Introduction to Specialty Team Based Care

Animation

Animation Complete

Participation from learners

Video

Agenda

Topic	Objectives
Introductions	
Chronic Care Model	• Explain how a prepared, proactive team contributes to positive patient outcomes • Describe how the components of the Chronic Care Model support the practice team
Team Based Care and Care Coordination	• Describe strategies to improve coordination across the care continuum • Describe effective processes of communication
Outcomes	• Define two outcome measures that indicate the Specialty team-based care is successful
Break	
Care Management Process	• Explain the care management press and actions which address the needs of high risk patients • Illustrate care management interventions to decrease ED utilizations and hospital admissions
Coding and Billing	• Illustrate how to use care management codes for daily care team activities

Welcome!

House Keeping 

Virtual Etiquette

Video and Audio:

- Unless distracting, please turn video ON. This is crucial for building trust and engagement.
- Test your video and audio before the meeting begins.
- Try to look at the camera when talking (to mimic the feeling of in-person eye contact).
- When possible, try to use good camera quality and sound.
- Adjust your camera if it is too high or low.

Meeting:

- Please hold off eating during the meeting as it can be distracting.
- Try not to multitask too much or make sure you're muted.

Environment:

- Be aware of your backgrounds to not be distracting.
- Position yourself in the light.
- Find a quiet place to join or mute yourself as necessary.

https://www.gend.co/blog/best-practice-tips-for-using-zoom

Michigan Institute for Care Management and Transformation (MICMT)

Who We Are	Partnership between University of Michigan and BCBSM Physician Group Incentive Program (PGIP)
Goal of MICMT	To help **expand** the adoption of and access to **multidisciplinary care teams** providing **care management** to populations served by the physician community in order to **improve care coordination** and **outcomes** for patients with complex illness, emerging risk, and transitions of care.

MICMT
Michigan Institute for Care Management & Transformation

[Insert Organization Name]

Who We Are	[Insert text]
Goal of [Organization]	[Insert text]

[Insert Logo]

Introduction to Specialty Team Based Care

Curriculum developed in partnership with:

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MICHIGAN MEDICINE
UNIVERSITY OF MICHIGAN


MICMT
Michigan Institute for Care Management & Transformation


OLYMPIA
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MedNetOne
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of the Blue Cross and Blue Shield Association


Mi-CCSI
Center for Clinical
Systems Improvement


GMP Network
For Physicians, By Physicians


BRONSON


IHP
Integrated Health Partners

Introductions: Poll

What is your role within your organization?

Successful Completion of the Introduction to Specialty Team Based Care (STBC) course includes:

1. Attend the entire Introduction to Specialty Team Based Care course, **in-person or live virtual**

   Attendance criteria:

   - If the Learner misses > 30 minutes; the Learner will not be counted as "attended" and will need to retake the course
   - If the Learner misses < 30 minutes; the Learner will be counted as "attended". The Learner will need to review the missed course content located here: https://micmt-cares.org/training
   - If course is virtual – must attend by audio and video/internet

2. Complete the Michigan Institute for Care Management and Transformation (MICMT) STBC **post-test** and **evaluation**.

   - **Achieve a passing score on the post-test of 80% or greater. If needed, you may retake the post-test**

You will have (5) business days to complete the post-test.

Goal of Care Management

To achieve an optimal level of **wellness** and improve **coordination of care** while providing **cost effective, non-duplicative** services.

Aug 13, 2018, The Center for Health Care Strategies, Inc. (CHCS)

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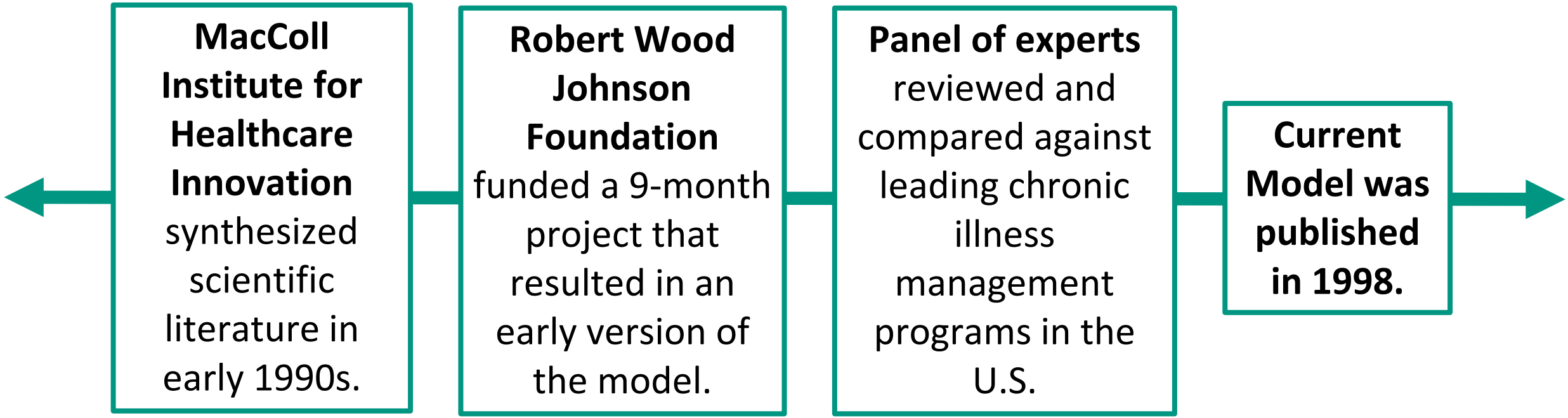
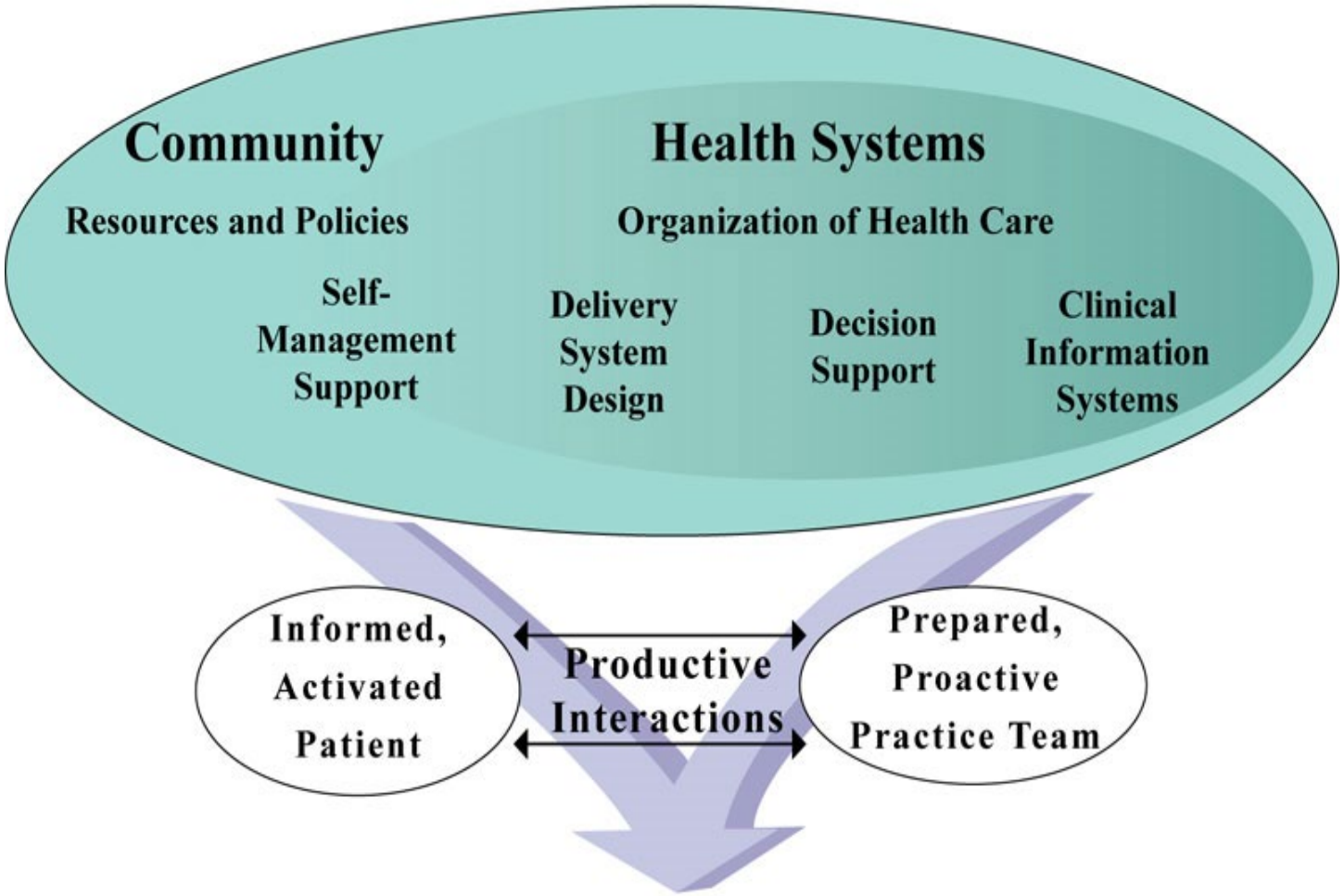
Objectives

