FOUNDATION OF POPULATION HEALTH… CARE MANAGEMENT – WEXFORD PHO

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AMBULATORY CARE MANAGEMENT

The face of nursing is changing

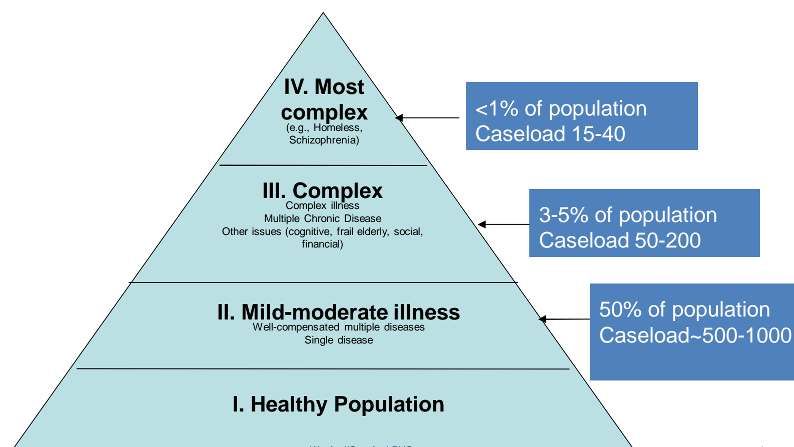
Nurses can now bill for nursing activities

Nursing services are being recognized in a whole new way.

BUT WHY USE RN'S IN PRIMARY CARE

- More complex chronic populations
- Payment shifting to value based care
- The scope in the PCP practice can be more efficiently managed in a team based approach

Managing Populations: Tiered approach to care management



OUR JOURNEY

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November 2011 – Notified of Michigan acceptance into CMS Demonstration

January 2012 – Start Date!!!

OUR JOURNEY

Care Management need

- 6 eligible PCMH practices
- 14 Care Managers (12 RN, 1 CDE, 1 MSW)

FOUNDATION FOR CARE MANAGEMENT - PCMH

- **PCP offices designated as PCMH's prior to 2010**
- **Registry use well in place**
- **PDCM pilot through BCBSM – partnerships with other Trinity Organizations that had been working on care managment**

CURRENT STATE JANUARY 2012

- **Few if any RNs in PCP offices**
  - **If any RNs – filled a phone triage role or managed teams**
- **There was not a role of care management in any PCP office**
  - **Physicians very clear they wanted RN Care Management**

RAPID RESPONSE

- Positions needed to be financed
- Reporting structure needed – office or PHO??
- Job descriptions required development, assignment of pay grades, etc.
- Job postings, recruitment, interview process – both for department and in potential offices
- Offers and acceptance
- Allocate FTE based on attribution model

TRAINING NEEDS!!!

- **Orientation and onboarding process needed to be developed – nothing in place (6 different locations and 4 different EMR's)**
  - Internal systems – EMR and hospital system, laptop, phones, etc.*
  - Scheduling*
  - Documentation – phone and face to face*
  - Comprehensive assessment visit* (align with AWV)
  - Role, processes, handoffs*
  - Care plans*
  - Scripting*
  - Self-management maintenance plan*
  - Case closure*
  - Medication adherence*
  - Hospital discharge follow up*
  - Billing*
  - Care Manager/Physician consult appointments, documentation , and tracking*
  - Quality Measures – evidenced based care* (most nurses do not understand this in a PCP world)*
  - Prioritization*

* Things to still consider

CONSIDER EARLY CHALLENGES

- Care Managers from varied backgrounds
- Only one had previous formal care management training when hired
- Space was required for Care Managers to work in physician offices – often times very limited or non-existent

EARLY CHALLENGES

- New Role in Office – office staff, care teams and physicians not aware of how to incorporate care manager into workflow

- **TURNOVER** :
  - Many MiPCT practice across the state had a lot of turn over. We were hit due to trail with MA's in moderate risk role and changes in the program.

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EARLY CHALLENGES

- The demonstration is focused on specific payers, not ALL patients**

BCN	Medicare FFS
BCBSM	Priority Health
Medicaid	

- Providers do not treat patients by product!!! Other office patients need care management

- Providers on an RVU system – no time to meet with care managers

- Finance team budgeted 10 visits per day in July 2012

*still going to be a challenge

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EARLY BARRIERS

- IT interoperability
- Reimbursement for all patients
- Documentation
- Staff engagement initially

EARLY WIN'S

- Support from HR to build a cohesive team
- Hiring for personality and fit rather than experience (flexibility, IT savvy, leaders of change in past positions, thrive on change, professional, good relationship building skills with all different type of people)
- Development of high functioning team than could implement care management in the office with support from the internal team. We all learned better together.
- Having an RN that was trained by MiPCT as a lead care manager.

