holland pho
Physician Hospital Organization

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Holland Physician Hospital Organization
175 S. Waverly Road
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9 Primary Care Practices representing 42 Physicians, 24 Care Managers (14 Registered Nurses, 4 Certified Diabetes Educator, 6 Behavioral Health Specialists), and 8 Care Coordinators (MA, LPN, other)
Care Transitions Team: 4 Registered Nurses

Holland PHO
Blue Cross Blue Shield Value Partnerships
Care Management Recognition Awards – Best Practice

Care Management Workflow – Building a Foundation for Consistency

Holland PHO's pathway to 100% PCMH and PDCM designation status did not happen overnight and without many opportunities for course-correction. What started as a team of just five care managers in 2015, has grown to a team of 35+ care managers and care coordinators across the clinically integrated network. ***Outlined below are the hallmarks of Holland PHO's highly successful, fast-growing care management team that are indicative of the many workflow improvements Holland PHO has implemented to overcome challenges in developing a high performing care management program:***

Care Management Policies and Procedures:
In the early days of Holland PHO's care management program, the PHO's Quality & Care Management Committee developed a Letter of Understanding (LOU) approved by the Board of Directors that laid out expectations to assure consistency in training, communication and key processes amongst care managers within the PHO. Within the LOU was a mechanism for sustainability of the care management program that took the form of an Assessment charge on payer incentives earned by the practice to support PHO care management staff and program oversight. With growing support for care management services from the payers, Holland PHO experienced a shift from centralized care management resources to embedded care management around 2017 as practices sought to hire and train their own staff. This de-centralization brought on a new challenge to ensure consistency in the function of care managers within the various offices. A subcommittee of care managers was appointed to develop a network-wide Holland PHO Care Management Policy and Procedure that defines the scope of care management, from patient selection to care manager assessment and implementation of a care management plan.

Regional Care Management Contact List
When Spectrum Health instituted Interactive Voice Recognition (IVR) robo-calls for all Spectrum Hospital discharges in late 2017, Holland PHO advocated for an option for warm-handoff to the patient's Primary Care Physician when patient issues were identified. Holland PHO worked with Spectrum Health on the rollout of this new program, including presentations to care managers and coordinators, meeting with office staff, and a shared care manager contact list to encourage collaboration. This list has since expanded to include Answer Health physicians and is also utilized by Holland Hospital care management to assist in discharge planning for at-risk patients originating from other networks.

Partnering with the Hospital
In 2016, a Care Transitions Team (CTT) was formed out of Holland Hospital as a means to improve hospital readmission rates for patients discharging with specific diagnoses that put them at highest risk for readmission.

The BOOST readmission risk tool was integrated into Cerner to provide automated early identification of specific readmission risk factors and corresponding interventions, preparedness checklists and discharge instructions, including patient "teach-back" instructions provided at bedside prior to discharge.

While focused efforts can contribute to improved performance, formation of this new team created a significant overlap in the outreach efforts of ambulatory care managers within the 30 day period post-discharge. In addition to using the regional contact list for case conferencing on shared patients a workflow was created as not to duplicate efforts. Since CTT does not bill for care management encounters as they are hospital-based, Primary Care Physician (PCP) Care Managers can still utilize transitions of care codes (99495 & 99496). Patients still may receive two calls in the two business days following discharge, but the telephonic assessments seek different information and the nurses work to inform patients accordingly of this team approach. For example, CTT will not do a medication reconciliation if the PCP care manager has already completed it. After thirty days, CTT completes a fax notification form "discharging" the patient from CTT to PCP, including pertinent readmission risk indicators for the ambulatory care manager to be wary of, including patient risk score based on the BOOST tool. Often times this hand-off results in a team conference to review the case. Condition-specific patient education materials are in a shared toolkit behind login on Holland PHO's website, so that ambulatory care managers can deliver a consistent message based on the information the patient received in the hospital.

Collaborating with Skilled Nursing Facilities

The Holland Hospital Care Transitions Team helped pave the way for building relationships with the local Skilled Nursing Facilities (SNF) as they case conference on patients within the 30-day surveillance period and hold them accountable for preventing unnecessary readmissions using a performance dashboard.

