Consortium of Independent Physician Associations

**Submitter Name:** Linda Mackensen
**Submitter Title:** Executive Director
**Submitter Email:** lmackensen@medadvgrp.com
**Submitter Phone Number:** 734-740-9195
**Physician Organization Name:** Consortium of Independent Physician Associations (CIPA)
**Practice Name, Address, # PCPs:**

| | | |
|---|---|---|
| Sita Medical Clinic | Western Wayne Physicians-Allen Park | Sterling Area Health Center-Ogemaw |
| 995 Ford Avenue | 8338 Allen Road, Suite 101 | 1827 E. Greenwood Road |
| Wyandotte, MI 48192 | Allen Park, MI 48101 | Prescott, MI 48756 |
| 4 PCPs | 6 PCPs | 1 PCP |

**Description of care team:**

- Sita Medical Clinic – 1 RN that is a Complex Care Manager (CCM)
- Sterling Health Centers – Ogemaw: 1 RN that is a CCM
- Western Wayne Family Practice – Allen Park: 1 RN (BS, CCM, CRRN, CRNI, CCP); MAs & Front Desk trained in SMS

**Executive Summary**

- CIPA has been actively involved in the PDCM program since its inception. Many practices were transitioning from the MiPCT program to PDCM.
- CIPA developed comprehensive training of its Practice Consultants on PDCM, who in turn educated their individual practices.
- "One size does not fit all" in implementing care management. CIPA developed its care management program at the physician organization (PO) level and due to the diversity of practices, it can be modified appropriately and tailored to each practice to meet its patient population needs.
- A documented workflow process helps the practices streamline care at the patient level. Use of PDSA's and/or iterations of practice workflows are necessary to determine what is the best approach for each practice. Ongoing education, training and coaching is required for sustained improvement and engagement.
- PCP involvement and engagement are critical to the success of the program.
- The workflow developed at the PO level has assisted practices to improve HEDIS quality scores, most notably in A1c testing and control of blood pressures. In 2017, CIPA had a 4.6% increase in closed gaps, and in 2018 a 1.6% increase in closed gaps. CIPA overall has shown a decreased inpatient admission rate. Process improvement is ongoing to lower inpatient admissions at the practice level.
- Practices have experienced incremental increases since 2016 in PDCM engagement and achieving PDCM Value Based Reimbursement (VBR).

**Category of Submission:** Care Management Workflow

**Title of Submission:** The Importance of Care Management Workflow Process in Team-Based Primary Care

**When did the intervention start and end?** CIPA had a change in leadership and practice consultants at the end of 2014. In 2015, the Practice Consultants actively worked with the practices (which were also part of the MiPCT program) to transition to the PDCM program. Interventions are still ongoing as we continue to engage more practices in care management.

**Goal of the program/intervention:** The goal of CIPA's care management (CM) program is to develop a comprehensive, interdisciplinary program aimed at implementing and sustaining care management and care coordination in the practices. This can be accomplished through ongoing education and coaching of its Practice Consultants, care managers, physicians and other members of the care team. CIPA aims to increase practice participation in PDCM so they can become eligible for PDCM VBR.

**Who developed the program/intervention, and how?** The program was developed by an experienced and diverse team with several years of CM experience. CIPA has several Practice Consultants who have worked on care management integration since before it was part of the healthcare landscape. Their involvement and work intensified with the inception of MiPCT which included enhanced training in CM at Geisinger and Self-Management Certification. In addition, two of our Practice Consultants managed the implementation of the DIAMOND Model and COMPASS integrating workflows to include the behavioral health component of care.

**Description of the Program/Intervention:** The care management intervention is a multi-step process that is tailored for the care manager but can be adapted to any staff member on the care team, independent of their licensure. Each team members' roles and functions are identified within the scope of their work responsibilities and documented. The process workflow is based on responding to "who/what/when/where/why" for each staff member and patient interaction. The primary (or lead care manager) directs the care management activities while under the direction of the physician.

