Care Management Recognition Award

Contact Information:
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Physician Organization Name: Integrated Health Partners
Practice Name: David M. Byrens, M.D., P.C.
Practice Address: 215 E. Mansion Street, Suite 2F, Marshall, MI 49068
How many physicians in practice: 1
Description of care team: 1 Physician, 2 Physician Assistants, 3 Registered Nurses/Care Managers, 1 Licensed Practicing Nurse, 3 Medical Assistants, 2 Receptionists, 1 Biller, and 1 Office Manager

Executive Summary:

- Our team began laying the groundwork for care management workflow in 2009 with PCMH and have continued to develop it through MiPCT, SIM, and CPC+.
- Dr. Byrens employs a larger than average number of support staff, including three registered nurse Care Managers, for a patient population of approximately 4500.
- The care management workflow has been developed and supported by Dr. Byrens and his staff.
- During office hours, there are two Care Managers available to work with patients: a designated Care Manager who is actively working on care management-specific tasks, and a secondary Care Manager who is answering phones or rooming patients and can provide care management to patients if the other is busy.
- The results have been measured based on ER and hospital utilization scores, PGIP scores, performance scores, and PCMH rankings.
- Our performance has been well below the PGIP average for emergency department rates and inpatient discharge rates. Additionally, we have ranked within the top 15 practices for Patient Centered Medical Home and have a Quality/Use Percentile ranking of 95% or higher statewide since 2013.

Category of Submission: Care Management Workflow

Title of Submission: Creating a Long Term and Sustainable System of Care through Care Management

Description of the Intervention/Process:
Our office began the process of creating its current environment of care and subsequent care management workflow in 2009 when we first became Patient Centered Medical Home designated. It continued to grow with the MiPCT program from 2012-2016 and has seen many developments through the CPC+ and SIM programs.

The goal of our system of care is to improve the health and services provided to our patients and maintain that consistent level of care. When this is achieved, the outcome is lower utilization costs in both emergency department usage and inpatient admissions. This also results in better performance in patient health metrics, such as controlling blood pressures and diabetic numbers.

This program, and the office environment which supports it, has been created and maintained through the support and drive of the owner/physician, David M. Byrens, M.D. He has managed his practice with a constant aim of always providing for his patients the support and resources needed to reach their health care goals. He further supports his commitment by acting as a Care Management Champion and Medical Director at our physician organization, Integrated Health Partners.

Dr. Byrens has been able to develop a unique care management workflow by building a support staff that is larger and has a higher licensure than is typical in a primary care office. He employs three full time registered nurses who have all completed and maintain care management training to provide care for a patient population of

approximately 4500. In addition to the nurses, he also employs two physician assistants, one licensed practicing nurse, three medical assistants, two receptionists, one biller and an office manager. His staffing choices have created an office environment that is efficient while also sustainable, allowing for cross staff support, training, and participation in programs including Patient Centered Medical Home, MiPCT, and CPC+, as well as Provider Organization and BCBS led collaboratives. The office's active and ongoing participation has ensured a continuous focus on patient care and practice transformation. This has led to very little turn over or burn out among employees. On average, his staff members have been with the practice for 6.5 years. They know office policy and procedure and have a strong history with the patients themselves, allowing staff to perform at the top of their licensure. The result is better patient care and in turn continuous and sustainable performance.

Dr. Byrens feels he and his staff are best able to provide care management services when they are available at the point of care with a well-trained and experienced staff member. He knew from previous experience that if you were able to meet the patients' needs before they left the office, they were much more likely to follow through and receive the service needed. In a typical workday, there is a Care Manager who shares a workspace with the providers and is dedicated to care management for the day, as well as a secondary Care Manager answering phones. This set up is beneficial in multiple ways. First, having a Care Manager sharing a space with the providers allows for frequent communication throughout the day. Second, having two Care Managers provides support if one Care Manager is busy with another patient. Dr. Byrens frequently sends a Care Manager in with a patient following his consultation with them. The benefits of this flexibility are: the patient receives care faster; there is a warm hand off between the patient and provider; and as a provider he increases his productivity while still ensuring a comprehensive visit by allowing the Care Manager to provide whatever service is needed. They may work on teach back or additional education with a patient he feels needs more support, clarify medication changes, work with a caregiver on a care plan, or any number of other services. Care Managers answering phones also allows them to be familiar with our entire patient population, rather than only those involved in care management. Patients are more comfortable with a staff member with whom they have previous experience and will be more inclined to work with a Care Manager if they need one.

