Contact Information

Submitter Name: Jamie Mallory
Submitter Title: Continuous Improvement Specialist, RN
Submitter Email: jmallory@mhc.net
Submitter Phone Number: 231-876-7148
Physician Organization Name: Wexford PHO
Practice Name: Cadillac Family Physicians
Practice Address: 8950 Professional Drive, Cadillac, MI 49601
How many physicians in practice: 5 MD, 1 DNP & 2 PAs
Description of care team (number of care team members and their degrees/qualifications, at the time of the best practice activity): The Care Management Team is made up of two trained CMAs that serve as Care Coordination Specialists and 3 Care Managers that are RN or BSN RN trained. We also have one RN trained Annual Wellness Nurse that has completed Care Management training.

Executive Summary (5-8 bullet points, must include summary of results)
Category of Submission (see page 1):

- Care Management Team within the Primary Care Office is embedded within the Quality Department which allows for patient identification to help close gaps in care.
- Embrace the Certified Medical Assistant Role where they are expected to work to the top of their licensure and assist with mildly complex patients who have needs related to Care Coordination
- Certified Medical Assistants follow patients who qualify for Care Management based on risk score and/or disease stage whose insurance does not cover Care Management services
- Systematic approach for identifying patients based on lab values (HbA1C >9%), gaps in care, Emergency Department/Inpatient stays, blood pressure values >150/90, and Social Determinants of Health Needs
- Providers engaged and understand the benefits and importance of the program. Open and frequent communication with Care Team is expected.

Title of Submission: Care Management Matters

When did the intervention start and end? (1-2 sentences)
January 1st, 2017 Care Management was embedded within the Practice. The intervention has no end date. Care Management is an ongoing process that will change and grow as the Health Care System continues to evolve.

Goal of the Program/Intervention: (1-2 sentences)
The goal of our Care Management Program is to reduce Emergency Department and Inpatient utilization, improve quality measures and make a difference in our patient's lives by offering them resources, accountability and self-management skills.

Who developed the program/intervention, and how? (2-4 sentences)
The Program was developed by the Providers and Care Team at our office and continues to change to meet our patient's needs. Examples of ongoing development for our Care Management Team are completing behavioral health and SBIRT training.

Description of the Program/Intervention (2-3 paragraphs):

Care Management cannot solely focus on risk scores because they are based on diagnosis codes only, not the whole person. Our department looks at many different facets that effect a patient's wellbeing including life changes, inpatient stays, new diagnoses, social, financial, behavioral health, and end of life needs.

Care Managers receive referrals from our Providers either via message or warm handoff, other office team members, care coordinators at local hospitals and by reviewing quality reports. The strength of our program comes from having our Quality team incorporated into our Care Management team. This permits ongoing discussion about patients with elevated blood pressure or elevated A1Cs and allows our team to address gaps in care. Our department finds that contacting our patients following Emergency Department visits and Inpatient stays is beneficial not only to our patients but in meeting our payer targets as well. Transitioning home from the Hospital or a Skilled Nursing Facility is often a confusing time for patients and their families, especially when they have lengthy and complicated discharge instructions. Unfortunately, not a lot of is time spent on education when patients are nearing discharge. We often find conflicting medication changes or no in-home resources to keep patients safe. In addition to providing ongoing education, our department is also responsible for reviewing and uploading Social Determinants of Health surveys which also helps us identify patients that have many social concerns that can impact their

physical and emotional health. We know if a patient is struggling to pay their bills, buy food or gas for transportation, that it becomes difficult to manage their disease state as well as to afford their medications. Having highly trained Certified Medical Assistants (CMA) as part of our team makes a difference. They help patients to remain accountable, collect patient data and work with patients who are mild in complexity.

Our Providers decided that everyone with an A1C of 9 % or greater should be care managed, whether it is a covered benefit of not. We run a report monthly in our EMR, Allscripts, which is reviewed by the team. If it is not a covered benefit for Care Management, we turn patient over to the CMA, who is able to gather blood sugars, send details to the Provider for follow-up.

How were patients identified for the program/intervention? (1-2 paragraphs)

Care Management should never be based on whose insurance will or will not cover, which unfortunately, is often the case. In our practice, Care Management is a covered and expected benefit for all patients. We use a systematic approach for identifying patients based on lab values (HbA1C >9%), gaps in care reports, Emergency Department/Inpatient stays, blood pressure values >150/90, and Social Determinants of Health Needs. Individual needs are identified during Emergency Department or Inpatient transition calls, Provider or other office staff referrals, outside referral from Skilled Nursing (once discharged), reviewing insurance reports, Annual Wellness visits, reviewing Social Determinants of Health screenings and lastly the patients may ask Providers for extra help.