Buy-in and physician engagement is important. Some key points for physician engagement that were utilized included:

- Sharing and helping them understand the financial impact of the program, including a business case model;
- Working with the most challenging patients to demonstrate change;
- Working with patients eligible for TCM and noting change in readmission rates.

Education of the care manager on role integration with other staff members and the physician/s is a key component of the program. Group meetings with the team members to develop patient workflow leads to improved communication and learning from each other the impact of each person's role. CIPA has an online PCMH Toolkit with tools available to assist the care managers and teams with implementation, such as templates for planned care visits by condition, population health guidelines, billing and coding tips sheets, and HEDIS analytic reports developed at the practice and physician level that is produced on a monthly basis. Every team member billing PDCM codes attends the required BCBSM billing course and becomes part of the team meetings, even though they may not provide direct patient care. This helps to ensure correct coding and documentation. CIPA developed a tutorial on checking eligibility for PPO and MA PPO patients and front desk staff are trained on it. Ongoing education with the Practice Consultant on PDSAs, workflow, case reviews, and a documented approach for each staff member have provided the most success in implementing and sustaining care management. CIPA requires all practices to attend their Billing and Coding education programs of which PDCM and TCM programs are included. Practice Consultants meet with their practices monthly and review the PDCM lists, billing and documentation, and discuss any changes to the workflow process.

Based on how patients are identified in the workflow, the CCM reviews the schedule to determine how soon the patients will be coming in and when to call the patient to discuss care management. When patients are being seen in the office for a planned care visit or post inpatient discharge appointment, the CCM introduce themselves to explain the purpose of care management and its benefits. The physician meets with the patient and reinforces the role of the CCM. Two of the practices have adapted the workflow to allow the CCM to see the patient before the doctor sees them, which resulted in increased patient engagement. After the office visit, much of the goal setting follow-up is done over the phone to accommodate patient's schedules.

In 2019 with major changes to the PDCM program, CIPA held two PDCM webinars for all its practices that included the former program, new program, billing, training requirements, care management workflow, and how to use the monthly BCBSM PDCM patient list.

**How were patients identified for the program/intervention?** Patients at the practices are identified by different means, depending on the progress of care management within the practice. Every practice started with one identified condition (diabetes), then as they became more adept or as a result of inadequate engagement, expanded their approach. Patients are identified through physician referral inpatient discharges, ER visits, the CCM, PDCM patient file, risk assessment, and/or chronic condition population. The workflow is initiated based on identification method. When using the PDCM patient list, the CCM and physician determines who would be a good candidate and prioritize by high relative risk scores, disease conditions, and/or potential high costs. All three practices are on an EHR and able to generate patient lists by condition and care gaps needed. Practices use CIPA's Carespective™, a secure web portal that imports continuous Admission-Discharge-Transfer (ADT) feeds and notifications from primary hospitals, to identify inpatient admissions and ER visits. All inpatient discharges are called within two (2) days to initiate the TCM process. All ER patients are called for follow up care needs.

**How was success measured?** Success was measured in several ways. First, through care management workflow implementation we were able to expand the number of practices submitting PDCM claims and increase the number of PDCM claims submitted overall. This supports that our tools and approach did increase the number of patients receiving PDCM services. Additionally, we were able to see changes in the following metrics over a 3-year period (2016-2018): A1c testing; A1c < 8; Controlled Blood Pressure; Total Inpatient Use/1000 (adult and children combined); Total ACSC inpatient rate (adult and children combined); and 30-day readmission rate.