- **Explain** how the prepared, proactive team contributes to positive patient outcomes.
- **Describe** how the components of the chronic Care Model support the practice team.

Brief History of Chronic Care Model



The Chronic Care Model

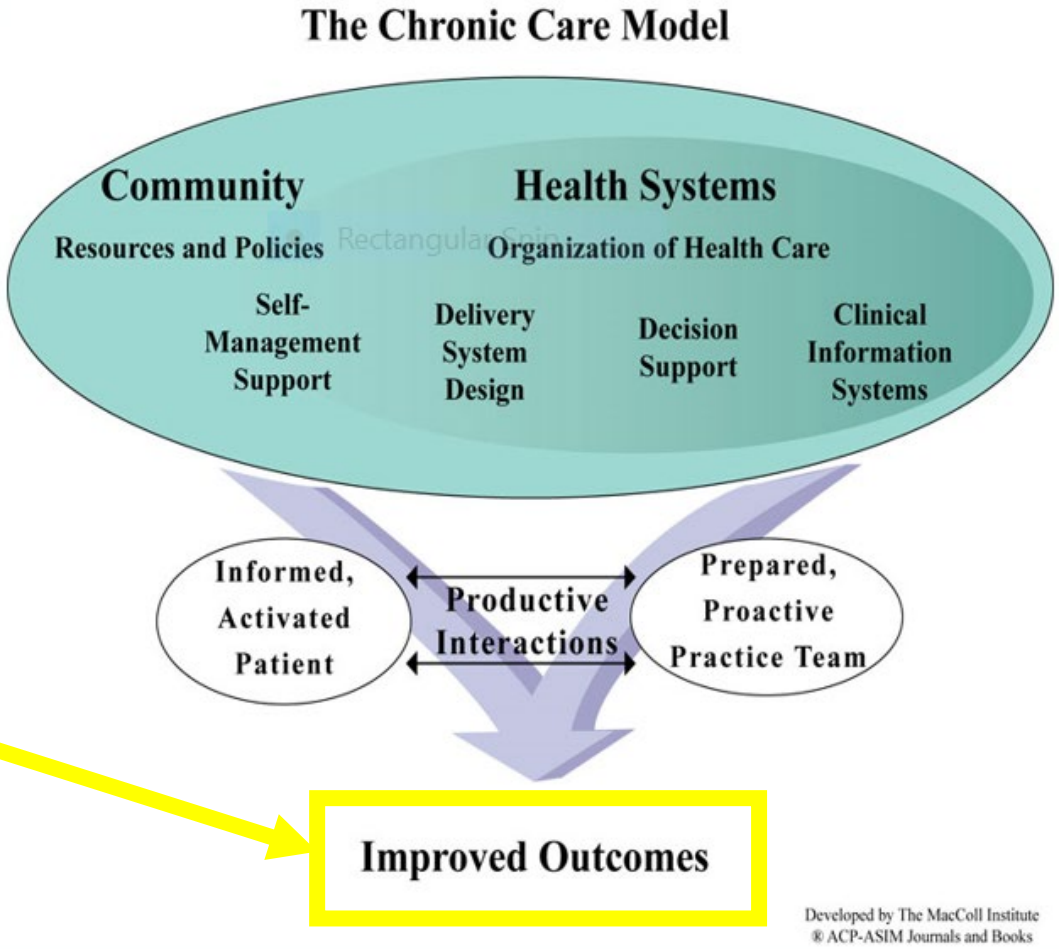


Improved Outcomes

Developed by The MacColl Institute
® ACP-ASIM Journals and Books

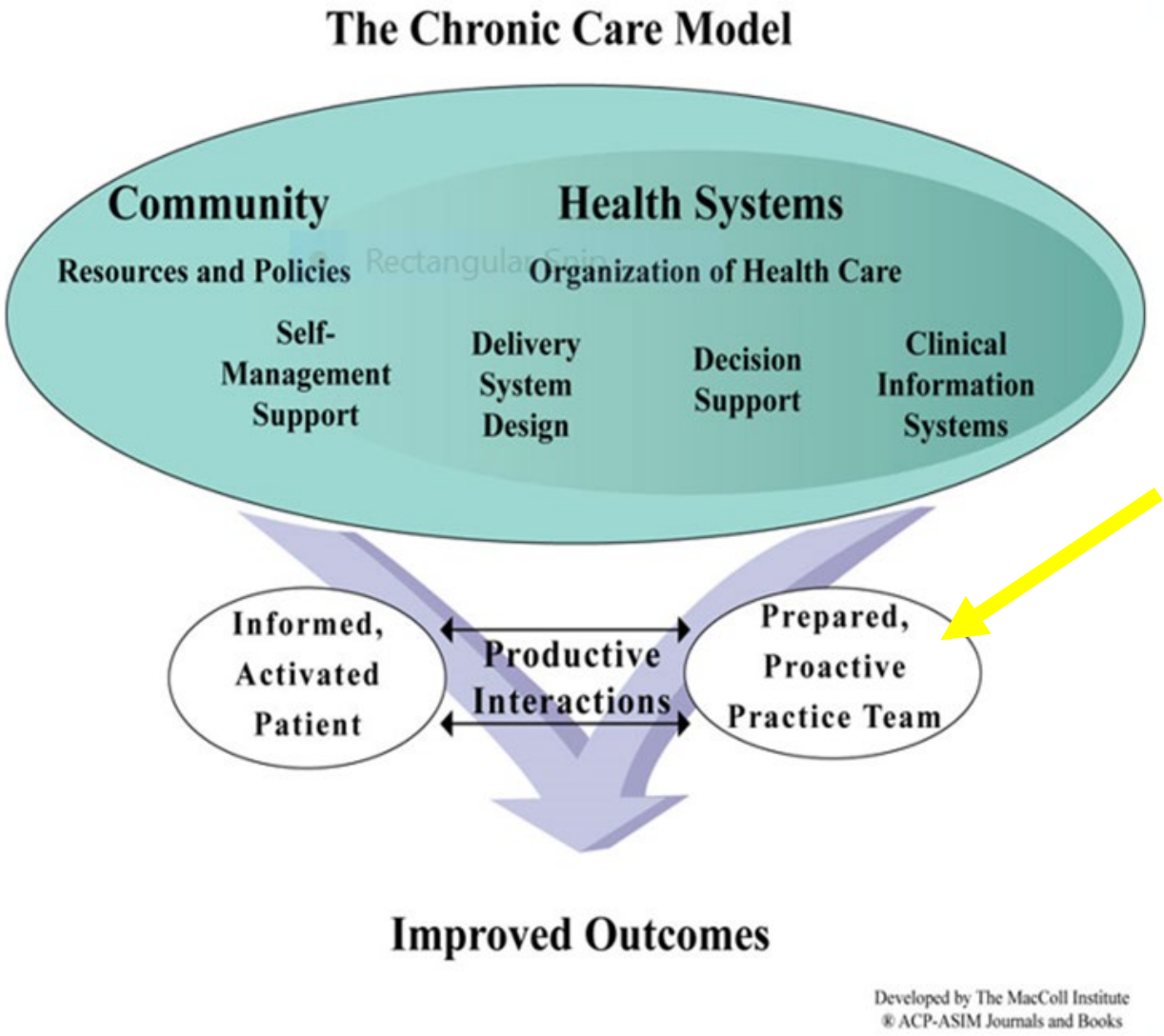
Improved Outcomes