How was success measured? Please delineate whether metrics were process-based or outcome-based (2-3 paragraphs)

For any successful program both process- based and outcome-based metrics need to be considered. We strive to focus on both our internal processes as well as the outcomes for the interventions that our team implements. The processes include patient identification, patient follow-up, and monitoring disease state and risk scores using the AAFP, and looking at monthly insurance reports to ensure that we are meeting measures. The outcomes that measure success are patient improvement in A1C values, lowering blood pressure, reduction in ED and Inpatient Utilization, meeting Social Determinant of Health Needs, and patient ability to use self-management skills.

We review the subsequent A1Cs and blood pressure readings on a monthly basis to see if Care Management inventions have improved patient outcomes. These reports come from both our EMR as well as the claims data from the payers. Our program is continuously reviewing and changing processes to verify the work in our office is effective and results in positive changes for our patients and providers alike.

What were the program results? Include qualitative data/graphs (2-3 paragraphs)

Care Management workflow is ever-evolving and outcomes are driven on an individual patient basis. See Data below for Care Management and patient information from our practice.

Year End 2018 Care Management Report

PU NAME	# of Providers with Paid Claims (including NPs, PAs, etc.)	PCMH-Designated 2018-19	PDCM VBR 2018-19	# of PDCM Paid Claims	# of Transition of Care Paid Claims	# of Medication Reconciliation Paid Claims	Total # of All Paid Claims	# of Unique Members with 2 or More Paid PDCM Claims with different Service Date (PDCM CODES ONLY)	PDCM Eligible Attribution	% of Engagement (Unique Members with 2 or More Paid PDCM Claims with different Service Date (PDCM ONLY))	% of Engagement (Unique Members with 1 or More Paid Claims (PDCM/TOC/Med Rec/HICM/CM))	% of Engagement (Unique Members with 2 or More Paid Claims with different Service Date (PDCM/TOC/Med Rec/HICM/CM))
Cadillac Family Physicians, PC	11	Yes	No	486	5	1	492	87	1540	5.65%	7.66%	5.78%

Blue Cross Blue Shield of Michigan

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Prospective Report Summary - ALL MEASURES

PU: Cadillac Family Physicians, PC

Claims Thru: 7/31/2018

Member Populations
1,310 : Adults
217 : Peds

Chronic Disease - Diabetes					
Comprehensive Diabetes Care - HBA1C Testing	80	91	87.9%	82.0%	94%
Comprehensive Diabetes Care - HbA1c Adequate Control (<8)	51	91	56%	47.0%	65%
Comprehensive Diabetes Care - HbA1c Poor Control (>9)	23	91	25.3%	39.0%	0%
EBCR Custom - Controlling High Blood Pressure - Total	100	188	53.2%	48.0%	75%

Were any new tools, processes, or resources developed to aid in the implementation of the program/intervention? (1-2 paragraphs)

The Care Managers have completed a Behavioral Health certificate through the University of Michigan and SBIRT training to aid in discussion about substance use with our patients.
Through the SIM project and our development of Care Management, we have connected with local resources in our community. This helps us refer patients to the right place to help them become self-sufficient.

What are you proudest of regarding this submission? Why does this work matter? (1-2 paragraphs)

Care Management matters because we are making a difference in the lives of our patients and meeting them where they are at. Helping them manage their chronic diseases, connecting them to resources, and impacting the overall cost of healthcare are all things that we are proud of. Our processes and interventions are satisfying to our providers, beneficial to our patients, and imperative to our payers. As Care Managers, the small successes mean the most, having a patient make the connection with their disease process and self-management skills help them to improve their quality of life. Patients taking charge of their lives and self-managing is always our goal and proudest accomplishment.

How will your organization use the funds if your submission wins? (1 paragraph)

Three options may include the following:

1. Pilot or use the funds to hire a social worker or behavioral health specialist that could offer counseling for our patients. The funds would allow us to embed someone as part of our practice and write a process as well as develop the program correctly to ensure sustainability.
2. Collaborate with our PHO to embed a Pharmacist in our office 2-3 days a week to meet or conduct phone calls with patients to complete a comprehensive medication review. Medication errors are a very common problem in the health care system that often goes unnoticed. The pharmacist would also be able to consider more cost-efficient options for the patients. By having the funds, it again gives us one year to build a strong foundation and focus on sustainability.
3. Use the funds to develop a Care Management “pantry.” We have patients that cannot afford and are in need of blood pressure cuffs, scales for daily weights, pulse ox and glucose meters /test strips, and so on. Food insecurities are also common and needs are sometimes difficult to meet in rural Northern Michigan. With these funds we could provide emergency food packs to patients.