2023 Indian Health Service Partnership Conference

Case Management & PRC Fundamentals

Robin Watkins, MSN, RN, CCM
FI Project Officer
IHS/ORAP/Division of Contract Care

Leah Westover, MSN, RN
PRC Supervisory Nurse
Whiteriver Service Unit

Jencie Rubio Majano, MSN, RN
Case Management Supervisor
Woodrow Wilson Keeble Memorial
Health Care Center

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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 Management

Collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote quality, cost-effective outcomes (Case Management Society of America CMSA, 2016).

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.
- Most practices lack established processes for closing the referral loop.

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

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

Patient Centered Medical Home

- ✓Sisseton Service Unit determined in 2018 that they were going to pursue Patient Centered Medical Home (PCMH) Accreditation
- ✓PCMH was officially initiated in 2016
- ✓Joint Commission certification was received in August, 2019
- ✓Pandemic declared March 2020
- ✓Normal operation returned January 2022 and we began reestablishing PCMH

Patient Centered Medical Home (con't)

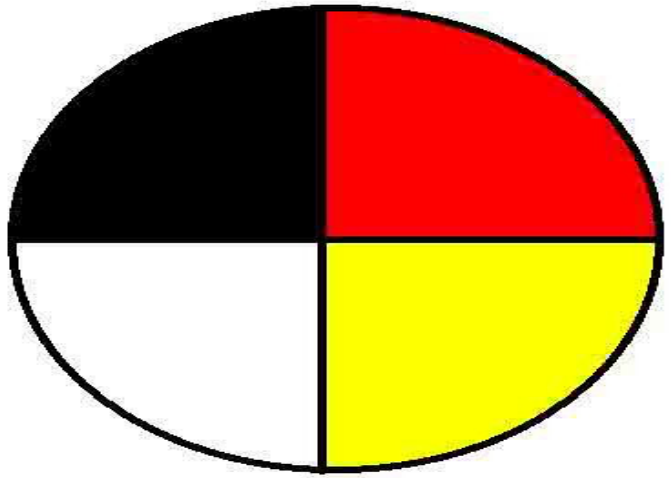
Care Teams

Teams: Black, Red, and Yellow

- Black and Yellow teams - adult health
- Red team - Pediatrics, OB/GYN and Women's health, Medication assisted therapy

The CORE PCMH team members:

- Provider
- Clinic Nurse
- Case Manager
- Care Coordinator
- Medical Support Assistant
- PRC Rep
- Health Information Management
- Dietician



Team Initiatives

Monthly Team meetings

- Communication
- Data
- PCMH processes

Morning huddles

- Core team meet each morning to discuss previous day patient and communicate care needs
- Discuss scheduled patient for the day

Quality Department expansion

- Hiring Quality Management Director
- Leads Quality Improvement Process Improvements projects

Staffing At Sisseton

Case Management Department development

- 2011- 1 Case Managers hired
- 2012- 2 Case Managers hired
- 2018- 3 Case Managers and 3 Care Coordinators hired

Outpatient Department

- 10 Providers
- 12 Clinic nurses
- 4 MSA

PRC Department

- 3 Schedulers
- 3 MSA
- 2 Biller
- 1 Budget tech

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 (Joint commission or 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

- Pre visit planning
- Review specialty clinic notes
- Assist with urgent referrals
- Ensure pre-op information is completed in a timely manner

Clinic Nurse Role

RN/LPN’s

- Room patient
- Vitals
- GPRA Screenings
- Stock rooms
- Schedule appointments
- Nurse visit
- Phone triage
- Follow up on results and plan of care

PRC staff roles

3 Schedulers
- Schedules all appointments
- Attends PRC meetings

3 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

Resources

- Excel Tracking logs
- ICare panels
- EHR
- RPMS reports
- Listserv

Changes: Lesson Learned

- ✓ PCMH is a model of care and roles continually need to be evaluated by leadership to ensure we are meeting the care needs of patient
- ✓ Change in leadership
- ✓ Nurse roles are changing
- ✓ Clinic case management/care coordination services are based on the needs of the services unit

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.