Creating this office environment has been a rewarding investment by Dr. Byrens with the continued support of payers like Blue Cross Blue Shield through an ever-evolving income model. Traditional fee for service care is not enough to maintain larger and more qualified staffing. Through continued focus on care and outcomes, value-based reimbursement and performance-based incentives have become a key portion of office revenue. This creates a cycle of reinvestment between Dr. Byrens and his staff with insurance payers and the patient, who benefit from the office's care.

How were patients identified?

In terms of identifying patients for care management, there is no one size fits all method. The process has evolved as the office grew their care management program and its capabilities. Initially patients were targeted based on chronic conditions (Diabetes, Hypertension, COPD, etc.). Under the CPC+ program, risk scores have allowed us to identify additional populations. As the office has progressed and developed new workflows, it has allowed us to target additional populations and refine existing care management practices to best provide patient care.

A unique aspect to our care management referral process is that anyone in the office can refer a patient to the care manager. This allows us to identify need at many different levels. For example, if a patient is speaking to the front desk and indicates that they cannot make a visit due to lack of transportation or loss of insurance, then the front desk person can ask a Care Manager to work with the patient to address the need.

How was success measured?

Success has been measured based on several metrics. These include ER and hospital utilization rates, PGIP scores, performance scores, and PCMH rankings. By working with our provider organization, Integrated Health Partners, we can regularly track our performance and review data for improvement. We meet regularly with our coach to assist in identifying areas for development, as well as opportunities to connect with our peers to explore best practices.

What were the results?
The results have been continuously high patient care and satisfaction, consistently lower ER and hospital utilization rates, and high rankings/scores in performance-based programs. We are proud to announce that we recently received recognition from the CPC+ Interventions Subcommittee and Steering Committee for our work in Emergency Department utilization and Inpatient Utilization, receiving a ranking of 2nd in Emergency Department Utilization and 12th in Inpatient Utilization out of the 432 Michigan CPC+ practices for 2018. Additionally, as illustrated by the charts accompanying this paper, one can see our performance has been well below the PGIP average for emergency department rates and inpatient discharge rates. Our work in maintaining and improving quality metrics like breast cancer screenings, controlling high blood pressure, HbA1c testing, monitoring for nephrology and especially colorectal cancer screening rates are clearly shown in the graphs following this paper. These continued efforts have resulted in rankings within the top 15 practices for Patient Centered Medical Home and a Quality/Use Percentile rankings of 95% or higher statewide since 2013.

What new process was developed?
In order to truly implement care management across our patient population, we created a process that allows Care Managers to be readily available at the patient level. Having Care Managers room patients and answer phones means that patients can be identified during every-day interactions where they may have otherwise gone over-looked. Registered nurses receive a level of training much higher than a medical assistant. As a result, they ask more questions, can offer more medical education, and can identify patient needs. In one case, a Care Manager was answering phones when she got a call from a patient requesting a prescription for a transportation chair to get her husband to treatments 45 minutes away. After some discussion, the Care Manager identified the wife's anxiety around transporting her husband to his treatments. She inquired with the specialist overseeing the patient's care and found he was being sent by the specialist to their standard facility, rather than one convenient for the patient. The Care Manager was able to facilitate an option available in town as an alternative, resulting in less stress and transportation concerns for the patient and his wife. Taking the whole picture into consideration instead of just the initial request resulted in positive outcomes that elevated patient care far beyond standard practices.

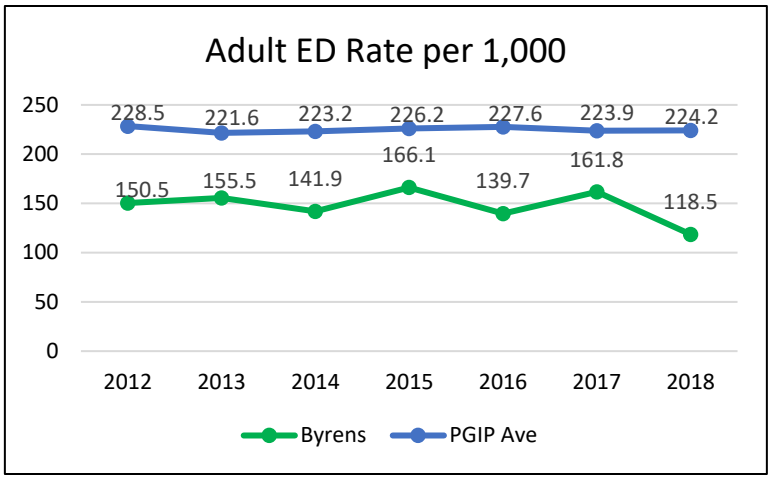
What are we proudest of as a result of this process?
We are proudest of the care and support we provide our patients. Our practice is independently owned and located in small, historic downtown Marshall. The patients we care for are members of our community. Dr. Byrens and his wife are actively involved in many of the town's organizations, and work to support resources like the Fountain Clinic, which provides care for under or non-insured individuals in our community. For Dr. Byrens, patient care is personal.

