2024
Indian Health Service Partnership Conference

Case Management & PRC Fundamentals

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Purchased/Referred Care

As defined in 42 CFR 136:

"Purchased Referred Care means health services provided at the expense of the Indian Health Service from public or private sector medical or hospital facilities other than those of the Service."

Purchased/Referred Care (PRC) Program

- The purchase of health care from private providers through the PRC program is an integral component of the Indian health system.
- PRC is funded each year through appropriations by the U.S. Congress.
- PRC **is not** an entitlement program and **does not** guarantee payments.
- PRC **is not** an insurance program.

Case Managers

- Who are they?
- They are nurses who are able to facilitate the care of our patients in a cost effective manner while ensuring the patient's needs are met.
- Case Managers (CM) in PRC is not a new concept. Many PRC programs have had Case Managers for several years.
- What to do if your PRC program does not have a Case Manager?
- Use your resources wisely. Get with the Nurse Manager in the IHS/Tribal (I/T) clinics and work with them to ensure our patient's care is managed.

PRC Case Management

- PRC programs can design their programs to meet the needs of the patient population.
- Components of PRC Case Management include Catastrophic health event fund (CHEF), referral management, follow up from specialty physician appointments, emergency room and inpatient stays.
- Oversee all patients in the hospital and assists admitting facility staff with transition of care
- Reviews all emergency rooms visits records and coordinates care if needed
- Manages chronic disease management patients referred by the primary care team
- Assist PRC with complex referrals upon request
- Completes or assists with pre authorization of service for patient on third party resource
- Create and manage CHEF cases.

PRC Case Management (con't)

- Negotiating, procuring and coordinating services and resources.
- Case managers are responsible for providing the most cost effective care that is safe and results in the best outcome for the patient
- Coordinates care with local, tribal, community, and state services to support the patient health care needs
- Use of clinical reasoning processes to facilitate a positive outcome.
- Utilizes critical thinking skills such as screening, assessing, planning, implementing, follow up, transition and evaluating while considering the PRC rules and regulations

Catastrophic Health Emergency Fund (CHEF) cases

The CHEF Fund

- By definition these cases are catastrophic and will need follow up. The cases may include any diagnosis which can include trauma, oncology and chronic health conditions which have acute exacerbations (not an inclusive list).
- The PRC Case Manager can identify other chronic conditions which can be submitted for CHEF cases such as dialysis, oncology, and complex wound care.
- CHEF cases threshold is currently >$25,000 per episode of care (usually inpatient stay)
- Services within 90 days of the episode of care can be included in CHEF case if related to primary diagnosis
- The nurse Case Manager must sign the CHEF worksheet, if no Case Manager then the Medical Director must sign.

Referral Management

- The referrals are a physician's order.
- Identify patient needs, current services and available resources, connecting the patient to services /resources to meet medical requirement.
- Serve as an advocate for the patient: Document case management and medical treatments to include any necessary referrals/ patient appointments; keep active communication with the outpatient, inpatient and emergency department nurse case managers, enhancing patient care.
- Ensure contracted vendors utilize Medicare Like Rates (MLR) for reimbursement; educate both patient and vendor on referral purpose and visits authorized.
- If an outside provider requests additional referrals- a new referral must be written by the primary health care team (physician &/or case manager) and receive authorization from the PRC committee, before funds can be allocated.

Referral Management (con't)

Some service units have local practice standards that allow the nurse Case Manager to enter the referral on the providers behalf. The recommendations of care documented in the Vista images by a referring provider (i.e. Emergency Department, specialty provider, or inpatient discharge summary). This is usually utilized for ongoing care not initiation of care. The service unit would need a policy in place to support this practice.

This practice can:

- Prevent a delay in care.
- Prevent an unnecessary clinic visit.
- Improve continuity of care.

Follow up

- Our patient population typically has multiple complex co-morbidities. If they are in the hospital for one diagnosis other health concerns can arise and need specialty consultation.
- If a patient is transferred out for a higher level of care the Case Manager must follow that patient. This includes assisting in arranging outpatient care or working with the outside facility to have the patient transferred back into the system (if appropriate).