Patient Centered Medical Home

Whiteriver Service Unit was one of the IHS Improvement of Patient Care or IPC sites in 2008

PCMH was officially initiated in 2016

Join Commission certification was received in June 10, 2018

Even during the Pandemic, PCMH and case management continued at Whiteriver and the team concept.

- Some processes had to be halted or changed
- The structure of case management and the team approach stayed the same

Care Teams

Teams:

- Primary Care: Pinon, Walnut, Gamble Oak, Cedar and Cottonwood (Cibecue Health Center)
- Specialty Services Clinic –Podiatry, Surgery, and Orthopedic

Core Team consists of:

- A group of MDs, FNPs, and Pas
- Clinical Care Coordinator (CCC)
- Clinic Nurse(s) and/or Medical Assistants
- Health Technicians
- MSAs
- Diabetes coordinator
- Pharmacists
- PRC scheduler
- Case Manager

Team Initiatives

Meetings:

- Weekly care team meetings for high risk cases which includes other departments not just core team.
- Monthly GPRA meetings and Process Improvement meeting
  - Plan Do Study Act (PDSA)
  - Process Maps
  - Hospital Wide improvement initiatives
- 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 Teams with everyone reviewing the cases prior to the meeting.
- Icare for Panel Management, Empanelment and GPRA monitoring

Case Management Role

Discharge Planners – RNs:

- Provide Case Management for patients who are admitted at our local hospital
- Assist with Discharge Planning for patients who are admitted at our local hospital
- Work with PRC for Referrals that are needed for discharge of patients at our local hospital
- Work with Clinical Care Coordinators on getting follow up appointments after discharge.

Case Managers – 2 RNs:

- Monitor WRSU patients who are admitted at outside facilities.
- Assist outside facilities with obtaining DME equipment needed for discharge,
- Enters RCIS and assists with obtaining approval for Acute Rehab/Skilled Nursing Facility for patient's who will require PRC funding.
- Work with Clinical Care Coordinators on getting follow up appointments after discharge.

Outpatient Department Role

DME Coordinator- 1 RN:

- Manages consults for DME equipment needed for patients.
- Verifying payor source for this equipment
- Obtaining approval for patients needing PRC funding
- Faxing the orders to the outside DME company and following up on the equipment.

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

- Assisting patients with navigation of their healthcare
  - Entering referrals as directed by the PCP
  - Education as directed by the PCP
  - Coordinating Outpatient care for high risk patients
- Monitoring the Teams GPRA measures and working with the team on improvement measures.
- Managing their Teams patient population using iCare.

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 All staff on the rules and regulations of PRC
- Weekly PRC meetings
- Work directly with all members of case management on communication between PRC and Case Management members.
- Assisting with training on the roles of each member of the team.
- 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 as well as working with the care teams on these referrals.
- Reviews CHEF report, Identify cases and submit to HQ

Resource

Icare:

- Panels for Primary Care Teams
- Panels for ER visits
- Panels for Inpatient visits
- Panels for Special Populations

Share Drives for important information

- Education topics
- Referrals

Competencies

- iCare Transfer Logs
- Care Management specific duties

Lessons Learned

Communication between Case Management/CCC and all PRC staff needs to be maintained on a daily basis.

Having a Nurse directly in PRC, either as the Supervisor or just a team member assists with continuity of care, patients getting care in a timely manner and helps with complicated referrals.

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.

Icare is essential in the PCMH initiative for monitoring patient populations and the team work approach.

PCMH is always evolving at WRSU as our staffing, and clinic needs change.

Questions

Contact Information

Robin Watkins, MSN, RN, CCM

FI Project Officer

IHS Headquarters

Robin.Watkins@ihs.gov

Leah Westover, MSN, RN

Supervisory Nurse of PRC

Whiteriver Service Unit

928-338-3514

Leah.Westover@ihs.gov

Jencie Rubio Majano, MSN, RN

Case Management Department Supervisor

Woodrow Wilson Keeble Memorial Health Care Center

605-742-3852

Jencie.Rubiomajano@ihs.gov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