- Patient/caregiver is successful with self management of chronic condition(s) so that they do not end up having to utilize the emergency department or be hospitalized.
- Outcomes are the measures used to understand the impact and success of the team-based program.



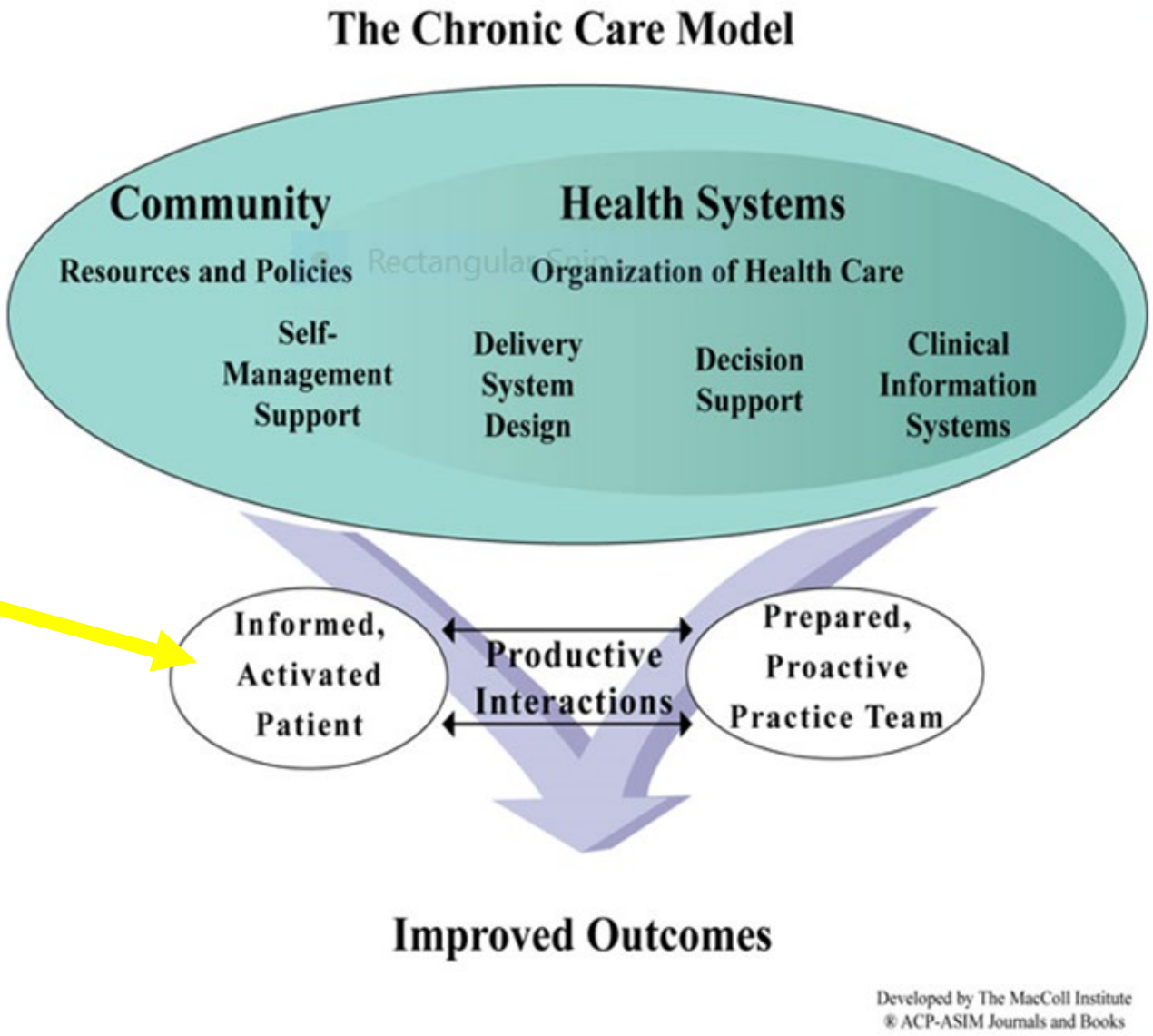
Prepared, Proactive Practice Team

- Patient information at time of visit
- Care team members available for visit
- Necessary equipment available
- Decision support
- Adequate time to provide care
- Care plan v. self-management goal



