BCBSM PGIP Care Management Recognition Awards – Best Practice

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Category: Care Management Workflow
Title of Submission: Centralized Care Management
Executive Summary:

1. Answer Health has been engaged in efforts to implement and support embedded care management in our participating PCP practices for many years. We began with an early grant prior to MiPCT, improved throughout the MiPCT years, and have continued to sustain and expand embedded care management across Answer Health PCP practices. Care Managers are employed by the Answer Health PCP practice and provide complex care management, self-management, and care coordination in a team-based environment.

2. Our goal has been to reach 90% of PCMH designated practices providing care management services with an embedded care manager in order to ensure our attributed patients receive care leading to better outcomes, while lowing cost and utilization, and improving patient experience. We had reached as high as 74% and decided in order to reach the 90% goal; we would need to look at other care management models.

3. We researched the centralized care management model and decided to embark on offering this model to our PCP practices, focusing on practices without a current care management program or embedded care manager. An experienced RN care manager was hired to start-up and run the program with an initial focus on transitional care management following inpatient discharges and ED visits, and expanding to providing more longitudinal care management and adding additional centralized care managers.

When did the intervention start and end?

Answer Health began looking for alternative care management models and workflows in early 2018. Our first Centralized Care Manager started in February 2019 and has continued to grow into a program positively received by physicians, practices, patients and caregivers, as well as providing high job satisfaction to our Care Manager.

Initial goals of the program/intervention:

1. Improve patient transitions for better outcomes
2. Reduce inpatient readmissions and follow-up ED visits
3. Assess barriers to adherence of care plan
4. Improve patient safety and safe use of medications during transitions
5. Increase follow-up visits with PCP post-discharge

Who developed the program/intervention, and how?

Many members of our Answer Health Team were involved in the development of the centralized care management program, including executive, clinical, and IT/analytical leadership. Upon hiring our first Centralized Care Manager, the on-going preparation and ramp-up work became her primary responsibility. Many steps and processes needed to be developed, including the following:

- New job description for centralized care manager
- Work space for care management
- Practice participant agreement and engaging targeted PCP practices
- MiHIN ADT notifications for participating practices
- Training and access to multiple practice EHRs
- Documentation templates and billing standards
- Care Management resources including educational materials for chronic disease self-health management support and community resources for patient support

Description of the program/intervention:

The Answer Health Centralized Care Management program employs a trained and experienced RN care manager to provide telephonic and/or telehealth transitions of care follow-up to patients discharged from inpatient and ED settings. Services include assessment of patient status, medication reconciliation, complex care management and chronic disease education, self-management support, referral support for identified barriers, and coordination of care with PCP, specialists and home health services.

The Care Manager begins each day with review of the current ADT notifications, transition volume and patient complexity/risk to determine the day's workflow. The patient's electronic medical record is reviewed for supporting information, as well as review of the patient's community medical record, GLHC - VIPR, as appropriate.

The care management office is set up appropriately with multiple monitors for viewing records and care management call templates and guidelines, as well as phone equipment to assist in high quality phone calls to patients. After performing the follow-up phone call, the Care Manager documents in the patient's PCP practice EMR and includes information for the practice to bill the appropriate codes for the care management services. In turn, Answer Health has developed a billing system to recoup payment from paid payer claims from the participating practices.

Within the Centralized Care Management program, Answer Health is piloting Care Convene, a platform that allows patients to have video visits with the Care Manager, to better facilitate education, medication reconciliation, and self-management via telehealth and chronic condition questionnaires.

How were patients identified for the program/intervention?

With our initial focus for Centralized Care Management program on transitional care management, patients are identified by MiHIN ADT inpatient admissions and ED visits notifications to Answer Health. All patient discharges from hospitals are included for intervention and ED discharges are reviewed for patients who can most benefit from care management.

How was success measured? Please delineate whether metrics were process-based or outcome-based?

With a fully go-live date of June 1, 2019, we have already identified many successes with our Centralized Care Management program. So far, we have engaged seven Answer Health primary care practices. Their patients are now receiving transitional care management services that otherwise would not have without participating in this program. And now more practices, with and without care management services, are asking how they can participate in the program.

