
Care

Grand Traverse Children's Clinic Care Management Program-

HISTORY:

- The program began in **2015** (7/24/15). **91 encounters (approximately 23 patients).** Physician referral only.
- **2016**. It was a very slow process and the program was very under developed throughout most of that year. There was no mention of the Care Management (CM) program in the office. Not even from the staff. It was the best kept secret. We had a total of **322 encounters (approximately 74 patients).** Still primarily a physician referral program.
- **2017**, Care Management became part of the office culture. Flyers were put in every room and the waiting room. We sent out portal blasts telling all our patients about the program. We had a total of **726 encounters (approximately 168 patients)**. We more than doubled our numbers from 2016.

CURRENTLY:

- **2018** (as of 11/20/18), we have had a total of **957 encounters (approximately 291 patients).** We need 336 patients to double our 2017 numbers. We currently have 21 new patients on the schedule through the remainder of 2018. Plus, we will get additional patients from the Health Leads.
- We have a licensed social worker from Adaptive 3 days a week.
  We have a registered nurse on staff 3 days a week.
  I believe that we would not have a successful (successful partially means meeting our numbers) Care Management program without an RN.

BREAKDOWN:

- **RN** – bills mostly telephone encounters.

  She works Registry reports for ADHD, Asthma, Obesity
  FitKids 360
  Fruit/Veggie Rx Program
  High Cost Utilization Reports
  Emergency Room Reports
  In-patient Hospitalization Reports
  Positive Patient Health Questionnaire - 2 (PHQ-2) forms
  Social Determinants of Health – Health Leads Screening*****

- **LMSW** – bills mostly face-to-face visits.

  Physician referrals
  Patient/parent self-referred
  Behavior issues for children with ADHD
  Anxiety
  Depression

***We get many contacts through our Health Leads**
*****A good place to begin for anyone starting a CM program**

Our Process:

A CM flyer-
Still remains in each exam room, the bulletin board in the waiting room and at the checkout desk.

Physician referrals-
IF, a physician is talking to the patient about Care Management, we will do a warm hand-off. Warm hand-off's have proven to be more effective than just speaking to the patient/parent. IF, one of the CM's are available they will go into the room and speak to the patient about CM services. IF, they are not available, one of the nurses will do the warm hand-off. We have a folder with information in it that we give to the patient/parent.

Schedule CM appointment at check-out-
We highly encourage that any new CM referral makes an appointment before leaving the office. IF, an appointment isn't made a telephone encounter is sent to our RN, CM. She will follow-up with the patient/parent to try to schedule.

Physicians send telephone encounters to our RN, CM and she will make sure the patient gets scheduled, if they did not schedule while in the office.

Appointments-
Any CM appointment that is made, cancelled, rescheduled or no-showed is sent to our RN, CM through a telephone encounter. She can track it to see if the appointment is followed through on or she may call to get them rescheduled.

Every completed appointment or telephone call gets logged (by date) on our "CM Patient Flowsheet [Year]". From there all SIM (State Innovation Model/Medicaid HMO's), Priority Health (PH) and Blue Cross/Blue Shield (BCBS) patients are put on their own separate logs. From here I track how many visits each patient has and I can keep track of numbers for each respective carrier.

Each of the above stated insurance groups send out reports that show which patients are counted toward measures. I compare these reports to my reports and reach out to the appropriate contact if differences.

Monthly Meetings-

The two CM's and myself have monthly meetings (a requirement of SIM). We discuss reports, patients, any new or changed criteria and any additional health leads resources.

Bottom Line that all Physicians want to know-

Approximately 25% of all income generated or earned from Care Management goes back to the CM salary.

Final Advice to begin-

Have a plan in place. It will be changed as development occurs, but, start with a plan and make sure it is communicated and it becomes part of the office culture.

Do whatever you can to make this as easy as possible for the providers. They won't be as willing to take on a new endeavor if it means more work for them.

From our Providers:

The care management team has been a huge asset to our clinic! At a recent visit, a preteen was in an anxious crisis and our care manager was able to carve out some time to immediately teach her some useful coping mechanisms. The family was so grateful! CM is helpful in keeping patients on track with healthy eating, proper use of asthma medications, and discussion of ADHD meds. They are tremendously beneficial for our patients and their families.

Having a consistent provider available -especially for families who are in crisis - has been immensely helpful. It is actually a value to the patient.

I have been very impressed with the ability of our Care Management team to quickly and effectively give kids who have mental health issues the initial care they need. It is very difficult to get this care anywhere else on a timely basis. For some of our patients, this initial care and some CM follow-up is all they need. My hope is that we can expand this success.