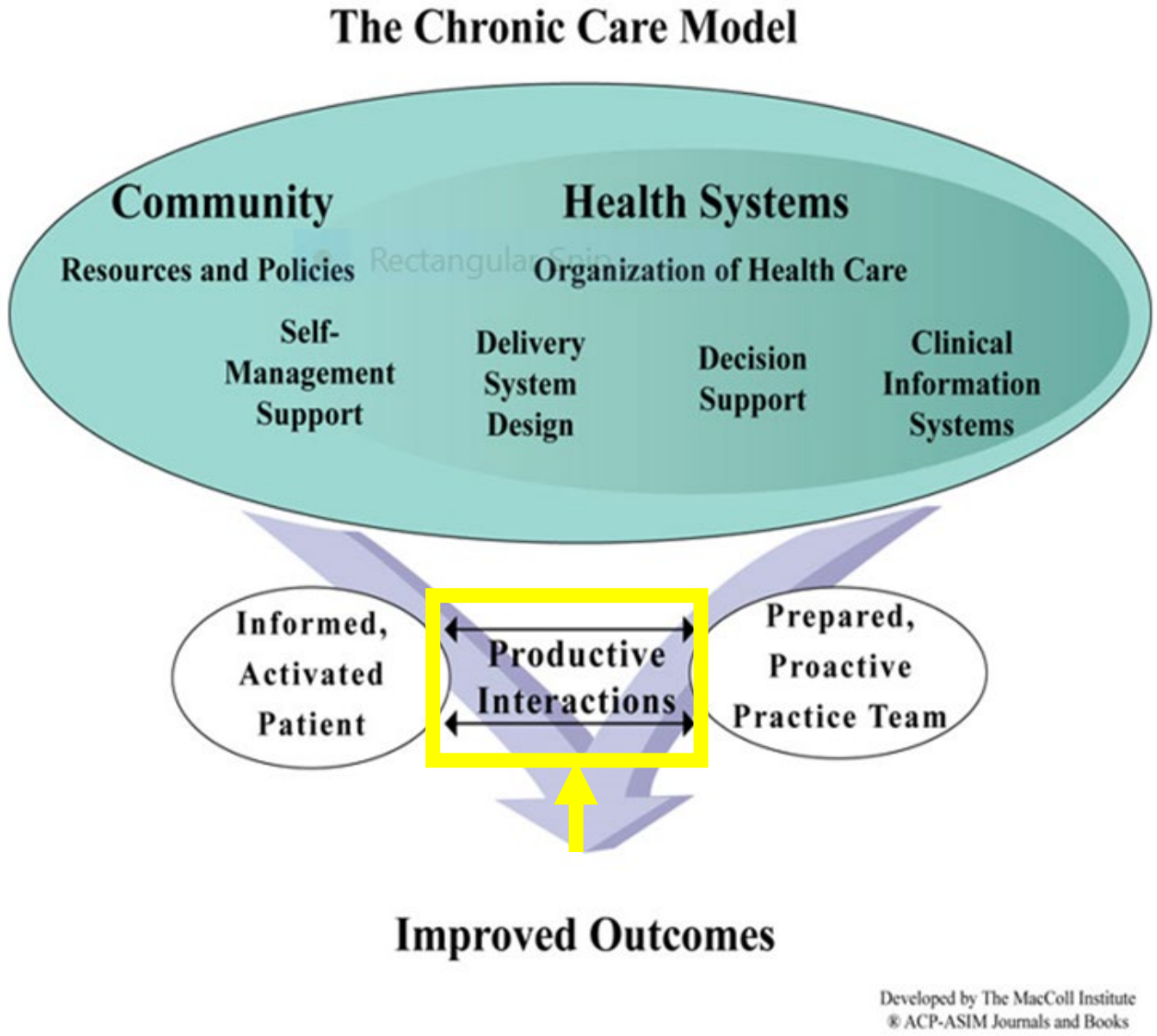
Informed, Activated Patient

- Understands disease process
- Understands prognosis
- Includes family and caregivers in developing care plans
- Views the provider as a guide
- Manages daily care



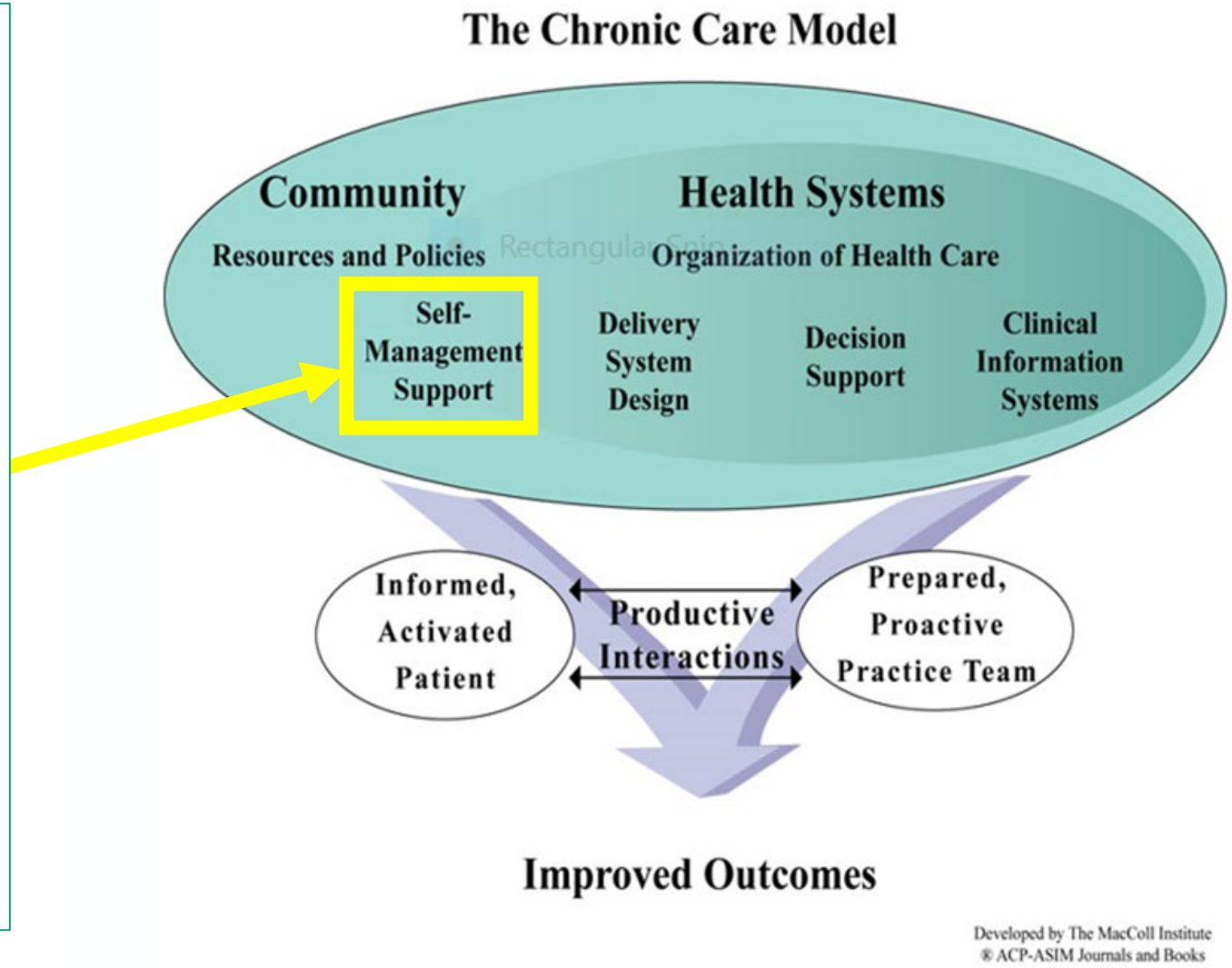
Productive Interaction

- Assess self-management skills and confidence
- Assess clinical status
- Tailor clinical management by stepped protocol
- Collaborative goal setting and problem solving in a shared care plan
- Active, sustained follow-up with patient is scheduled