**What were the program results? Include qualitative data/graphs.** The number of practices billing PDCM codes has increased and the number of paid PDCM claims more than doubled from 2017 to 2018. (BCBSM data file for YE 2017 and 2018 supplied to CIPA; 2016 was not supplied for that year by BCBSM).

| | Number of CIPA Practices Submitting 2 or more PDCM Claims | Number of PDCM paid claims |
|---|---|---|
| 2017 | 17 | 1232 |
| 2018 | 24 | 3260 |

The workflow has helped to decrease inpatient utilization and improve HEDIS scores for CIPA. Clinical and utilization measures were based on year-end results comparing three years data from 2016 to 2018. Based on retrospective utilization reports, CIPA's overall inpatient rate has decreased from 59/1000 to 55/1000. Ambulatory Care Sensitive Condition (ACSC) inpatient use has decreased from 4.22/1000 to 3.22/1000. The 30-day all cause readmission rate has increased slightly from 6.97% to 7.69%. Testing for A1c has increased from the 50$^{th}$ to 75$^{th}$ NCQA percentile. A1c Control < 8 is stable at the 50$^{th}$ percentile for 3 years. The Controlling Blood Pressure measure has increased from the 50$^{th}$ to 90$^{th}$ percentile.

CIPA chose three practices to highlight due to their increased level of PDCM engagement and the ability to pull historical data files. HbA1c tests are in the NCQA 90$^{th}$ %; Only one of the practices has an A1c < 8 in the 25$^{th}$%; the other two are 90$^{th}$%. Controlling Blood Pressure are in the 90$^{th}$% for all three practices. Inpatient admissions are decreasing every year. One practice had no readmission or ACSC rates reported. Western Wayne had increases in inpatient admissions and 30-day readmits in 2017, with large decreases in 2018. Their ACSC rates decreased every year. Sita had inpatient admissions and ACSC increases in 2017, with large decreases in 2018 to below their 2016 rates. Their 30-day readmission rate decreased every year. See Addendum for results and graphs.

**Were any new tools, processes, or resources developed to aid in the implementation of the program/intervention?** CIPA created an online PCMH Toolkit of resources that includes the BCBSM PCMH program resources, process development and implementation guides, and is updated as changes and new material becomes available. Practices can download materials or listen to webinars 24/7. It also includes billing and coding resources and tools ("QTIPS"); PDCM resources; a webinar catalogue; access to daily ADTs via Carespective$^{TM}$ (interfaced with MiHIN); monthly patient gaps in care lists; population health guidelines with monthly activity tracking; and patient attribution files. The BCBSM monthly PDCM patient lists are sent to the CCMs. CIPA modeled a financial impact template to determine the cost-benefit and return on investment for a CCM and based on the number of potential TCM and PDCM encounters. Planned care visits were developed with a process workflow, templates by role and chronic condition, and action plans, to meet the needs of the practice and patients. An additional process workflow was created and based on type of patient identification. CIPA started a bi-monthly webinar series in 2018 which are recorded and available to all CIPA members. TCM, Billing and Coding, and PDCM webinars have been held since 2017. Two more webinars focused on PDCM are scheduled for August and October, which also includes a physician presentation on PDCM.

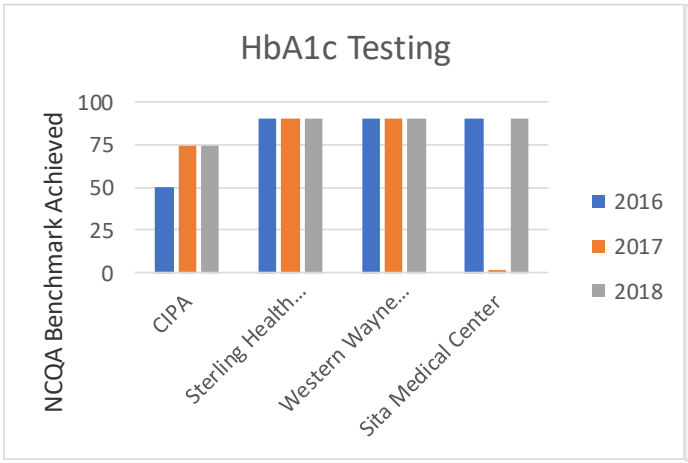
**What are you proudest of regarding this submission? Why does this work matter?** All three practices have received PDCM VBR in 2015, 2016, 2017 & 2018. One is receiving Advanced PDCM VBR in 2018 and participates in the CPC+ program. The practices have expressed that patients have a better understanding of their disease process. They are feeling empowered to make healthier choices. Practices are experiencing less ER visits and inpatient admissions, and improved overall quality scores. Additionally, the care teams are developing trusting relationships with each other, resulting in team-based care. They are excited to be doing this work and willing to share their experience and help other practices do the same. The physicians have expressed they could not do their job without their CCM. CIPA knows the importance of this work and is proud of the improved HEDIS scores and decreased use of health care resources as it means that patients are excelling at better self-care.