PATIENT IDENTIFICATION

- MIPCT lists – generated monthly, risk scores
  - GR – added last appt and upcoming appt and matched list to PCP
- Patient Registries – not at goal Chronic Disease
- Care team referrals (office staff have been some of the best referral source)
- Physician referrals
- Transitions of care
- Payer referrals

A DAY IN THE LIFE…………………

- **Research/coordinate resources**
  - Transportation issues
  - Diabetes Center
  - DME supplies
  - Mental Health
  - Community resources
  - Pharmacy
- **Talk with Home care/providers/specialists offices/other resources in home**
  - Clarification on medications
  - Assessment if resources are sufficient
- **Field incoming calls/voicemails from patients**
  - Questions on medications, treatment plans, resource finding help.

A DAY IN THE LIFE………………….

- **Hospital discharge calls** (ranges about 1-7 patients)
  - Pull hospital list
  - Review medications on discharge list prior to calling patient.
  - Call patient and perform an assessment of patient's adjustment back to home.

  -Understanding of discharge instructions.

  -Ability to perform adl's

  -Pain control

  -incision/wound

  -psych/social needs (transportation, support in home, need for home care)

  - Review medications verbally with patient

A DAY IN THE LIFE………………….

Face to Face Visits

- Assessment, self-management goal setting, care plan
- Providers often pull CM's into their appts throughout the day
- Schedule pt an appointment with PCP within 7 days (if not done already)
- Answer questions or relay questions to PCP
- Coordinate resources as needed (order glucometer, homecare, transportation, community resources, etc.)
- Education provided

Make outgoing calls for care management follow up

- Assessment of goals previously set
- Assessment of issues after medication change

Meet with individual provider monthly – review patients progress, barriers, review potential new referrals from registries or providers.

CURRENT MARKET FORCES TO SUPPORT CARE MANAGEMENT

- MIPCT Demonstration continuing 2 additional years
- Risk based contracts in some parts of the state
  - ACO's
  - Priority Health
  - Priority Health Medicare Advantage
  - Bundled payment methodologies
  - CCM payments

LESSONS LEARNED

- 'Warm Handoffs' from providers are better received by patients
- 'Cold Calling' patients is least effective
- Unintended consequences:
  - Patients now have a direct line into busy offices for resolution of issues other than care management
- Implementation is a cultural transformation
- Efficient Care Management requires high quality documentation, tracking, scheduling tools

LESSONS LEARNED

- There is not an unlimited supply of experienced Care Managers BSN prepared nurses
- Care Management is not just a nursing function
- It is a continual education process

HOW DO WE MEASURE SUCCESS

- **Population Performance**
  - Identification of population/risk
    - What % of the population are CM impacting
  - Population outcomes
    - Evaluating impact on population
- **Staff Performance**
  - Care management productivity- meaningful, value added
  - Monthly caseload reports
- **Staff Performance Evaluation**
    - Core competencies
    - Performance based
    - Annual goal setting and performance assessment tools

WHAT WILL CARE MANAGEMENT IMPACT

- Generic medication utilization
- Protocol development (Clinical Pathways, medication protocols and PCP driven palliative care protocols)
- Patient satisfaction
- Provider satisfaction
- Care manager productivity
- CMS/HEDIS
- Utilization data

OPPORTUNITIES FOR SUCCESS

- Several projects focused on Care Coordination
  - Hospital/PHO transitions of care
  - Grayling Family Practice Leased Care Manager
  - Cadillac Family Physicians team redesign (CCM focus)
  - Grayling Network focused team
  - Creekside Clinic RN scope of practice team

CADILLAC HOSPITAL/WEXFORD PHO PARTNERSHIP

Transitional Care Manager

- Focused on readmission rates
- Part of Ambulatory Care management team (embedded into PCP practice just like care managers)
- Manages top 6 diagnosis (COPD, Stroke, MI, Pneumonia, Orthopedic Surgery and DM)
- Manages 30 days in partnership with Care manager, home care, SNF, etc…
- Pre-hab for high risk surgical patients next step in the journey

GRAYLING FAMILY PRACTICE

Leased Care manager

- Leased from PHO to increase connection with already established team and in order to not change pay scale at practice
- Model
  - AWV (on steroids)-*main reimbursement tool*
  - Complex Care management utilizing billing
  - Changing relationship with patient to meet the CMS CCM guidelines

CADILLAC FAMILY PHYSICIANS (CCM FOCUS)

- Currently have RN's in MiPCT, doing AWV and as phone nurses.
- Need standard process and care plan that the team can use
- Would like to utilize a team approach to care management with RN/MA teams
- Current focus is redesign of care plan in AllScripts to support documentation and billing for CCM in the future.