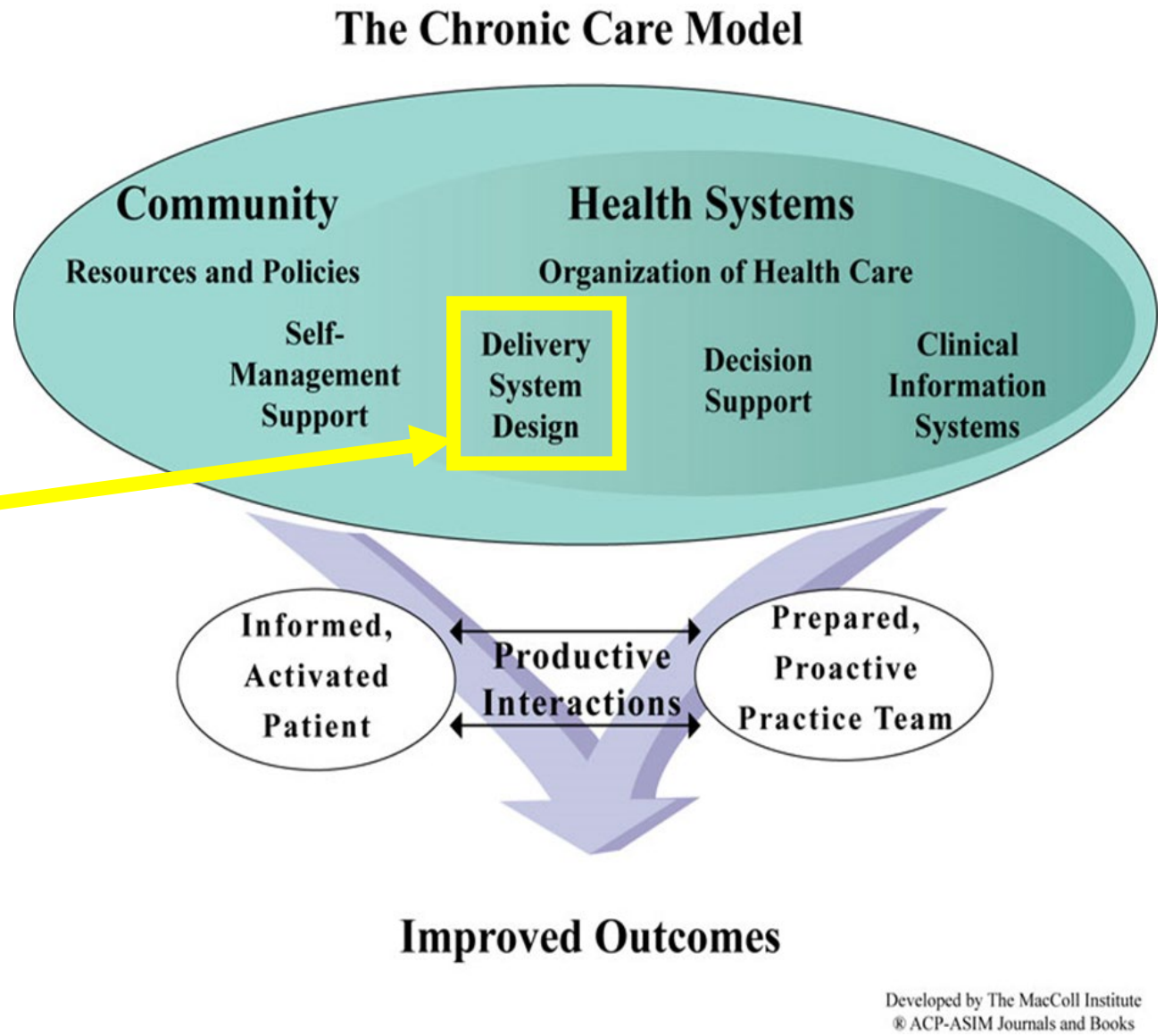
Self-Management Support

- Emphasize patient's central role in care
- Effective self-management strategies include:
  - Assessment
  - Goal setting
  - Action planning
  - Problem solving
  - Follow-up
- Organize resources that provide patient support



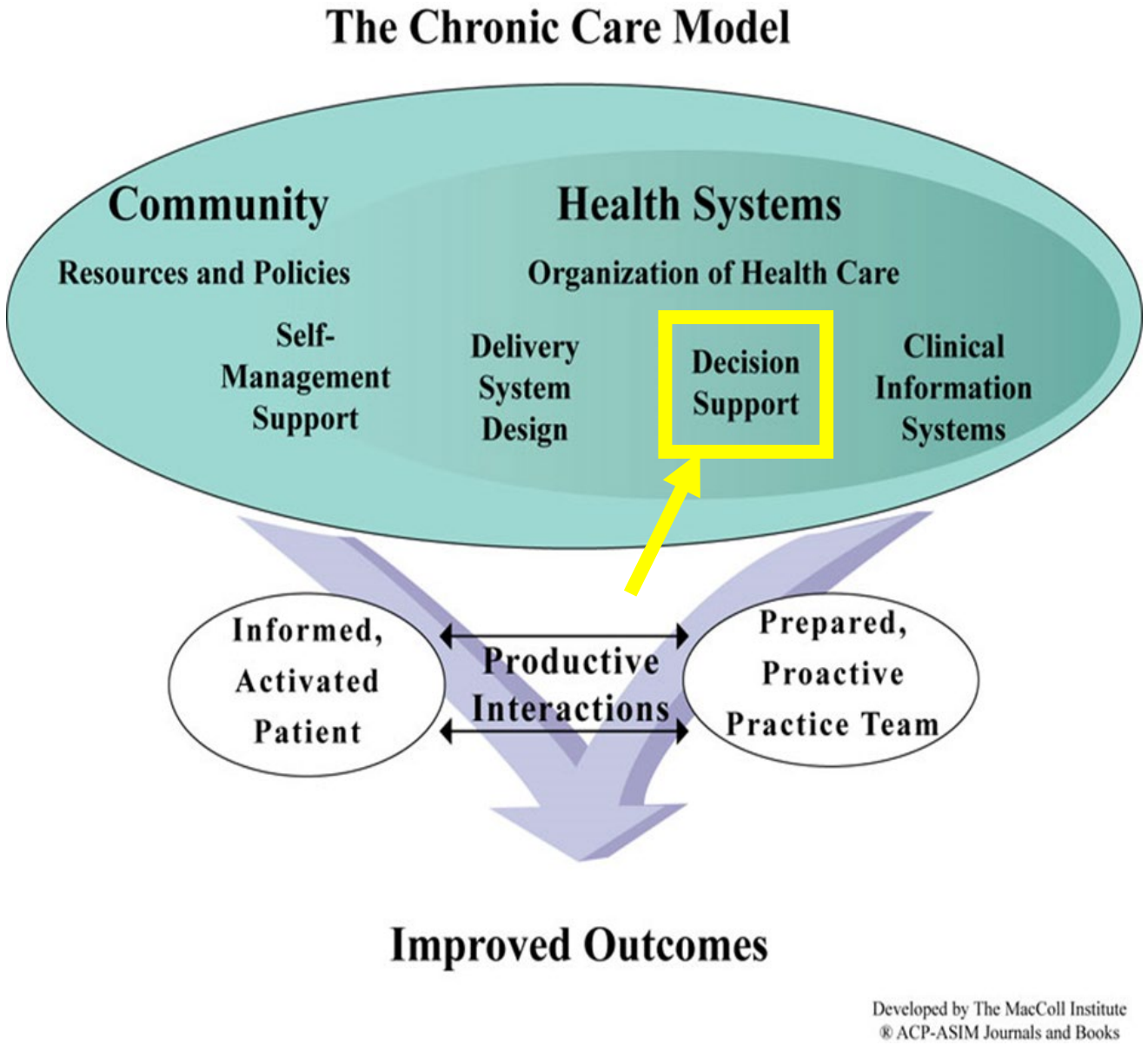
Delivery System Design

- Define roles and responsibilities of team members
- Planned interactions support evidence based care
- Clinical case management services i.e., care managers
- Ensure regular follow-up appointments
- Give care patient understands and is culturally appropriate