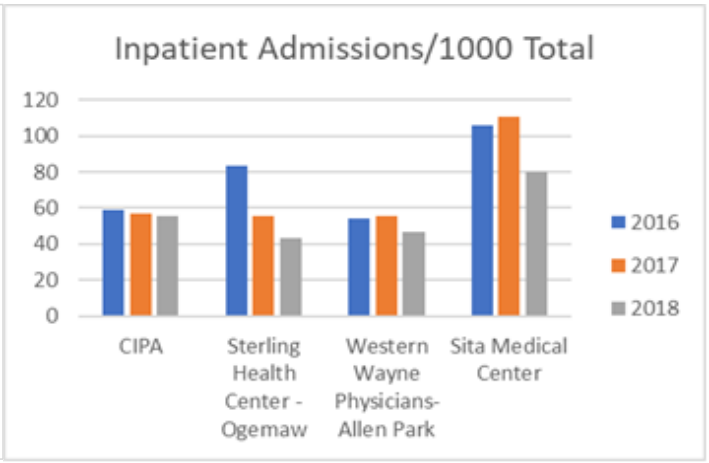
**How will your organization use the funds if your submission wins?** If CIPA is a recipient of the Care Management Workflow Best Practice award, it plans to use the funds to implement care management using the best practice workflows as identified here, targeting those practice units that are unable to sustain care management efforts independently. Webinars on the financial rewards of investing in care management, developing a written workflow specific to a practice, planned care visit implementation, and billing and documentation will be offered. CIPA will also include continued 1:1 coaching for a successful outcome.

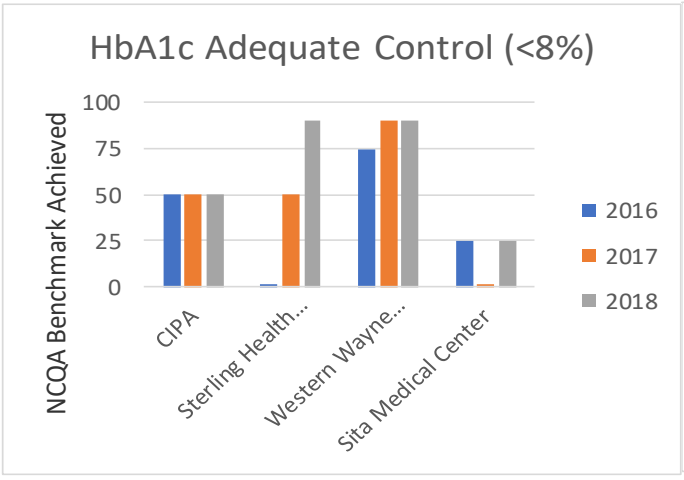
Self-management support (SMS) is a vital component of the PCMH model of care and PDCM. CIPA would train two CIPA Practice Consultants in formal self-management who will then train and work with practices on implementing SMS. Implementation of SMS would improve communication skills among team members and with patients, resulting in highly effective, engaged practice teams. CIPA will target high-volume independent practices, RHCs, and FQHCs first. Use of self-management support techniques with the patients should lead to further improvements.

