Case Management Society of America Chicago Chapter 25th Anniversary Conference Thursday, April 19, 2018

Kate LaFollette, RN

Quality Improvement Organizations
Sharing Knowledge. Improving Health Care.
CENTERS FOR MEDICARE & MEDICAID SERVICES

Telligen

Welcome & Introductions

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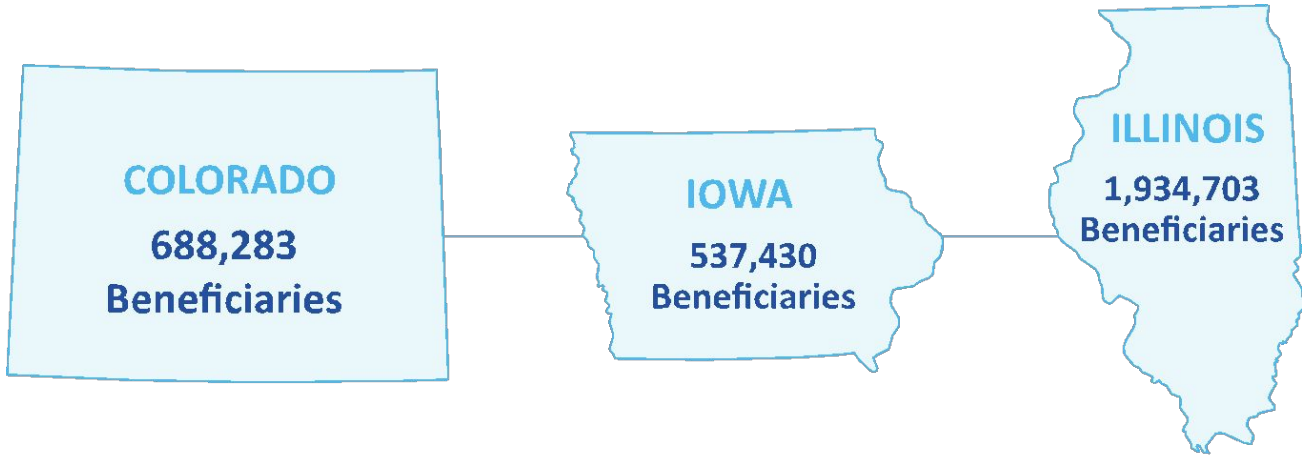


TOTAL BENEFICIARIES = 3,160,416

Data Source: Medicare Enrollment: Hospital Insurance and/or Supplementary Medical Insurance Enrollees, as of July 1, 2012, http://kff.org/other/state-indicator/hospital-supplementary-enrollees/

What We Do

AREAS OF FOCUS

Antibiotic Stewardship: Helping outpatient care settings prevent antibiotic overuse and misuse

Cardiac Health: Preventing heart attacks and strokes through evidence-based practice

Care Coordination and Medication Safety: Collaborating with communities to reduce avoidable hospitalizations

Diabetes Care: Providing diabetes self-management education classes and improve clinical outcomes

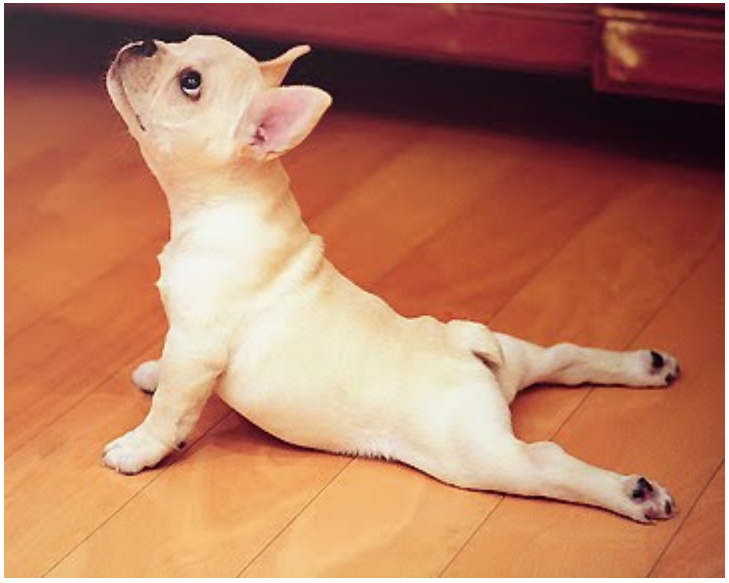
Immunizations: Promoting flu, pneumonia, and shingles vaccinations