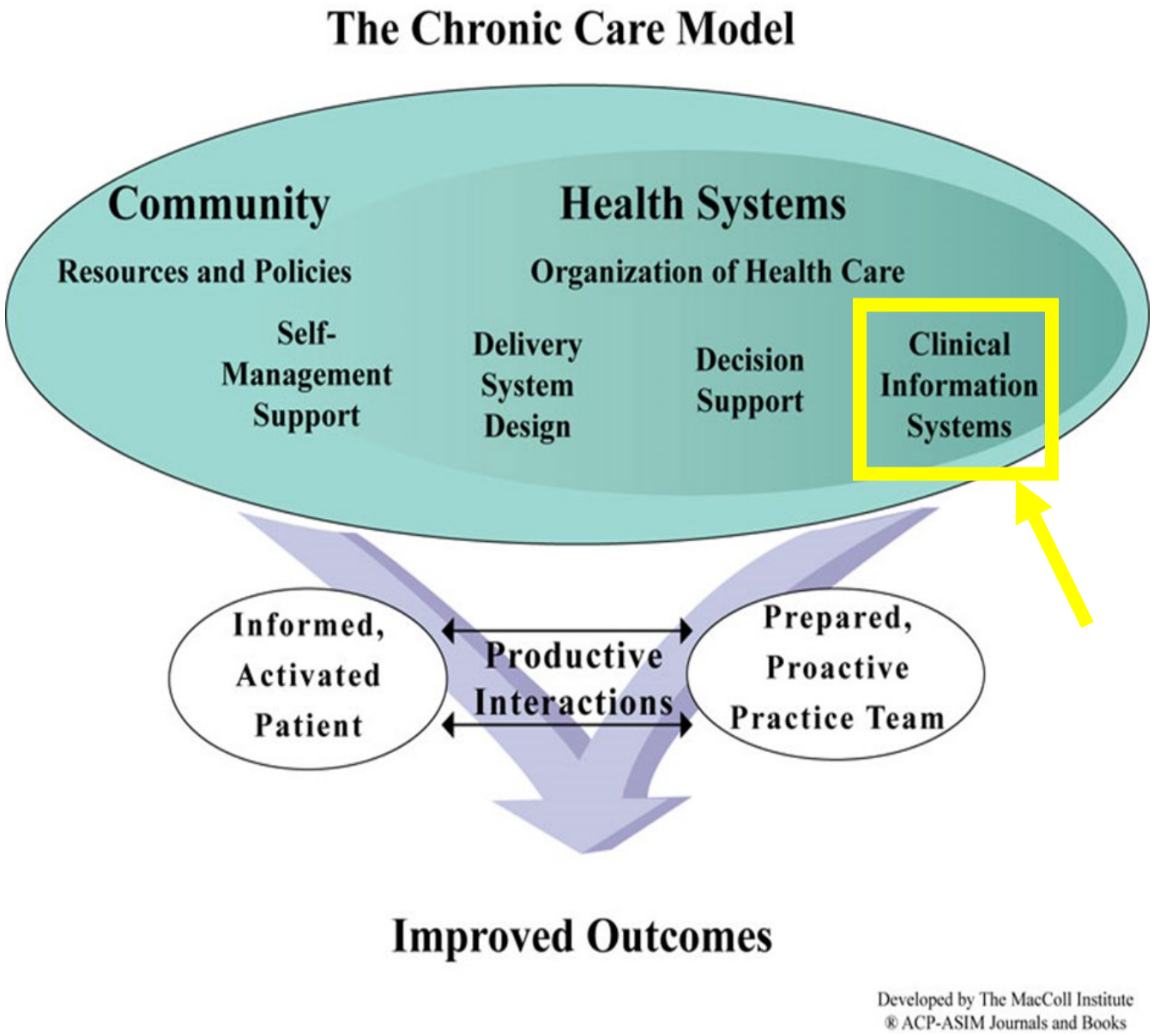
Decision Support

- Incorporate evidence based guidelines into daily clinical practices
- Primary care and specialty providers collaborate to provide care
- Use provider education materials
- Share information about care guidelines



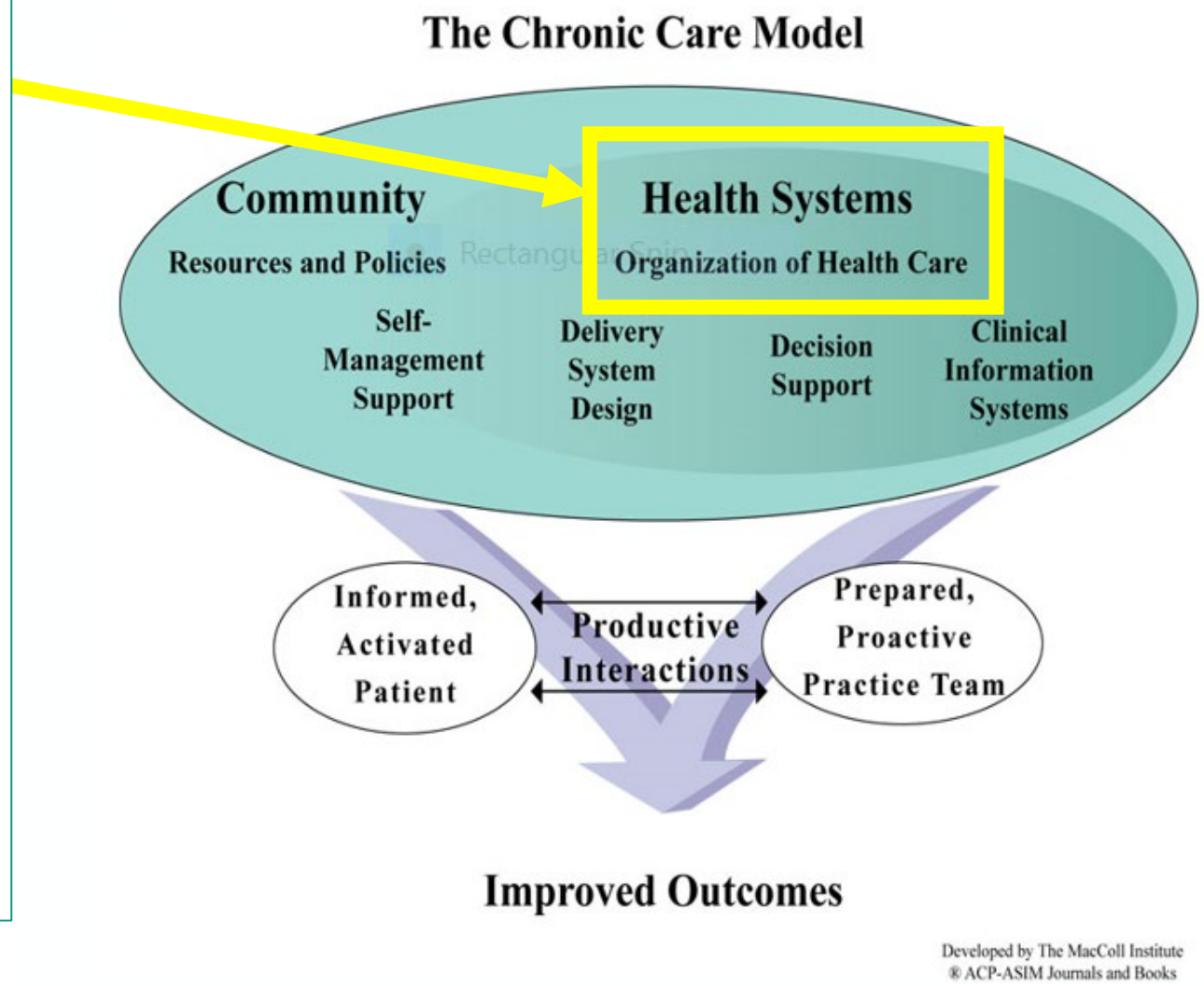
Clinical Information Systems

- Provide reminders for patients and providers
- Identify patient populations for proactive care
- Enable individual patient care planning
- Share data with patients and other providers
- Monitor team and system performance