As the relationship with local SNFs developed through quarterly meetings, the request was made to the SNFs to improve their discharge process, particularly with regard to notifying patient's PCP. Differences in electronic medical record systems and operational workflow within the SNFs culminated in the adoption of a standard discharge fax notification form and utilization of the regional care management contact list beginning in early 2019. Care coordinators in the PCP offices are also using a spreadsheet to track SNF admissions as they are made aware via daily ADT monitoring activities.

Care Management Targeting

Currently, care management targeting methodologies vary from practice to practice; some practices use unique, internally-developed reports, and other practices rely on standard reporting from Holland PHO and payers to target patients for care management interventions. It is speculated that inconsistent processes with regard to proactively targeting patients for care management has inadvertently emphasized the reactive/episodic aspect of care management with increased focus on Admission, Discharge, Transfer (ADT) notifications and Emergency Department use. Holland PHO plans to refocus its longitudinal care management approach with the recent implementation of a new tool called the Johns Hopkins ACG Risk Manager within our existing Wellcentive registry to systematically assign a quantitative patient risk score to better prioritize patient care within Holland PHO.

Furthermore, there may be efficiencies to gain with this enhanced reporting in regard to which care management team member is most appropriate to work with the patient in a given scenario. In the example of emergency department follow-up for a low risk patient, perhaps a care coordinator is more appropriate than a registered nurse to initiate contact. Despite not being able to bill all payers for that encounter based on different interpretations of a qualified health professional, it creates availability for higher licensed staff to focus on longitudinal engagement for sicker patients.

Reconciling Care Management Encounters

One of the most difficult challenges of building a sustainable care management program is capturing the efforts made from a billable services perspective. Before the Michigan Care Management Resource Center (MiCMRC), now Michigan Institute for Care Management and Transformation (MICMT) posted the Multipayer Billing Code Summary, Holland PHO had developed its own billing resource to support its care managers. Holland PHO's version is unique in that it;

- Highlights which codes are included as part of the various payer incentive programs as there are areas where the different programs do not overlap. Our experience has been that where there is misalignment between programs is where there is most often a gap in reported encounters. We continue advocate for greater alignment between programs, from included codes to the qualifications of the professional rendering care management services.
- Outlines required elements for the various codes which has helped shape care management encounter templates within practice EMRs in an effort to aid workflow efficiencies.
- Troubleshoots popular care management billing/incentive tracking issues to mitigate unnecessary inquiries. *For example: Was the patient attributed to the correct PCP on the date of service.*
- Includes payer contact information to assist in claim resolution for care management encounters.

For practices leasing a care manager from the PHO, encounters are tracked in an Access database to aid in reconciliation efforts and allow for productivity monitoring as the offices are billing for care management encounters on their own. Holland PHO has served as a mentor for other networks in their development of a centralized care management program, and this tracking mechanism for care management encounters has been a distinct characteristic contributing to our success.

Communication and Networking

Expectations for PHO meeting attendance as laid out in the Care Management LOU have ensured that all care managers are engaged in the strategic priorities of the clinically integrated network and aware of important updates. The care managers have enjoyed the opportunity to discuss operational challenges and workflow best practices with one another in these bi-monthly forums. Private PHO contact lists ensure care managers receive timely information as needed in between meetings without being bombarded by other email contacts. The PHO website even boasts a security access level unique to care managers to view relevant information including all PHO meeting materials.

On a semi-annual basis, the PHO hosts a Care Management Summit luncheon to provide education and networking for all community care managers, including key care management contacts from other networks. On odd-years, the Fall Summit is repurposed into a Community Resource Fair with local agencies presenting information about the services they offer to care providers and administrators in our community. Just last week we welcomed over 70 attendees to our 4th bi-ennial Community Resource Fair promoting 34 local agencies.

If Holland PHO was rewarded the Best Practice award in the amount of $125,000, funds would be used in the following manner:

- $31,250 (25% of funds) would be retained by the PHO for the oversight and coordination activities within the clinically integrated network
- $8,750 to add Continuing Medical Education credits for registered nurses and licensed social workers to attend semi-annual Care Management Summit presentations and cover operational expenses associated with the events for 2020-2021.
- $85,000 expense associated with hiring additional FTE to expand the scope of the Holland Hospital Care Transitions Team program to additional targeted diagnoses. It is important to note that CTT encounters are not reimbursed as the CTT team cannot bill for care management encounters under the auspices that they are a hospital-based program.