PCMH User Group Highlights 11/29/18

Slides from presentations are attached to email and on website (slides and highlights under PCMH User Group)

Introduction
Linda Slater-Marschner, Assistant Office Manager at Grand Traverse Children's Clinic, provides administrative support to her practice's care management (CM) team. NPO invited her to share details and successes from GTCC's CM program.

GTCC program beginnings
Linda's presentation (see page one attachment "2. CM presentation"), chronicles GTCC's progression in developing a CM program. She shared that their CM program had a gradual start in 2015 at physician-referral-basis only and was not promoted to patients by staff until 2017, when it became present in the office culture. Their office has six providers working four days a week. Today, info flyers in every exam room and portal blasts keep CM on the staff/patient radar. As of 11/30, Linda reported GTCC currently had 7,212 active patients with 6,695 of those patients seen in the office in the last year.

Setting an achievable goal
The first program goal set for staff was to double the number of patients receiving CM, Linda said. GTCC employs both a Licensed Master Social Worker from Adaptive Counseling and an RN trained in care management at three days per week each to meet this goal. Generally, their social worker addresses behavioral health referrals in face-to-face appointments, i.e. patients experiencing anxiety and/or depression, and she also serves State Innovation Model (SIM) population patients, while their RN addresses Heath Leads Social Determinants of Health screening referrals via telephone encounters. (See page 2 of attachment "2. CM presentation" for a breakdown of responsibilities).

Some process anchors
- **Consistent use of a "warm hand-off"** to engage patient participation with the CM program is key, Linda said.
- **A folder including program info** also has become an important patient take-away. See attachment "3. GTCC Folder"
- On a spreadsheet, Linda **tracks by payer those receiving care management services** and this sheet acts as a working master list. Data needed to maintain the spreadsheet is generated by EMR report. Care managers also fill out a flowsheet with **their running list of CM encounters and** provide this flowsheet to Linda for use in updating her working list. This tracking especially helped when one provider retired, and the practice did not want to lose patients attributed to the practice. See attachment "4. Excel Spreadsheet Example Pt Log"
- At GTCC, **care managers track patients' statuses in receiving CM** and they provide the follow up to those who either never scheduled or cancelled their scheduled appointment.

Response to Provider feedback
Linda reported that providers asked her "Is Care Management Profitable?" and she was able to share that revenue far exceeds fee for service and incentives received from payers such as SIM, BCBSM VBR and Priority Health PMPM.

GTCC has been successful in collecting on CM billing codes through ASR, CIGNA and Confinity, Linda shared. See attachment "5. 2018 CM Billed Units per carrier 11.21.18"

Linda also shared:

- The CM flyer the practice uses and some patients have self-referred – mainly parents wanting help with behavioral issues. Attachment "6. Care Management Flyer"
- The Health Leads Social Determinants of Health survey the practice uses. This practice participates in SIM so is required to ask all these questions. Attachment "7. Health Leads"
- A template used for CM documentation – "8. Template Example"

Advice for implementing CM services at a practice

- Have a plan. Linda shared that this would be preferred as opposed to kind of falling into providing CM.
- Require little of the providers administratively. The only thing providers are asked to do is to create the tele encounter to the care manager, and they do, she said.

Possible future PCMH User Group Topic decided upon by group in November: Transition of Care calls and subsequent billing requirements.

2019 meeting dates:

- Tues, 1/22/19
- Wed 2/20/19
- Thu, 4/25/19
- Tues, 6/18/19
- Wed, 8/21/19
- Thu, 9/26/19
- Tues, 10/22/19
- Wed, 11/20/19