Closing the Referral Loop

- Closing-the-loop requires bi-directional information sharing and communication between practices.
- Practices should log and track every referral request through completion.
- Receiving practices should also log referrals and notify requesting practices of the referral request disposition, including appointment date and time, and if referral is not appropriate or if unable to schedule.

Why is Closing the Loop Important

- Closing-the-loop for clinical referrals improves patient safety and satisfaction, as well as clinical care coordination.
- Lack of referral tracking can lead to inefficiency and frustration and ultimately adverse patient outcomes.
- Many referrals are not completed. Of the ones that are completed, notes are often not sent back to referring practices, leaving them unaware of new diagnoses or changes. It is imperative the referrals have adequate follow-up.
- Closing the loop can decrease fragmented care ensuring care is timely, appropriate, cost effective, sensitive and coordinated.

Practice Standards

Practice standards will vary based on site specific models. For example some sites are PRC only sites and do not have a direct care service component. The practice at a PRC only site will differ from a direct care site.

Reports generated from the Referred Care Information System (RCIS) or the Electronic Health Record (EHR) can be printed to show whether there has been an appointment scheduled.

Case Manager Tasks

- Working directly with clients at home or in hospitals. We must look at the patient from a holistic standpoint.
- Finding out the needs of clients and helping them reach their goals or fulfill their needs. This may require a referral to another program or Benefit Coordinator.
- Maintaining electronic case records, working with various agencies, acting as an advocate between agencies and clients
- Case Managers may have/share Care Coordinator duties

PRC RN Case Manager's role in the Managed Care Committee

The PRC Managed Care Committee function is to review PRC referral requests and notifications regarding emergency episodes of care and to determine medical priority and rank based on relative medical need within the same medical priority level. Utilizing physician approved Medical Priorities the PRC nurse case manager will review the referrals daily assigning a priority rating to the case, only the medically complex cases will be sent for medical oversight. If the service unit does not have a nurse case manager then the referrals will need to be sent to the PRC review committee for priority rating.

Woodrow Wilson Keeble Memorial Health Care Center (Sisseton Service Unit)

Patient Centered Medical Home

What is PCMH?

- The patient-centered medical home is a model of care that puts patients at the forefront of care. PCMHs build better relationships between patients and their clinical care teams.

- Research shows that PCMHs improve quality and the patient experience, and increase staff satisfaction—while reducing health care costs. Practices that earn recognition have made a commitment to continuous quality improvement and a patient-centered approach to care. It is a model of care that puts the patient at the center of their care

- **“It’s not a place… It’s a partnership with your primary care provider”**

https://www.ncqa.org/programs/health-care-providers-practices/patient-centered-medical-home-pcmh/

Patient Centered Medical Home

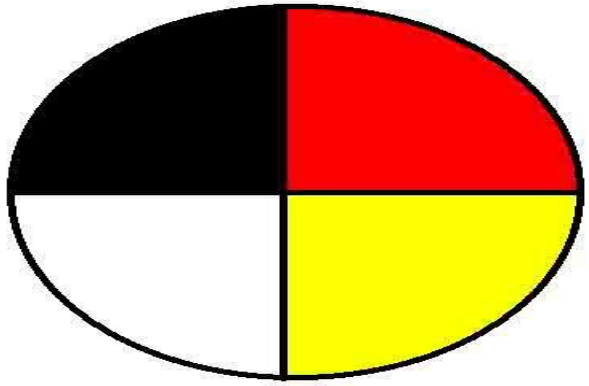
PCMH Managed Care Team

Teams: Black, Red, and Yellow

- Yellow teams - adult health
- Red team - Pediatrics, OB/GYN and Women's health
- Black team – same day and specialty clinic

The CORE PCMH team members:

- Provider
- Clinic Nurse
- Case Manager
- Care Coordinator
- PRC Rep
- Health Information Management



PCHM Team Initiatives

Monthly Team meetings

- Communication
- Data
- Processes and updates

Morning huddles

- Core team meet each morning to discuss previous day patient and communicate care needs
- Discuss scheduled patient for the day
- Non urgent matters are brought to huddle to discuss

Quality Department expansion

- Hired Quality Management Director in 2023
- Leads Quality Improvement Process Improvements projects for the facility