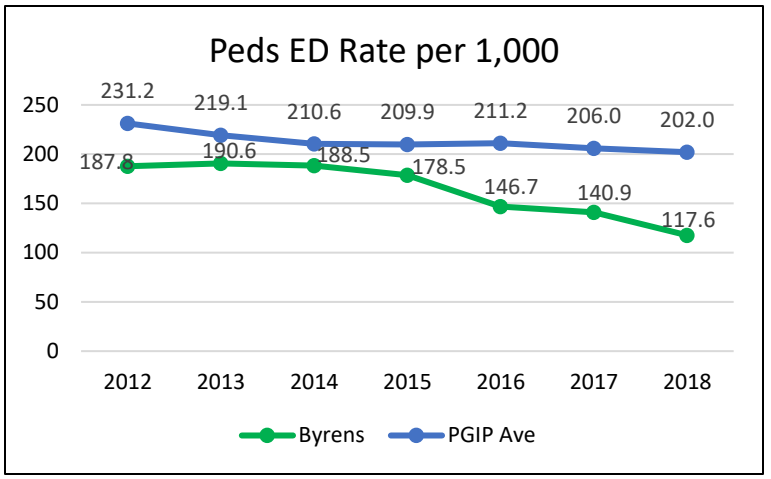
What would our practice to with the funds if honored?
If our office is honored with a Care Management Recognition award, funds will go toward rewarding the efforts of staff in this process, as well as towards continuing to fine-tune and adjust our program to benefit our patients. Additionally, we would like to add an employee to the staff in order to further support care management and workflow. In order to achieve the goals that care management sets forth, support from payers like Blue Cross Blue Shield remains critical. Fee-for-service medicine is becoming more outdated in its ability to support comprehensive, quality patient care, like that offered within our practice. Years of work has gone into growing a care management model that is both effective and sustainable. We look forward to continuing in our efforts, with the help and support of Blue Cross Blue Shield, to improve the health and care of the community we serve.

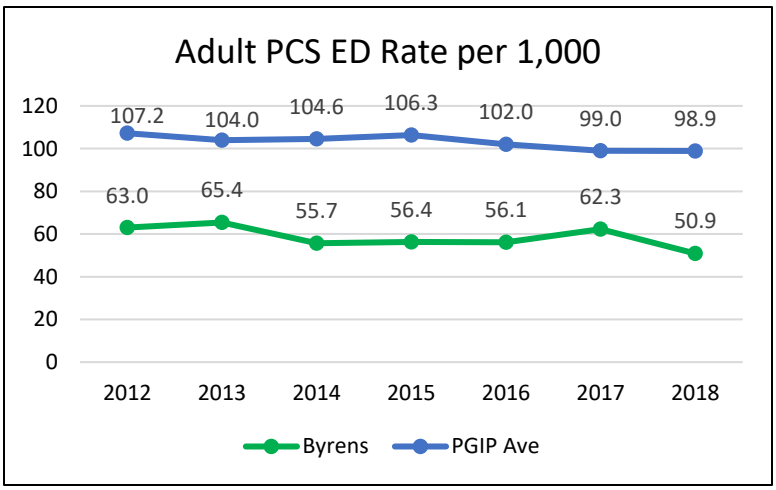
Appendix 1

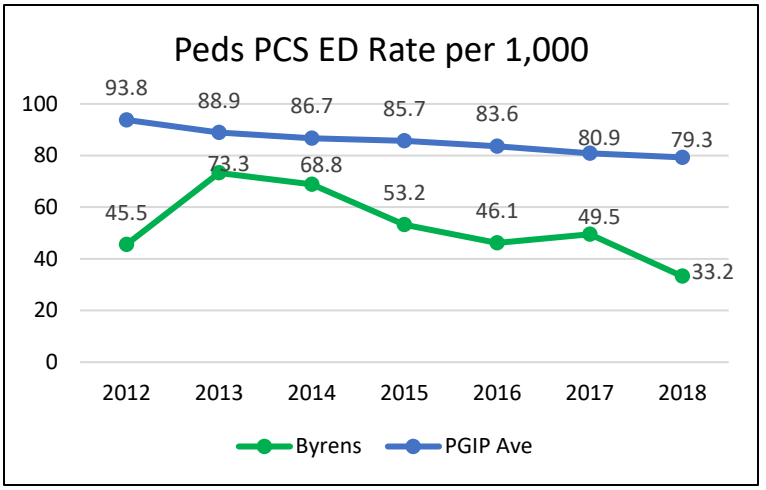
Emergency Department Utilization Improvement

