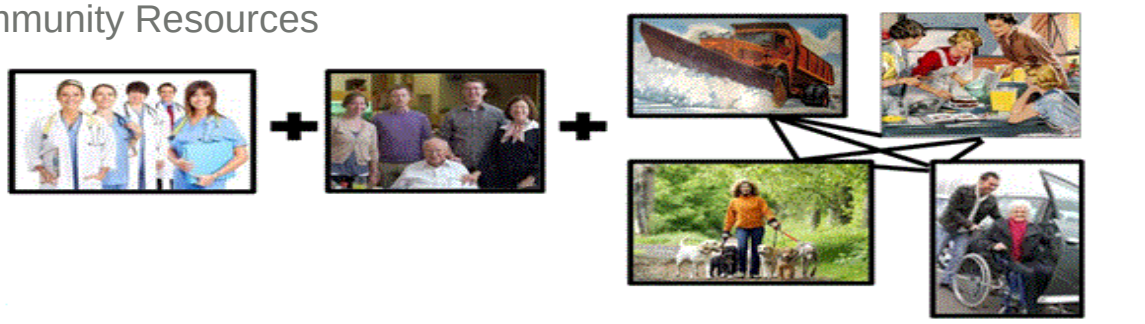
HealthCare and Health

- Clinic Staff and Other Professionals
- Patient
- Family and Care Givers
- Community Resources



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The Care Team

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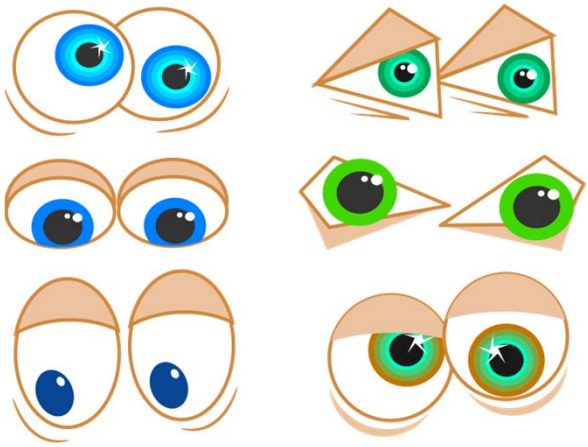
Community Resources



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Shared Goals

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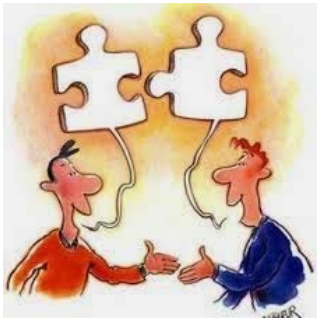
Communicating and Relationship Building



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The Community Resources and The Care Plan

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- The Ask
  - It's about the care plan

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Information Gathering

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- Seek out info
- Care Coordinator contacts Community Resources
  - Recruit
  - Build Network
  - Invite to Care

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Inviting into the Patient's Care and HIPAA

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In the consent for CCM during enrollment:

My agreement also authorizes my primary care provider and other care team members related to the primary care provider practice to electronically communicate my medical information with other treating providers and home and community resources as part of the care coordination involved in chronic care management services.

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Information Gathering

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- Intake information
- Bi-directional
  - Contact initiated by community resource or Care Coordinator
    - Phone
    - Visit
    - Email
    - Get signed up in CrossTX

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Information Gathering

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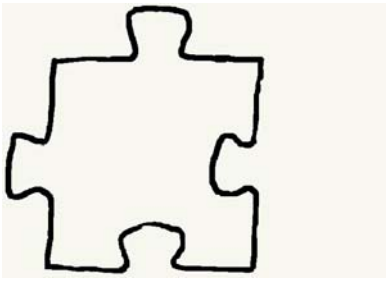

Each piece separately might not mean anything

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Putting the Pieces Together

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- See the Big Picture

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Thank you!

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If you would like more information or would like to discuss implementing or expanding our care coordination program, please feel free to contact me.

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strategy solutions support

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