PRC staff roles

- 3 Schedulers
  - Schedules all appointments
  - Attends PRC meetings
  - Attends Huddles
- 1 MSA
  - Answers phone and window
  - Update referrals that are called in
- 1 Budget tech
  - Ensures funds are available
- 2 Billers
  - Issues the purchase orders
  - Works with vendors on payment issues

Case Management Supervisor

- Identify process improvements with nursing leadership
- Establish PCMH best practices to ensure staff is meeting the elements of performance standards set by the accreditation bodies (AAAHC)
- Develop templates in EHR
- Create policies to support the Case manager (CM)/Care coordinator (CC) roles
- Educates tribal, community, and other health care partners on the roles of the CM/CC
- Monitors performance and submit productivity reports to executive staff
- Provides guidance to CM/CC when needed
- Review CHEF report, identify cases and submit to HQ

Case Management Role

3 Case Managers- RNs

- Oversee all patients in the hospital from admit to discharge. Calls patient within 72 hours of discharge to ensure care needs are met
- Reviews all emergency rooms (ER) visits records and coordinates care if needed
- Manages chronic disease management patients referred by the primary care team
- Assist PRC with complex referrals
- Assist with pre authorization of service for patient on third party resource
- Liaison between the care team and PRC
- Nurse educators for patients and staff

Care Coordinator Role

3 Care Coordinator- RNs

- Review specialty clinic notes
- Ensure pre-op information is completed in a timely manner
- Referral manager
  - Ensuring loop is closed
  - Assisting with difficult/complex referrals
  - Assisting with authorization from 3rd party resource, appeals of 3rd party coverage, and navigating the appeal process

Standardized Case Management Practices

Note titles

- CMD- Outside Admission
- CMD- Transition of Care – ED
- CMD- Transition of Care – IP
- CMD- Disease Management
- CMD- Case Management
- CMD- Care Coordination
- CMD- Referral
- CMD- Chart Review
- CMD- Telephone
- CMD- Letter
- CMD- Record Review

Standardized Case Management Practices

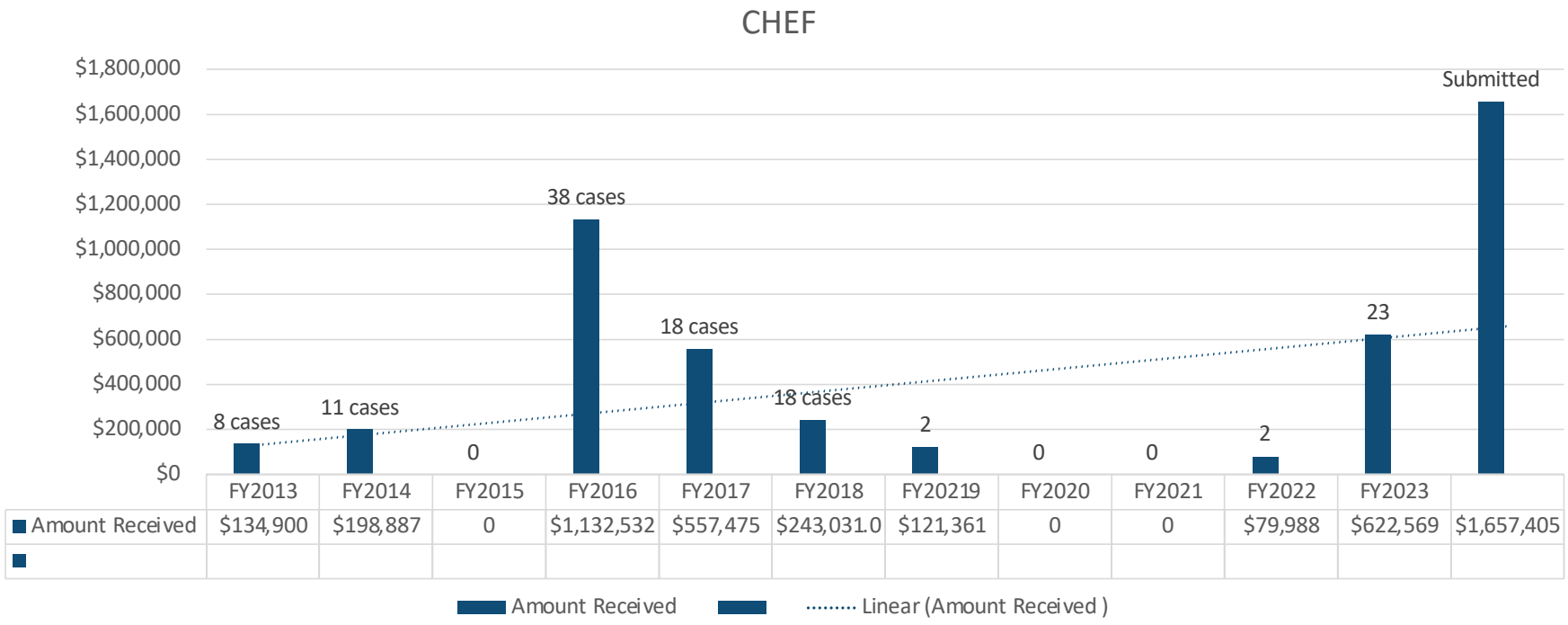
Templates:

-  Chart Review-CMD
-  Letters Patient - SIS-CMD
-  Outside Hospital Admission-GPA-CM
-  Record Review-GPA-CM
-  Telephone Call CMD - Combined
-  Transition of Care-

Case Management Policies

- Case Management Consult
- Case Manager Focus
- Referral Guidelines
- More policies are needed to standardize case management practices!

CHEF Data



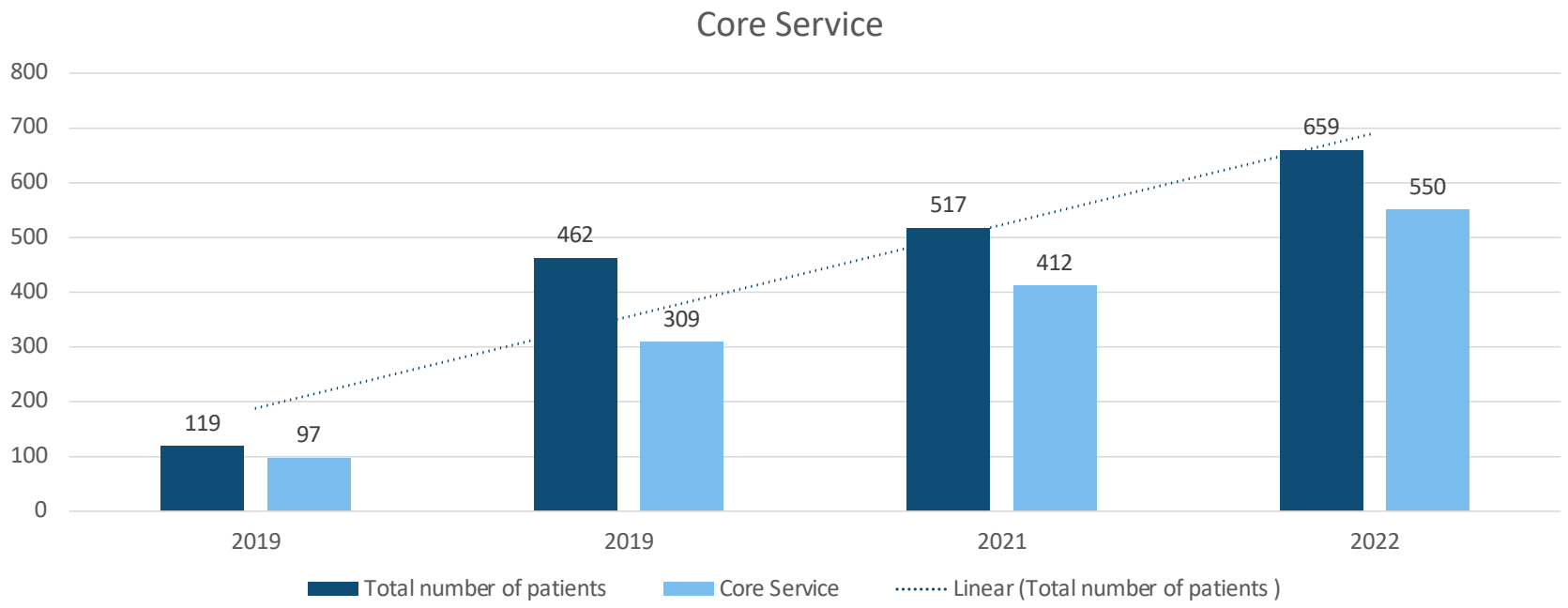
	FY2013	FY2014	FY2015	FY2016	FY2017	FY2018	FY20219	FY2020	FY2021	FY2022	FY2023	
Amount Received	$134,900	$198,887	0	$1,132,532	$557,475	$243,031.0	$121,361	0	0	$79,988	$622,569	$1,657,405