Patients, including those with highest risk, who experience a transition in care and would not otherwise receive care management services, are receiving a post-discharge phone call within 24-48 hours. Patients have engaged in the phone calls with our Care Manager, medication reconciliations have been completed, discharge instructions and plans have been clarified, barriers to improvement have been identified, additional services have been obtained, and patients have been scheduled for a follow-up visit with their PCP, including those who would not have followed up without this assistance.

We have developed tracking of a number of metrics for our Centralized Care Management Program. Currently the metrics are process-based, including the 24-48 hour post- discharge follow-up call completed, medication reconciliation completed, patients scheduled for follow-up visit with PCP.

As our program matures, we look forward to measuring and reporting success with outcome-based metrics, including reduction in inpatient admission/re-admission and ED utilization rates. We are planning for expansion of our Centralized Care Management team to better identify patients at risk for inpatient admission/readmission, and better track and manage related chronic disease outcome-based metrics, including controlled HbA1C and blood pressure.

What were the results? Include qualitative data/graphs.

To date, we have had the following results:

- 116 Patients received a post discharge follow-up phone call
- 116 Medication Reconciliations have been completed
- 69 Patients were scheduled for a follow-up PCP visit
- 68 Patients kept the follow-up PCP visit appointment

- 72 Patients received education and self-management support for their chronic disease or medications and/or referral to community support programs, (i.e. Tandem 365 and Core Health)
- 7 Patients were identified for follow-call care management phone calls

Were any new tools, processes, or resources developed to aid in the implementation of the program/intervention?

The Centralized Care Manager visited with each partnered primary care practice personally to meet with providers, leadership, and care team members to facilitate the development of the care management workflows for each practice and develop established communication. This was vitally important to promote buy-in for care management, and allow staff to personally meet the Care Manager, as they will address questions from patients regarding who is calling them after discharge. The Centralized Care Management program has been very well received by participating providers, practice teams, and patients; a high level of satisfaction exists knowing patients are receiving transitional care management that did not previously exist within the practice.

A database to track inpatient and ED discharges and follow up and billing was developed. It has been further expanded to facilitate billing the participating practices for reimbursement of care management codes.

Local community resources were identified and the Care Manager met personally with key resources to attain additional information regarding the services provided, eligible patients, and referral processes. The Care Manager developed a list of community resources with which to connect patients and families, to address barriers to care, reduce risk factors, and improve patient/family satisfaction.

Chronic disease and self-management resources were developed to further support patients, with emphasis on easy to read materials and lower health literacy options. Self-management action plans and chronic disease care plans were developed. This includes Congestive Heart Failure, Diabetes, Hypertension, COPD and Asthma.

As an unintended benefit, our Centralized Care Manager has proven to be a valuable resource for education and mentoring for the embedded Care Managers within our other Answer Health practices.

What are you proudest of regarding this submission? Why does this work matter?

We have several reasons to be proud; the program has experienced high physician and practice engagement and satisfaction, and patient willingness to engage in phone outreach and follow-up. Many patient concerns and complex situations have been identified before they became issues. We have been able to experience that this work makes a difference. We share one example below:

A patient discharged after a 10-day hospitalization for respiratory failure had discharge instructions for albuterol via nebulizer. The Care Manager identified that the hospital progress notes had documented several times that the patient was allergic to albuterol, and Xopenex had been administered while inpatient. However, the albuterol had not been added to the allergy list. Upon contacting the patient, the Care Manager learned that her reaction to albuterol was “my lungs shut down.” The Care Manager contacted the provider at the PCP office, and discussed this issue. Albuterol was then added to the allergy list and discontinued, and Xopenex was prescribed for the patient. Additionally, the Care Manager identified that the patient did not even have a home nebulizer, so this was ordered as well. Upon learning this, the Medical Director for Answer Health stated that the Care Manager outreach and follow up “could have potentially saved this patient’s life.”

How will your organization use the funds if your submission wins?

Funds received for this recognition award will be used for on-going support of our Centralized Care Management program, including:

- Expanding the Centralized Care Management program, with additional Care Managers, to provide transitional care management to more Answer Health PCP practices without embedded care managers
- Engaging additional practices with embedded care managers who are requesting assistance with high level, evidenced-based transitional care management
- Expanding to provide longitudinal care management services to patients determined to be at risk for future inpatient admissions and readmissions and frequent ED utilization
- Add consultative pharmacist care management services for patients with complex medication plans