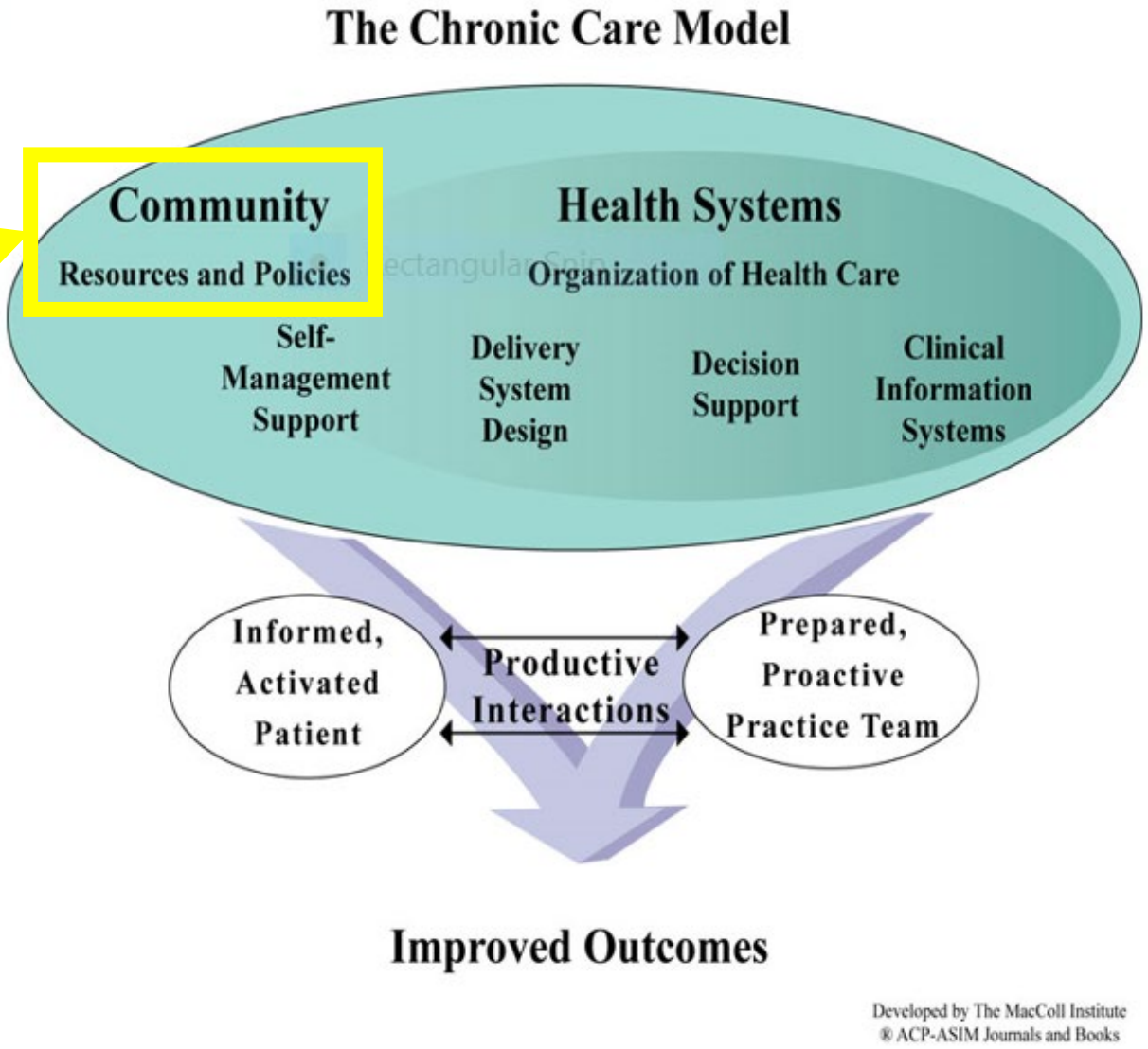
Health Systems: Organization of Health Care

- Senior leaders and all levels visible support improvement
- Promote effective improvement approaches aimed at comprehensive system change
- Encourage open and systematic problem-solving management
- Provide quality of care incentives
- Develop care coordination agreements



Community: Resources and Policies

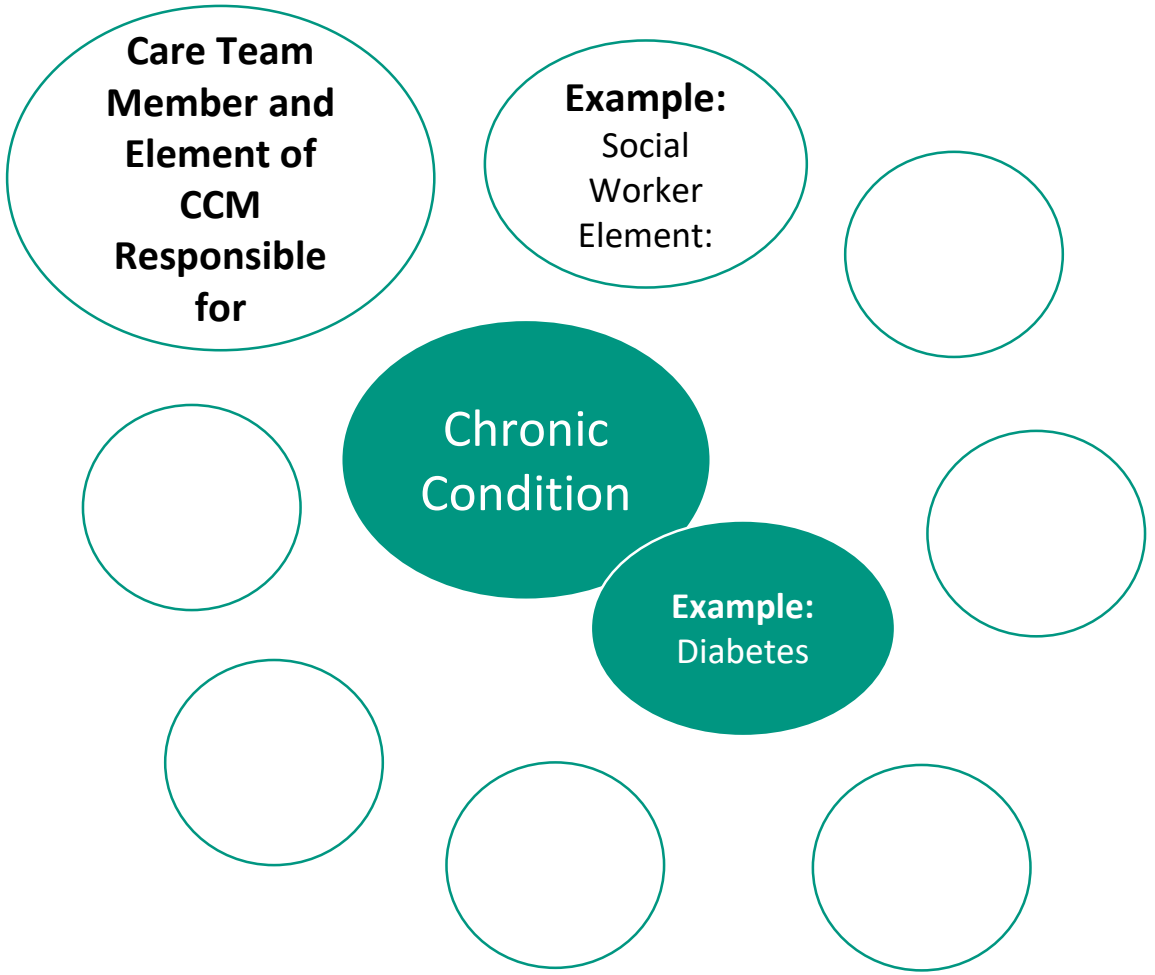
- Encourage patients to participate in effective community programs
- Partner with community organizations in supporting and/or developing programs
- Be an advocate for policy change



Prepared, Proactive Practice Team

Activity

- Choose a **chronic condition** for the center bubble
- Use the surrounding bubbles to map out how **care team members** use different Chronic Care Model (CCM) elements to provide care to a patient with that chronic condition.
- **Possible Care Team Members:**
  - Physician
  - Specialist
  - Dietitian
  - Behavioral Health
  - Pharmacist
  - Nurse
  - Medical Assistant
  - Care Manager
  - Case Manager
  - Physician Assistant
  - Dentist
  - Administrative/support staff
  - Community health worker
  - Technician/technologist



Summary

- The prepared, proactive team contributes to positive patient outcomes.
- Components of the Chronic Care Model support the practice team