South Dakota Health Home program for Medicaid patients

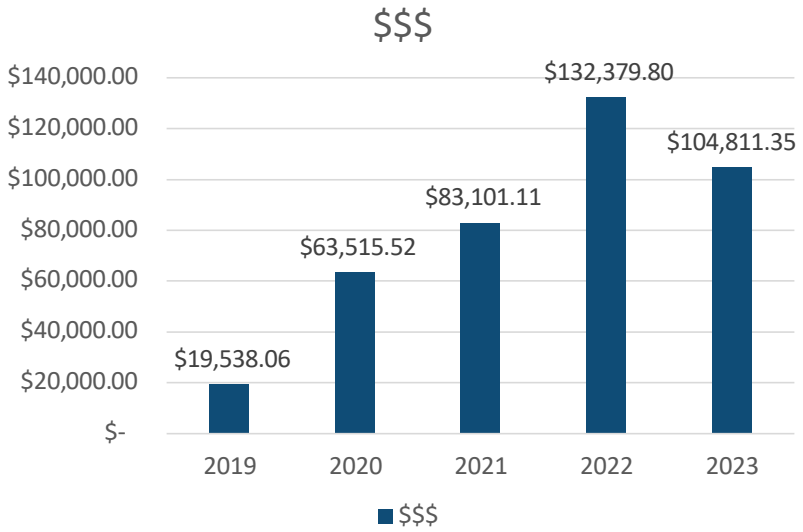
Core Services

- Comprehensive Care Management
- Care Coordination
- Health Promotion
- Comprehensive Transitional Care (including appropriate follow up within 72 hours from outpatient/inpatient to other settings including home)
- Individual and Family Support
- Referrals to Community and Social Support Services

Health Home data



Home Health Reimbursement



South Dakota Medicaid
Health Home PMPM Fee Schedule
Effective July 1, 2022

Providers should refer to South Dakota Medicaid's provider manual webpage for applicable coverage criteria and claim instructions: https://dss.sd.gov/medicaid/providers/billingmanuals/.

Community Mental Health Center		
Tier 1	$	11.77
Tier 2	$	43.12
Tier 3	$	62.72
Tier 4	$	197.24

Primary Care Provider		
Tier 1	$	11.77
Tier 2	$	37.90
Tier 3	$	64.03
Tier 4	$	308.18

The state developed fee schedules are the same for both governmental and private providers

South Dakota Medicaid
Health Home PMPM Fee Schedule
Effective January 1, 2023

Providers should refer to South Dakota Medicaid's provider manual webpage for applicable coverage criteria and claim instructions: https://dss.sd.gov/medicaid/providers/billingmanuals/.

Community Mental Health Center		
Tier 1	$	11.77
Tier 2	$	43.12
Tier 3	$	62.72
Tier 4	$	160.00

Primary Care Provider		
Tier 1	$	11.77
Tier 2	$	37.90
Tier 3	$	64.03
Tier 4	$	250.00

The state developed fee schedules are the same for both governmental and private providers

Whiteriver Service Unit (WRSU)

Care Management At WRSU

Case Management Department developed in 2015

- Discharge Planners
- Case Managers

Outpatient Department

- DME Coordinator
- Clinical Care Coordinators for the Primary Care Clinics (position opened in 2013)
- Women's Health Coordinator transitioned to nursing in 2014

PRC Supervisor transitioned to a Supervisory Nursing Position in April of 2023.