GRAYLING PRIMARY CARE NETWORK

- Focus on Care Coordination across the continuum of Care
- Director of Care Coordination responsible for Hospital case management and PCP care managers
- Will start with Transitions of Care
- Working on a grants to have an all patient all payer approach
- Will partner with the PHO to support the independently owned practices in the community

CREEKSIDE CLINIC

- Have a current Team of RN's that do AWV, Triage and team lead
- Will expand this team to include Care management
- Supports the Team approach and give depth to reduce gaps in service
- Currently developing the responsibilities and how to utilize a team of Four in each of these roles
- Development of the care plan as well

TIME TO THINK OUTSIDE THE BOX

KEY TO SUCCESS

Quality Care Manager

- Care manager needs to love change
- Ownership of the process
- Critical thinking skills
- Excellent communication skills
- IT savvy

Billing process is a must

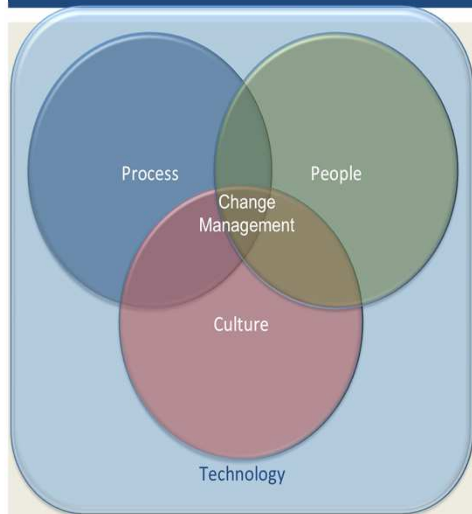
Community collaboration

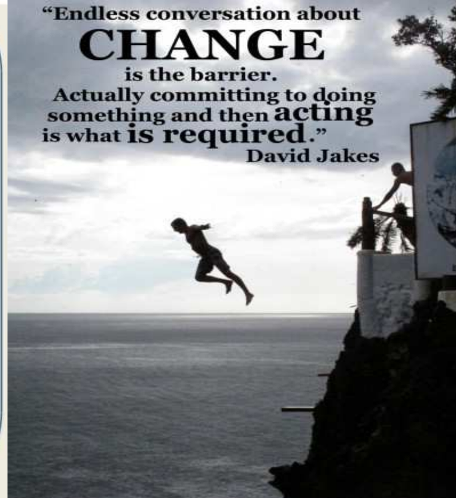
FLEXIABILTY

CURRENT BARRIERS

- Highly compensated role for PCP office
- Need good training programs (mentorship)
- Different payment processes by payer cause inefficient processes
- EMR's are not set up for nursing documentation
- Need a community based care plan and that is not available (yet)
- Some providers are resistant
- Scope creep

REMEMBER CHANGE IS HARD





WHAT IS IN IT FOR THE PROVIDERS

- Care Management aligns with payer based incentive programs and Quality Measures
  - Payers are focused on value based payment transformation
    - Decreased ED and IP
    - Improved Chronic Disease Management
    - Supports gaps in care
    - Engages patients in self care and problem solving
- Care Managers **reduce the burden** of complex patients on the Provider

CARE MANAGEMENT CASE STUDY- MS. W

- 50 y/o Female
- Type 2 DM, HF and Depression (main concerns)
- Also-hypertension, hyperlipidemia, Degenerative Disc Disease, lumbosacral radiculopathy and anxiety
- In May
  - BMI of 39.3
  - A1C was 14.0

SUCCESS ONE PATIENT AT A TIME

- Ms. W 5 months later more engaged in the management of her chronic health conditions.
  - A1C was 8.3
  - lost 28lbs
  - not missed a scheduled appointment since the onset of care management
  - She stated that she “finally **feels empowered** and encouraged to take the help that is being offered and use it.”

SUCCESS
Because you too can own this face of pure accomplishment