TBC

Team Based Care

Care Management

Ensuring patients who are at high risk or have complex needs are well cared for during and between office visits.

Key Changes

- **Design** a care management program to meet the needs of patients in transition and at high risk of major morbidity and hospitalization.
- **Shift** registered nurse (RN) roles toward care management.
- **Decide** how patients will be referred for care management.
- **Establish** relationships with key hospitals to co-manage patients discharged from the hospital.
- **Create** protocols, standing orders, and standard work flows for engaging these patients with the care team.
- **Ensure** care managers have protected time to do their work.
- **Develop** a support structure for care managers.

Examples

- Ask providers and/or use an algorithm to find out which patients may be "high risk." This may be based on medical and/or social support needs.
- Train RNs on self-management support and medication reconciliation to overcome clinical inertia.
- Support RNs to conduct independent visits with complex patients by creating standing orders for primary and secondary prevention.
- Create scheduling protocols and explore billing codes to support independent RN visits.
- Providers, behavioral health specialists, or other RNs regularly meet to review data on high risk patients and discuss care management intervention.
- Registry or individual-level data reports are regularly used to help care managers organize their efforts.
- Review Emergency Department (ED) discharge records to ensure follow-up care is provided within 24 to 48 hours.
- Develop workflows for ED follow-up visits, including communication methods between the hospital and primary care practice.

Primary Care Team Guide Assessment-Related Questions

Care Management

	Components	Level D	Level C	Level B	Level A
18	Follow-up by the primary care practice with patients seen in the emergency room (ER) or hospital…	generally does not occur because the information is not available to the primary care team. 1☐ 2☐ 3☐	occurs only if the ER or hospital alerts the primary care practice. 4☐ 5☐ 6☐	occurs because the primary care practice makes proactive efforts to identify patients. 7☐ 8☐ 9☐	is done routinely because the primary care practice has arrangements in place with the ER and hospital to both track these patients and ensure that follow-up is completed within a few days. 10☐ 11☐ 12☐
19	Clinical care management services for high-risk patients…	are not available 1☐ 2☐ 3☐	are provided by external care managers with limited connection to practice 4☐ 5☐ 6☐	are provided by external care managers who regularly communicate with the care team 7☐ 8☐ 9☐	are systematically provided by the care manager functioning as a member of the practice team, regardless of location 10☐ 11☐ 12☐

How Primary Care Teams Achieve the Quadruple Aim