KANSAS HEART AND STROKE COLLABORATIVE
A healthcare innovation award program of The University of Kansas Hospital

What is Chronic Care Management?

Chronic care management is designed to help you transition from a hospital visit into your home setting. It can be thought of as on-going medical supervision, or health coaching.

You and the Chronic Care Manager/Health Coach can make a plan of care for your health, and communicate up to once per month for a minimum of 1 year. The CCM in no way replaces home health services or a medical provider. The main goal is to help prevent you from having repeated hospital visits and to provide you reassurance while managing your health at home . It is also a way for your care to be communicated with your health care provider monthly and as needed.

Your health coach will help with continuity of care, assessment of medical needs, oversight of medication self-management, coordination of recommended preventative care services, enhanced opportunities for communication with a healthcare provider, and coordination of community based services.

Health coaches follow up with patients face-to-face for the first initial visit. They follow up a minimum of 20 minutes each month thereafter for a year.

What does Transitional and Chronic Care Management cost the patient?

Nothing! At this time, Medicare is billed for the services. There is a small (less than $10) amount that the Kansas Heart and Stroke Collaborative grant covers. There is no cost to you for the initial or follow up visits at this time! This program has been made possible through a grant program through KU Medical Center. After the grant period is over, the hospital has agreed to continue to offer TCM and CCM services.

What kinds of things are covered at an initial face to face health coach Visit?

Medication reconciliation and review
Medication Education with patient and/or family members
Safety hazards/concerns
Diet review
Exercise encouragement and review
Compliance with preventative cares, specialty provider appointments, and health maintenance
Identifying and Offering Support Systems
Identifying and Obtaining Resources
Chronic Illness questions addressed and education provided
Nursing head-to-toe assessment
Coordination with health care provider
The chronic care management program can also offer in-home exercise programs, dietician services, and in-home vital signs monitoring.

All assessment information, the plan of care, and progress notes for follow-ups are given to the provider. If a problem or concern is identified, it is discussed with the provider or their nurse at the WaKeeney Family Care Center.

I am interested! Who do I contact?

Questions or interested people can be directed to Niki Mattheyer, LPN at WaKeeney Family Care Center. You may also contact your provider or their nurse at the WaKeeney Family Care Center. Niki can be reached for questions at Ext: 281 or called on her work cell phone at 785-656-9475. A copy of the referral form is attached.