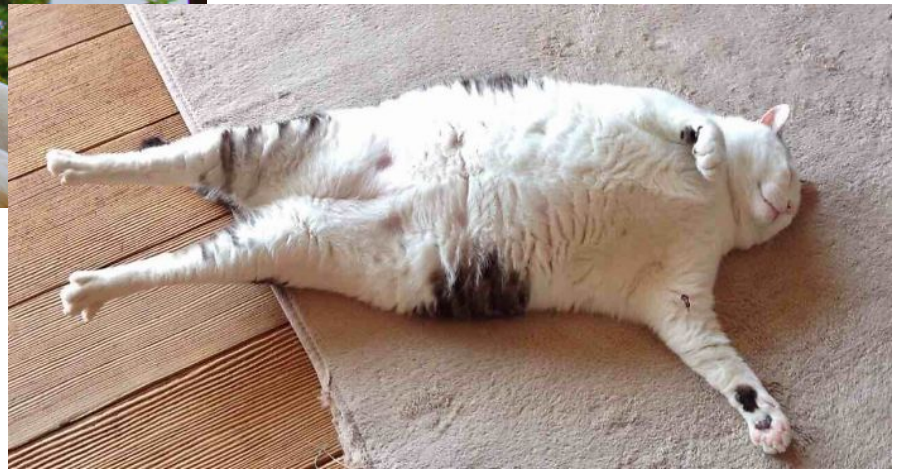
Nursing Home Care: Using quality improvement strategies to improve care

Quality Payment Program: Helping Medicare providers transition from fee-for-service to value-based care

Transforming Clinical Practice Initiative: Conducting quality improvement assessments

How about you?