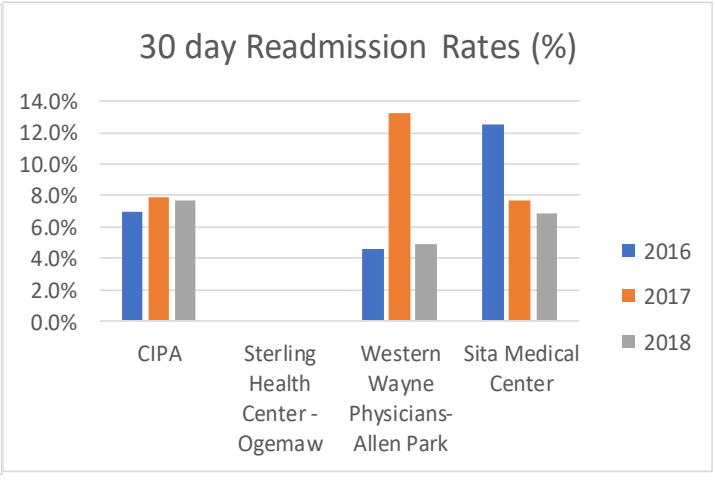
**Addendum 1**

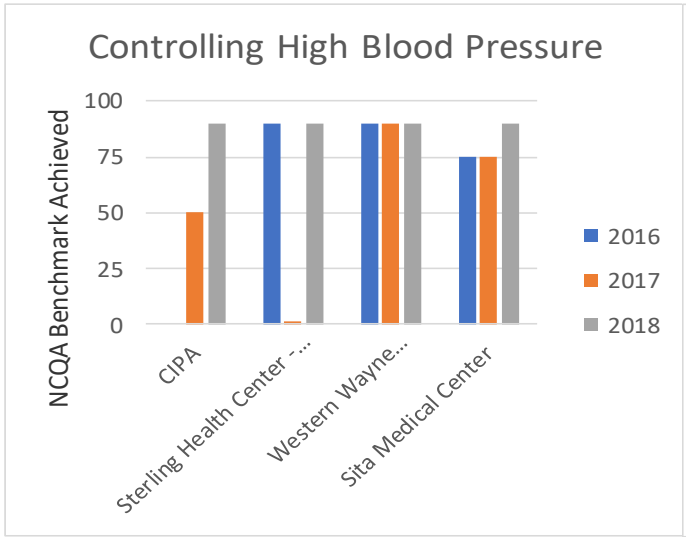
**Clinical Measures and Utilization 2016 – 2018**

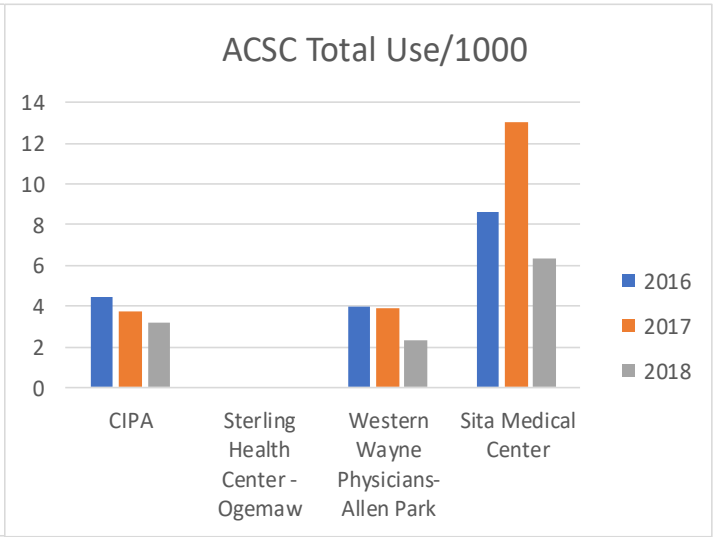



Sterling Health Center – Ogemaw had no ACSC IP admissions in 2016, 2017 or 2018