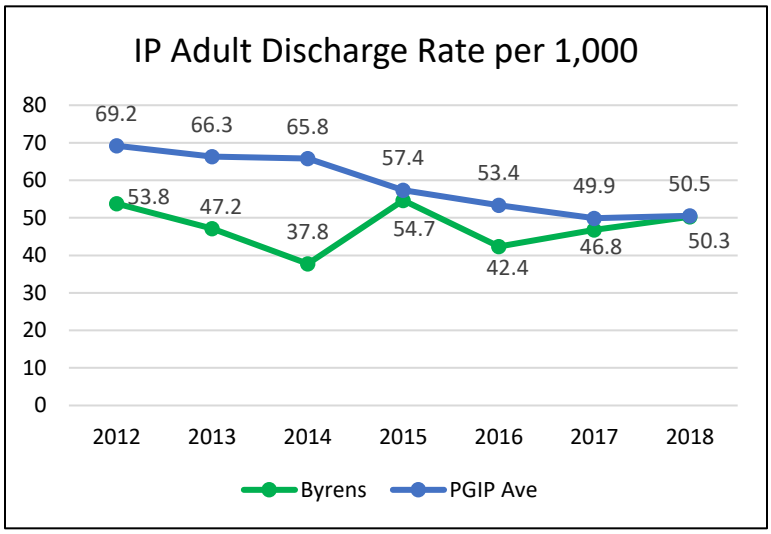
David Byrens, MD

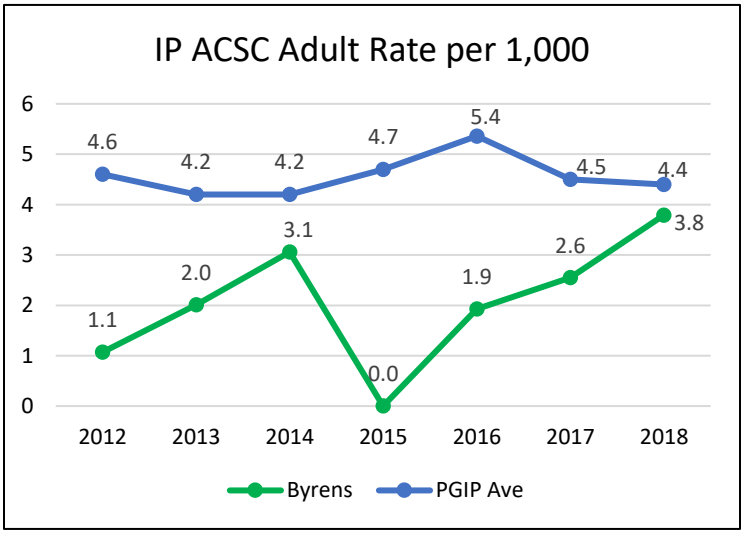








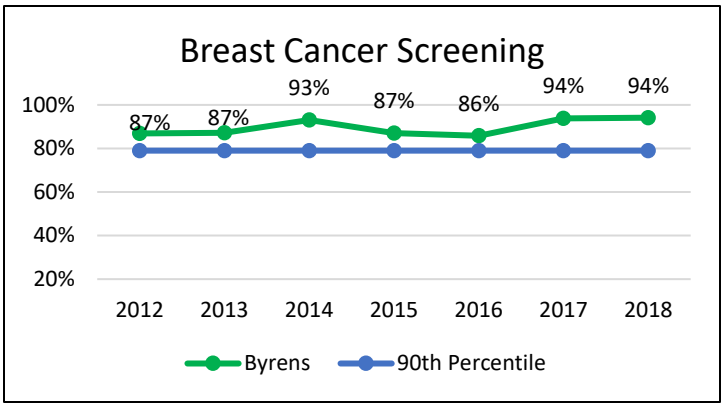


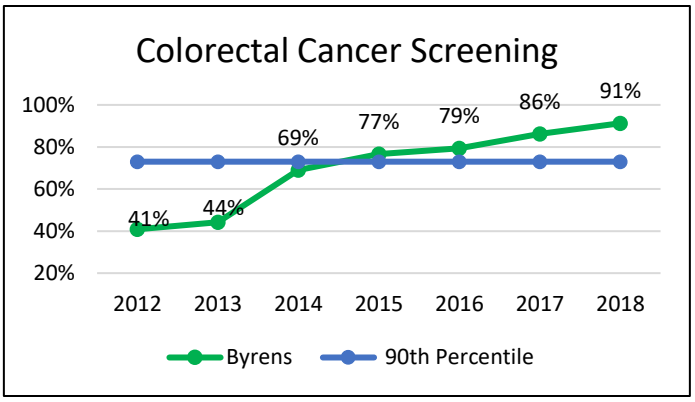


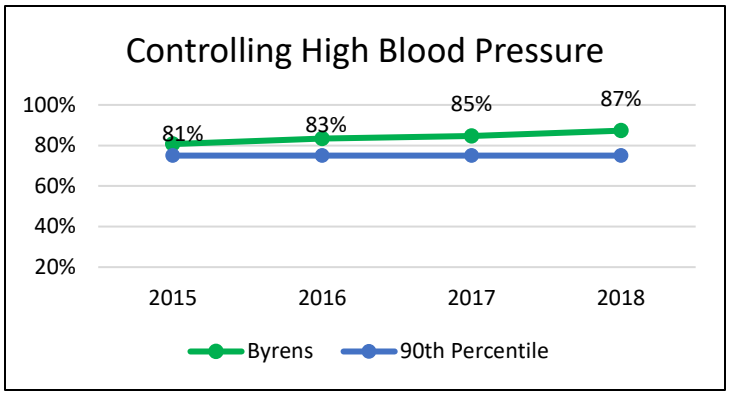
Appendix 2

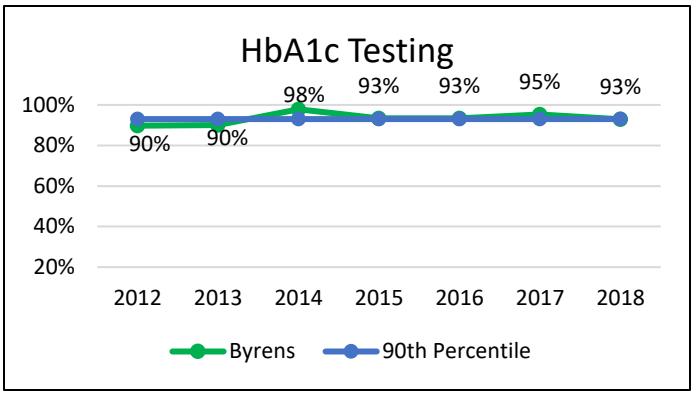