Team Initiatives

Meetings:

- All members of Case Management attend the weekly PRC committee meetings
  - Pre Pandemic the CCCs presented the referrals in person
  - Due to space, Meetings are still on Webex with everyone reviewing the cases prior to the meeting
- Icare for managing Fiscal Year Referrals
- Icare for ensuring referrals get entered for transfers from the Facility
- Members of the HQ/ORAP PRC metrics

Case Management Role

2 Types of Case Managers: Currently 4 total

- Discharge Planners – Manage patients admitted to our facility
- Case Managers – Manage patients who are admitted in outside facilities

Duties:

- Entering consults and referrals for follow up needs for patients as appropriate
- Assist the DME coordinator with obtaining DME equipment for admitted patients
- Working closely with the Clinics on follow up appointments with the care team
- Working with other members of the Care Team to obtain appointments and supplies as appropriate

Outpatient Department Role

DME Coordinator- 1 RN:

- Obtaining orders for DME equipment for patients
- Verifying payor source
- Entering Referrals, and forwarded the orders to the appropriate DME company
- Following up on these orders

Clinical Care Coordinator- 5 total or one per care team:

- Assisting patients with navigation of their healthcare
  - Specifically entering Referrals and consults for specialty care as directed by the Provider
- Assisting with Referrals for patients who are not PRC eligible so that care they need is received

Outpatient Department Role (2)

Women's Health Coordinator- 1 RN:

- Manages the High Risk Prenatal List
  - Ensuring RCIS are entered, approved and faxed
  - Works with the PRC Scheduler on getting these appointments
- Manages Mammograms for all Women of the Service Unit
  - Entering Consults for the Internal Screenings
  - Entering RCIS for Diagnostic testing
  - Documentation of the results in EHR
  - Assisting patients with getting appropriate follow up
- Managing GYN referrals to outside facilities similar to Mammograms
- Using iCare to follow up on Abnormals that require more frequent follow ups

PRC Supervisor Role

PRC Supervisor Role:

- Educate staff and vendors on PRC process
- Weekly PRC meetings
- Work directly with all members of case management on communication between PRC and Case Management members
- Ensuring that the PRC process works seamlessly with the communication of every member of the Care team and outside departments.
- Conducting Chart reviews for Appeals and Problem Referrals
- Reviews CHEF report, Identify cases and submit to HQ
  - Over $1 Million dollars in the last 18 months after no cases in 10 years
- Participation in the HQ/PRC reporting metrics

Lessons Learned

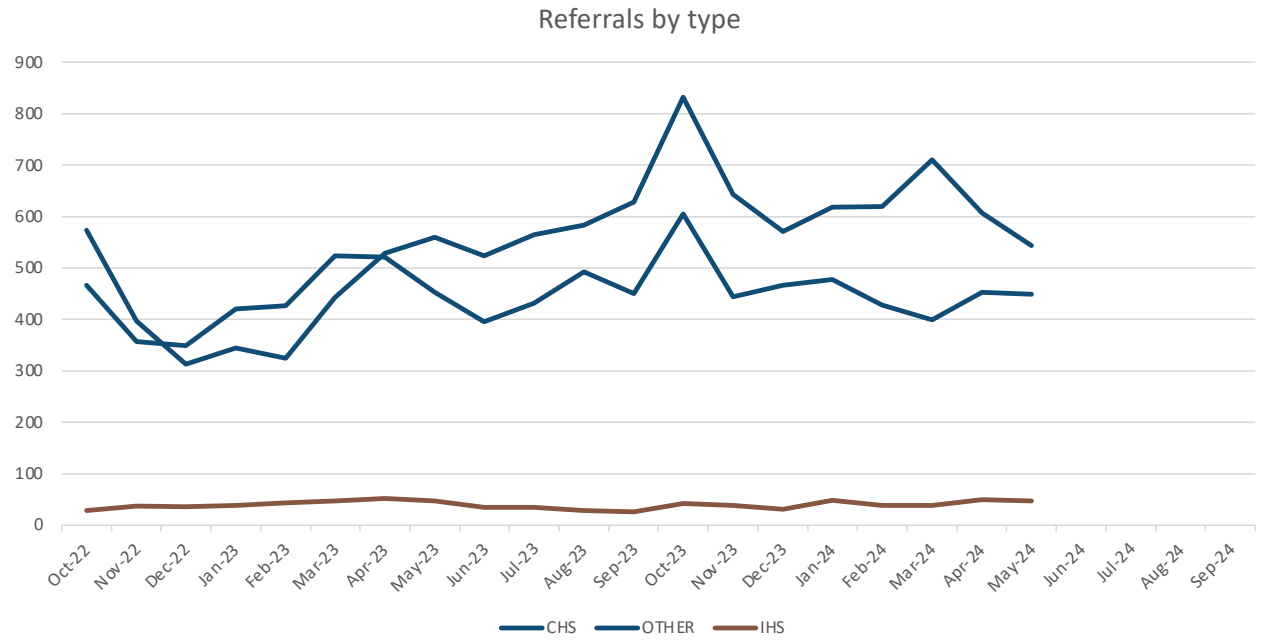
Communication between all members of the Care Team is essential for ensuring timely medical care.

