Success Story:

Chronic Care Management Program Reduces Readmissions and Generates Revenue

Patients now have a personal advocate and guide at the Memorial Hospital of Sweetwater County to help them navigate the health care system, thanks to implementing a chronic care management (CCM) program.

After attending a Mountain-Pacific Quality Health conference in 2017 where chronic care models and data was discussed, the quality team at the hospital saw value in the chronic care management model. Not only would the CCM program help its patients manage their chronic conditions better, but the initiative would also decrease acute care readmissions through education to recognize the signs and symptoms that could cause a readmission.

The quality team then proposed implementing a CCM model to the hospital's leadership. The service would be of value to the community, the hospital's patients and it would also bring in additional Medicare reimbursement revenue. The hospital's leadership recognized value in the project and supported the initiative.

Encouragement and assistance helps drive success

Implementing a CCM program takes a tremendous amount of time and energy. The hospital established internal work teams to implement the new care model and then they reached out to Mountain-Pacific for support with implementing the program. The hospital also hired a consultant to assist with the implementation.

"Mountain-Pacific staff and another consultant helped us jump off the cliff to implement this program," said Leslie Taylor, clinic manager for the hospital. "We were kind of hesitant on how this would go, but they were so supportive and provided everything we needed. They were just amazing!"

Amanda Molski, director of quality at Memorial Hospital elaborated, "they gave us just such a great framework. We needed to build better processes and they helped us build those. They also provided reassurance to us to trust the system and the processes."

Building a program

Memorial Hospital already had a transitional care management (TCM) program in place. The team evaluated the TCM program with the goal of integrating elements from that program into the CCM program. Once the processes were defined they were then integrated. The team also received a hands-on training from its consultant. After the training, the team rolled out new

processes, including 24-hour phone triage coverage, discharge planning and case management processes. The hospital formed partnerships with two local nursing homes to provide 24-hour phone triage to their residents.

Memorial Hospital also hired a full time CCM coordinator to help patients navigate through the health care system and to provide crucial education and information. The feedback from patients has been glowing.

“I have been told by many patients that this service is immensely helpful,” said Katherine Moczulski, care coordinator for Memorial Hospital. “Patients have expressed a greater sense of well-being knowing there is someone they can turn to for a myriad of questions.”

Moczulski also directly coordinates with the physicians serving patients, educates patients and assists with advanced directives and advanced care planning, among other duties.

Working with patients one-on-one to create care plans that are meaningful and tie to personal goals is a critical element to the program. For example, a person may have a health condition they need to manage and tying in a personal goal – like being able to play with your grandchildren or being able to hike and hunt – is often a stronger motivator than “just” managing their condition.

“Our ultimate goal with all of this is to improve the quality of life in our community,” said Molski. “The program is really lending itself to reduce acute care readmissions, too.”

The coordinator also recruits new patients and educates the public about the program. The hospital held a community-wide luncheon to educate the community about the new service.

A framework for other projects

The CCM implementation gave the team at Memorial Hospital a solid understanding of the necessary framework to build other similar programs. In fact, the team is now discussing a behavioral health care coordination program.

“We feel like we can roll it out without too much difficulty,” said Taylor about the behavioral health initiative. “We have a high behavioral health population that we can help, and we are hoping that this program can help us decrease visits to the emergency room. We learned a lot from the CCM implementation and we will be able to improve our processes from that experience.”

About Mountain-Pacific—Mountain-Pacific is a 501(c)(3) nonprofit corporation and holds federal and state contracts that allow them to oversee the quality of care for Medicare and Medicaid members. Mountain-Pacific works within its region (Montana, Wyoming, Alaska, Hawaii and the U.S. Pacific Territories of Guam and American Samoa and the Commonwealth of the Northern Mariana Islands) to help improve the delivery of health care and the systems that provide it. Mountain-Pacific’s goal is to

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