Contact Information:

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Physician Organization Name: Professional Medical Corporation
Practice Name: N/A
Practice Address: N/A
How many physicians in practice: N/A – this program serves 21 practices and 41 primary care physicians
Description of care team (# of care team members and their degrees/qualifications, at the time of best practice activity): 1.0 FTE of Clinical Lead Registered Nurses, 1.0 FTE Behavioral Health Counselor, 0.6 FTE PharmD, 0.5 FTE Registered Dietitian, 1.0 Licensed Practical Nurse

Executive Summary (5-8 bullet points, must include summary of results):

- Providing specialized and supportive care management to PO-specific members free of charge
- Serving the managed Medicaid, BCBSM commercial/MA, and other commercial populations
- Centralized specialists (pharmacist, behavioral health counselor, dietitian) available for unlimited referrals to 21 primary are practices
- Supportive personnel to reduce administrative burden on individual care managers of report generation, program-related troubleshooting and oversight, and data entry
- Provide centralized support for the transition of care process, initiating the phone call requirement

Category of submission: Care Management Workflow

Title of Submission: Improving Patient Outcomes Through Centralized Multidisciplinary Care Management

On January 1, 2017, Professional Medical Corporation (PMC) began piloting this intervention as part of the Michigan State Innovation Model (SIM), which continues to this day. The goal of this program is to provide specialized care management support to all participating practices as well as administrative support to all embedded and centralized care managers. In turn, it allows for maximum direct patient care time, increased member outreach, and an improved transition of care process which reduces emergency department utilization, inpatient readmissions, and overall cost of care in Genesee County's most underserved patient populations.

This program was developed by PMC leadership with consulting input from the population health department at Medical Advantage Group. This model was developed as part of the Michigan State Innovation Model (SIM) but has expanded beyond the grant-mandated managed Medicaid populations to also serve BCBSM commercial/Medicare Advantage and other commercial plan populations. The formation of this model was primarily in recognition of the strong needs for behavioral health, nutrition, and pharmacy support in PMC's independent physician organization structure. This model utilized previous program experiences and successes and built a model to include not only embedded care management, but a supportive, specialized centralized care team.

Professional Medical Corporation's model encompasses a centralized care delivery model that is both specialized for direct patient care and supportive administrative personnel. This intervention improves the workflow of embedded care managers, who are registered nurses and licensed Master's level social workers (LMSWs), by giving them an additional level of specialist support including a pharmacist, behavioral health counselor, and Registered Dietitian. Eligible patients can be referred to a centralized, specialized care manager for an unlimited number of visits for any reason. Referrals are made to these three individuals by the embedded care manager or physician using paper or electronic referral forms. This improves the workflow of not only the embedded care manager but also the participating practice, as it reduces the administrative burden of referring patients to external agencies or organizations in Genesee County, where resources are already sparse or overburdened. The behavioral health counselor, pharmacist, and dietitian can meet with patients face-to-face for counseling, either in their provider's office or in a patient room located at PMC's office located in Flint, Michigan.

In addition to the specialized care managers, a supportive individual known as a panel manager is a primary support for PMC's care delivery model. This individual, a Licensed Practical Nurse, has a multitude of tasks that remove administrative burden from embedded and specialized care managers. She is responsible for generating population health reports based on registry data, that assist the embedded care managers with providing targeted care management in the practice setting. Reports focus on key measures such as related to blood pressure, hemoglobin A1c, and high BMI. By creating these reports on behalf of the embedded care managers, it allows for maximum direct patient care at the practice level.

In addition to registry reporting and development of targeted patient lists, the panel manager also contributes to reducing ED and inpatient readmission rates by performing the initial telephone portion of a transition of care (TOC). The panel manager monitors Admit, Discharge, and Transfer (ADT) feeds from multiple sources and initiates a telephone call to the patient or their caregiver. Patients are screened to ensure that they feel comfortable with their discharge plan, including a social determinants of health (SDOH) screen using a comprehensive, validated SDOH screening tool. She ensures the patient has a follow-up visit scheduled, and if not, she is initiating a 3-way call to the practice to schedule this appointment. In turn, this removes the responsibility for the embedded care manager to be conducting these calls or scheduling follow-up appointments and removes the responsibility of the patient to make this appointment themselves. The panel manager also assists with maintaining a comprehensive directory of local community agencies that address SDOH needs, which includes key information, such as key contacts, eligibility requirements, and referral needs in addition to the location and telephone information. Finally, this panel manager identifies patients with no recorded office visit and connects them to their primary care provider to learn about services provided by the Patient Centered Medical Home and circumvent inappropriate utilization.

Lastly, PMC's care delivery model supports improved care management workflow by incorporating clinical leads. Two registered nurses, making up 1.0 FTE, oversee embedded and centralized care managers; educate practices about care management, workflow, and billing; generate care management performance reports; and monitor and drive success with program goals.