Inpatient Utilization Improvement

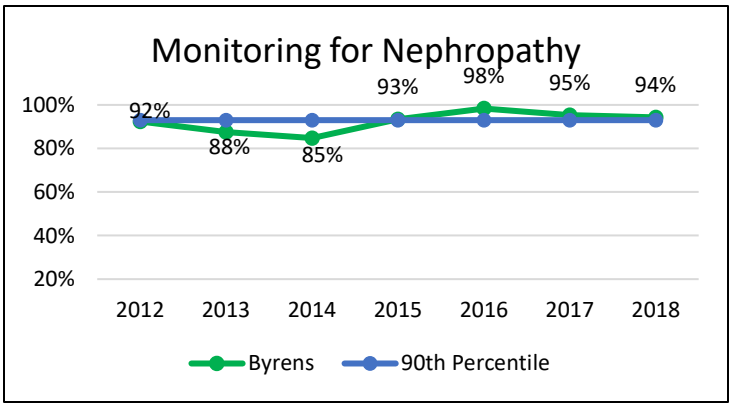
David Byrens, MD

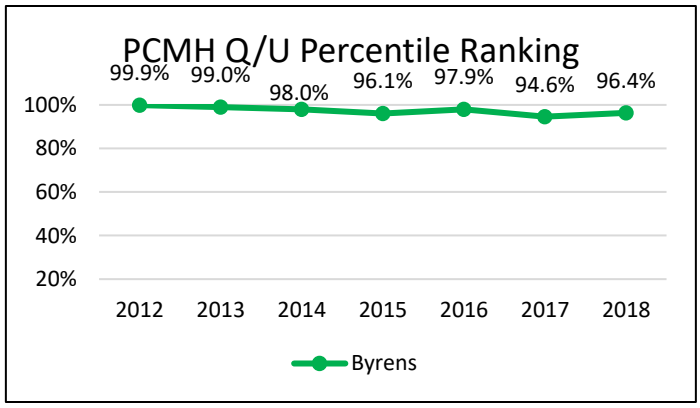












Year	Dr. Byrens' Rank
2012	1st of 62
2013	1st of 61
2014	1st of 58
2015	2nd of 61
2016	2nd of 50
2017	1st of 49
2018	1st of 47