Having a Nurse directly in PRC whose focus is 100% on the PRC process is crucial to ensure continuity of care and high risk patients are followed.

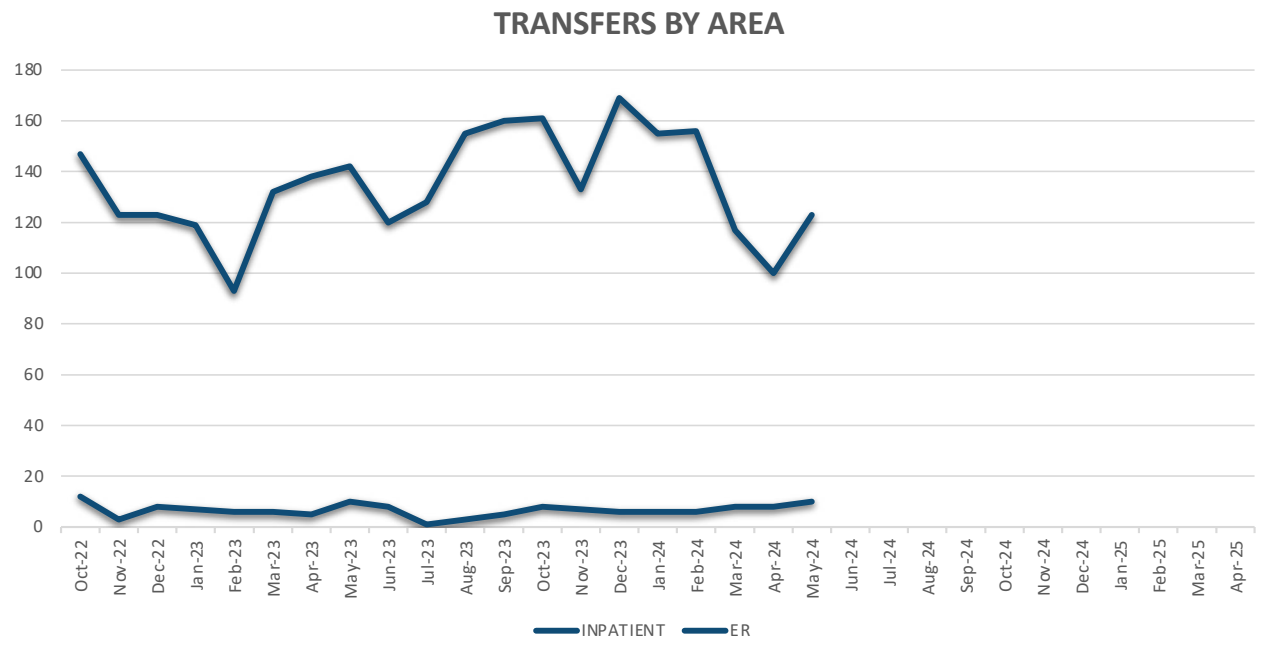
Case Managers and care coordinators initiate referrals as directed by the providers prevents the lapse in care, unnecessary clinic appointments and improves the care team flow and efficiency.

Each Member of the care team is important, even in the PRC process.

Workload of PRC Referrals



Transfers


TRANSFERS BY AREA
180
160
140
120
100
80
60
40
20
0
Oct-22
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Apr-25
INPATIENT
ER

Contact Information

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Questions

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