Patients for the centralized specialized care managers are identified as being an ideal referral through SDOH screenings, quality measure and registry reporting (e.g., BMI), or discussion of needs via a physician or care manager. Patients referred to the behavioral health counselor can be referred if they express a need for mental or behavioral health services or have a positive screening on the PHQ2, PHQ9, and GAD7 screenings. Patients referred to the dietitian can be referred if they express a need for weight or special diet counseling, if their provider identifies them as underweight, overweight, or obese, or other identified nutritional needs. Patients referred to the pharmacist can be referred through physician refers when non-compliance is suspected, or if the patient is having difficulty affording or obtaining their medications. Referrals are either faxed to the care manager or submitted electronically via the eCW Care Coordination Medical Record (CCMR).

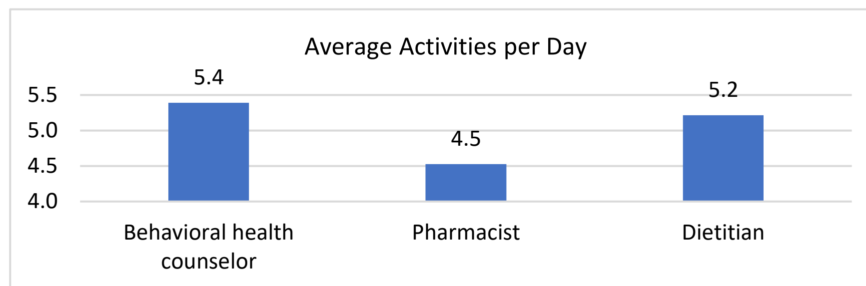
Patients who receive telephonic follow-up after hospital discharge from our panel managers are identified using the MiHIN ADT use case. Our panel managers are monitoring multiple sources of ADT feeds, reaching out to patients via telephone within 24-48 hours of discharge.

Centralized specialized care managers have set performance benchmarks in order to ensure success with both program-defined outcomes as well as patient impact outcomes. Each centralized care manager has a goal of 4 activities per 8 hour day, in which an activity is defined as any qualifying billing code and/or quantity stemming from a patient or physician interaction. Each centralized care manager also "huddles" or completes two G9007's with 80% of the practices that they receive referrals from. To ensure that interactions with patients are effective and that care managers are applying motivational interviewing techniques, each team member is observed by the clinical lead utilizing motivational interviewing and provided ongoing feedback.

Success for the panel managers is measured by set performance benchmarks as well. Panel managers are required to successfully complete 48-hour telephonic outreach to 60% of inpatient discharges. They are also required to deliver panel management reports within 48 hours of a request 90% of the time.

Success for the clinical leads is measured by performance on overarching program goals, which include outreach to 10% of the patient population each year, completing transition of care for 40% of inpatient discharges, and providing feedback on motivational interviewing observations.

In 2.5 years, the specialized centralized care managers have outreached and counseled hundreds of patients. Specifically, the behavioral health counselor has received over 700 referrals and completed over 1,600 patient encounters on over 330 unique individuals. The part-time pharmacist has completed over 900 encounters on over 500 unique individuals and the part-time dietitian has worked with over 350 unique patients, completing and documenting over 750 encounters in just 2.5 years. The behavioral health counselor, pharmacist, and dietitian are also exceeding their daily activity goals, as noted below.



Panel managers, who are assisting with not only registry reports and targeted patient reports, have outstanding rates of reaching patients following an inpatient discharge with 100% of patients attempted to be contacted within 48 hours of discharge. In 2.5 years, panel managers have completed over 1,300 transition of care calls to nearly 1,100 unique patients. The panel manager turns around registry reports to practices and their care managers within 48 business hours 100% of the time, allowing the practice to focus on high-need and high-cost patients.

Clinical leads have driven success with overarching program metrics. Patient outreach averages 2.5-4% per quarter across the program and is on track to outreach to over 20% of unique patients in 2019 and full completion of transition of care visits average 50-70% per quarter. All employees have been observed conducting motivational interviewing and feedback is being provided.

Professional Medical Corporation made a significant investment of resources for this program by employing a 1.0 FTE LMSW to be the behavioral health counselor, a 0.5 FTE Registered Dietitian, 0.6 FTE PharmD, 1.0 FTE clinical lead, and 1.0 FTE panel management. In addition to direct counseling services, the behavioral health counselor also developed a pain management curriculum/program that is aimed to address pain management alternatives to chronic opioid users. A significant amount of resources was also invested in internal MiHIN capabilities, platforms, and improvement of ADT feeds that ensure more accurate and complete transition of care follow-up.

If PMC is awarded Best Practice funding, PMC will utilize the funds to support this centralized, specialized care delivery model for long-term support of PMC's practices. Currently, the program is limited to several of PMC's primary care practices, but by winning such an award would allow transition of care services to be expanded to all of PMC's patients, regardless of practice or payer type. It would also allow PMC to maintain this provision of mental and behavioral health services free of charge to patients, without a limitation on the number of referrals or visits.

PMC is exceptionally proud of this submission as the inclusion of specialized, centralized care managers have significantly improved access to behavioral health, nutrition, and pharmaceutical needs of Genesee County's most vulnerable populations. Supportive care coordinators also remove the administrative burden from embedded care managers, allowing them to not only maximize the amount of time spent in direct patient care, but to do so with PMC's highest acuity patients. Lastly, PMC is proud of this model as they are truly embracing and exemplifying what it means for their practices to be Patient Centered Medical Homes.