

Care Coordination to Support Palliative Care

July 2, 2020

Presented By: Faith Jones, MSN, RN, NEA-BC



Upon completion of the presentation, the participant will understand:

1. The elements of Chronic Care Management
2. How Palliative Care needs and be identified and met in the CCM program
3. How to develop relationships and resources

“Our goal is to recognize the trend toward **practice transformation** and overall improved quality of care, while preventing **unwanted** and **unnecessary** care”

CMS CFR 11-12-2014

Care Coordination Growth and Development

Team Based
Care
AWV 2011

2013/2015:
TCM / CCM Care
Management

2016: Chronic
Care
Management for
RHCs and FQHCs
and Advance
Care Planning

2017: Complex
CCM, Behavior
Health Integration,
Collaborative Care
Management
2018: RHC and
FQHC Care
Management and
the Diabetes
Prevention Program

2019: Team based
Documentation,
Chronic Care
Remote
Physiological
Monitoring
(CCRPM)

2020: Additional Time
allowed for CCM, Expand to
allow for billing of concurrent
services, Principal Care
Management (PCM)

Practice 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

Patient Eligibility

- Medicare Patient (some other ins)
- 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

The IOM (Institute of Medicine) defines patient-centered care as:

"Providing care that is respectful of and responsive to individual patient preferences, needs, and **values**, and ensuring that patient values guide all clinical decisions."



Comprehensive \neq Complicated

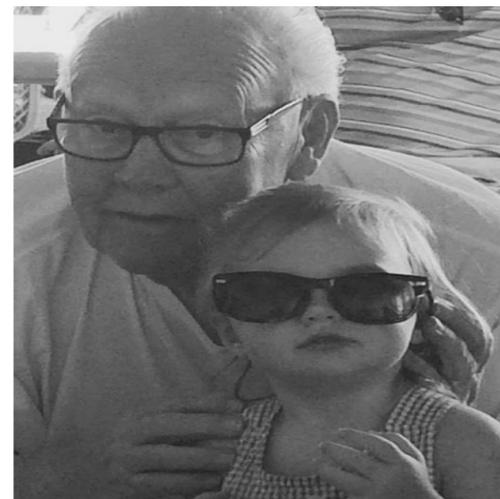
Change over time
Short Term
Long Term



Relationships
Developing over time

4Ms

#1 What matters to the patient?

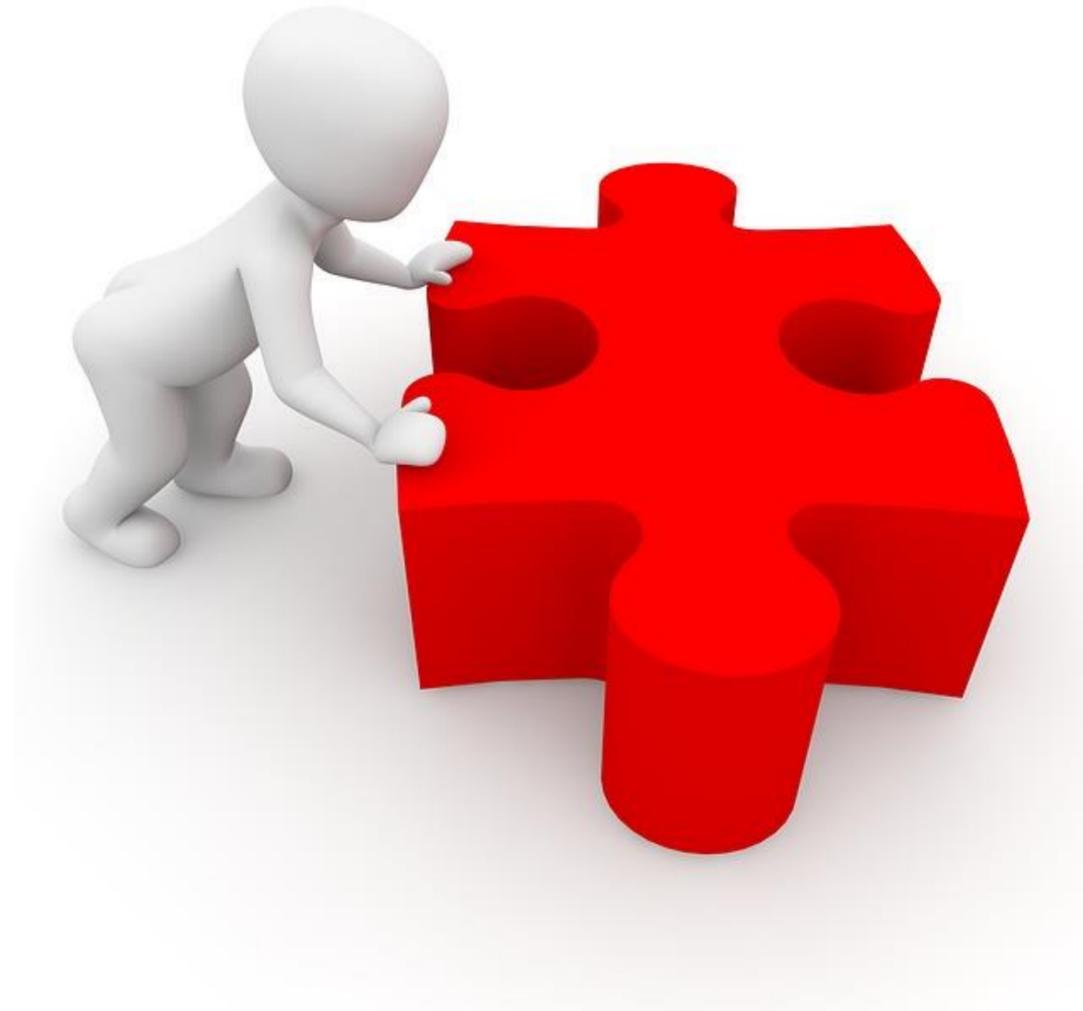


CCM

- 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
 - **Represents 68.6% of all Medicare patients**

Palliative Care

- Seriously ill patients
- Management of disease symptoms
 - **Represents at least some of the CCM patient population**



HealthCare and Health

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



Never too early to start planning...

- Identify your Patients
- Build relationships with them to be able to have the “what matters to you” conversation – Really Listen
- Get to know your Community Resources
 - What skills do they have
 - What would they need to learn
 - Resources for the family/care givers
- Healthcare personnel
 - Palliative Care Specialist
 - Pain Specialist
 - Specialists to help with emotions/stress/anxiety
 - Specialists to help with mobility
 - Referrals – etc.



THANK YOU



Faith M Jones, MSN, RN, NEA-BC
Director of Care Coordination
and Lean Consulting

I hope this information has been helpful!

HealthTechS3

5110 Maryland Way, Suite 200
Brentwood, TN 37027

Office

476 N Douglas St
Powell, WY, 82435
307-272-2207

Website: www.healthtechs3.com

Faith.Jones@HealthTechS3.com

Questions?