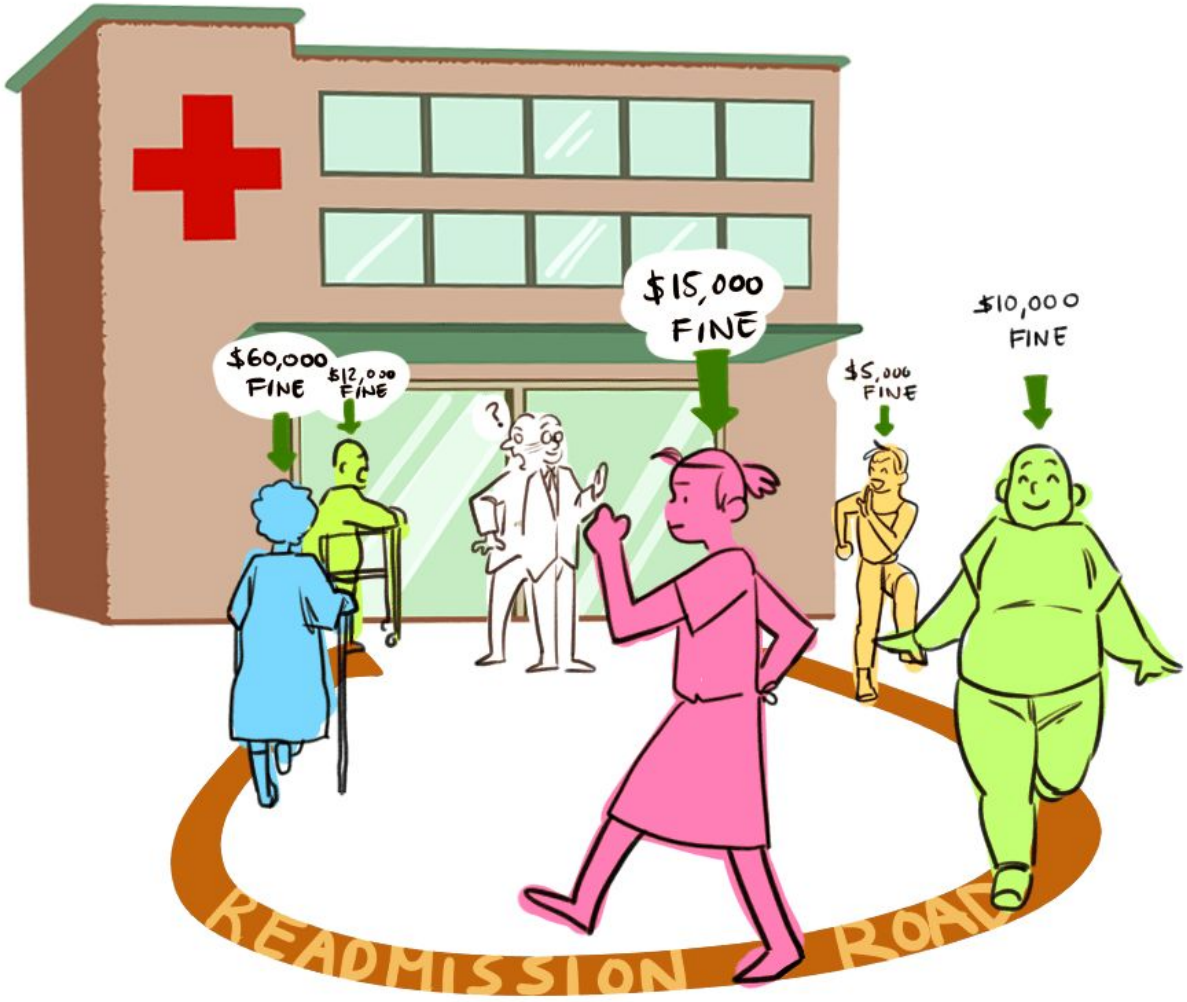


For Today

- Discuss benefits of coordinated care
- Identify strategies to overcome barriers
- Share best practices for sustainability

How Did We Get Here?!

Why This Matters Now



The Impact of Readmissions

"The negative consequences of fragmented care may include the duplication of services, inappropriate or conflicting care recommendations, medication errors, patient and caregiver confusion and distress, and higher costs of care."

Carla Parry, PhD, MSW, Eric A. Coleman, MD, MPH, Jodi D. Smith, ND, GNP, Janet Frank, DrPH, and Andrew Kramer, MD. "The Care Transitions Intervention: A Patient-Approach to Ensuring Effective Transfers Between Sites of Geriatric Care." *Home Health Care Services Quarterly* 22.3 (2003): 1-17. Print.

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Coordinated Care

Involves ***deliberately organizing*** patient care activities and ***sharing information*** among all concerned with a patient's care to achieve **safer and more effective care**

From AHRQ (Agency for Healthcare Research and Quality)

Case Management

A collaborative process

- Assesses
- Implements
- Coordinates
- Monitors
- Evaluates

Options and services required to meet health and human service needs

Characterized by

- Advocacy
- Communication
- Resource management
- Promotes quality
- Cost effective
  - Interventions
  - Outcomes

Strategies to overcome barriers

- Blue post-it
  - Barriers you encounter frequently
- Pink post-it
  - Make a Wish!!

Recurring Themes

Best Practices

- Teamwork
- Care management
- Medication management
- Health information technology
- Patient-centered medical home

Specifically…

- Establishing accountability and agreeing on responsibility
- Communicating/sharing knowledge
- Helping with transitions of care
- Assessing patient needs and gals
- Creating a proactive care plan
- Monitoring and follow-up, including responding to changes in patients' needs
- Supporting patients' self-management goals
- Linking to community resources
- Working to align resources with patient and population needs

But **HOW** do we do that?!?!

- Community Coalition meetings
- Collect data
- Learn Quality Improvement basics

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Questions

Contact Information

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This material was prepared by Telligen, the Medicare Quality Innovation Network Quality Improvement Organization, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. 11SOW-IL-C3-04/12/18-2689