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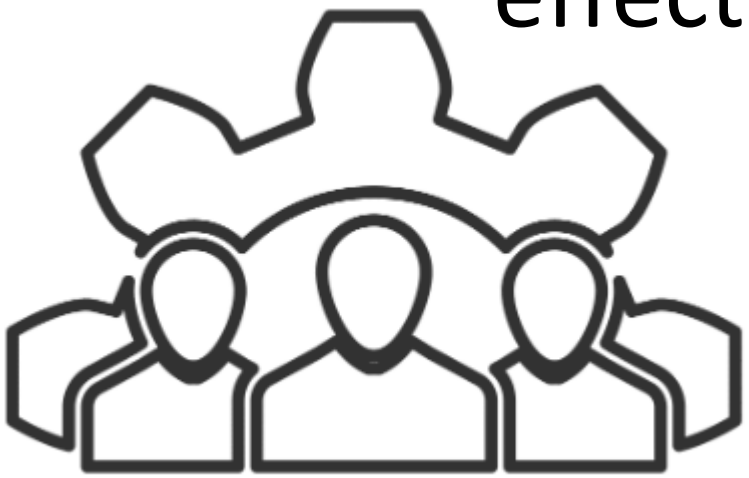
Objectives

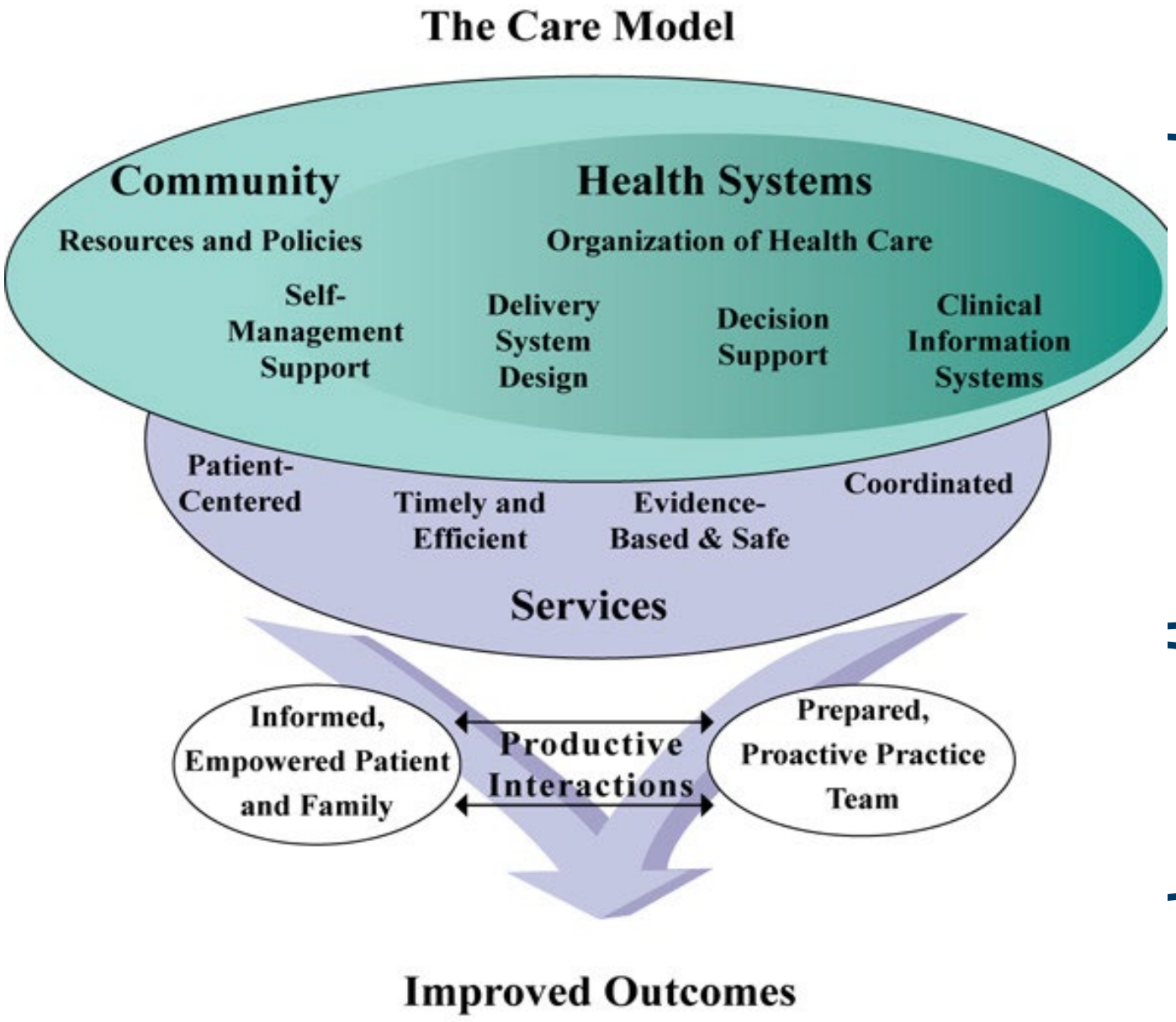
- Describe **strategies to improve** coordination across the care continuum
- Describe effective **processes of communication**

Team Based Care

"The high-performing team is now widely recognized as an essential tool for constructing a more patient centered, coordinated, and effective system of health care delivery."

(Mitchell et al., 2012)



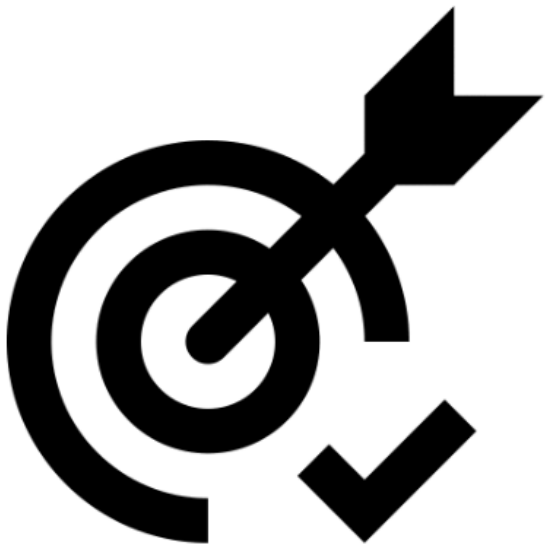


Together the clinical and community organization Care Team Members support the patients.

Effective Care Team Members apply communication skills with the other clinicians and team members within the office as well as the patient for improved outcomes.

https://www.ahrq.gov/ncepcr/tools/pf-handbook/mod16.html#fig16.2

Care Coordination



"**Effective Care Coordination** supports achieving the **Quadruple Aim**: improving the care experience for individuals, improving individual health, improving the work life of health care providers, and reducing costs."

Bodenheimer & Sinsky, 2014

Activity

Where have you seen good care coordination with a patient's Specialist(s) and Primary Care ?
What made it good?

Care Coordination: A Multidimensional Concept

Activity: How are these Care Coordination concepts linked to the Chronic Care Model (CCM)?

Concepts	Effective communication among healthcare providers, patients, families, caregivers (regarding chronic conditions).	Safe care transitions	A longitudinal view of care that considers the past, while monitoring present delivery of care and anticipating future needs.	The facilitation of linkages between communities and the healthcare system to address medical, social, educational and other support needs that align with the patient goals.
Examples				
Identify the CCM Element:				

Source: National Quality Forum's Care Coordination Endorsement Maintenance Project. 2017

Who is on the Patient's Health Care Team?

- Specialists Practice Team
- PCP Practice Team
- Hospitalist
- Home Care Agency
- Health Plan Care Manager
- Patient/Caregiver
- Community Resource
- Hospital Discharge Care Manager

Key: Specialist and PCP team – it is about communication and relationships!

Activity

- Based on the patient your practice serves, what medical healthcare agencies do you coordinate with?
- Where is the opportunity?

Care Coordination:
Linkages with Community Resources

Patient education
(programs offered in community)

Patient transportation

Affording medication

Caregiver support

Activity

Which community resources do you anticipate developing a relationship with?

Examples of Care Team Coordination

Share the Care
PCP and Specialist share patient care.

Consult
PCP refers patient to Specialist for consult. PCP carries out the treatment plan.

Handoff
PCP sends request, Specialist sees patient and oversees the patient's care.

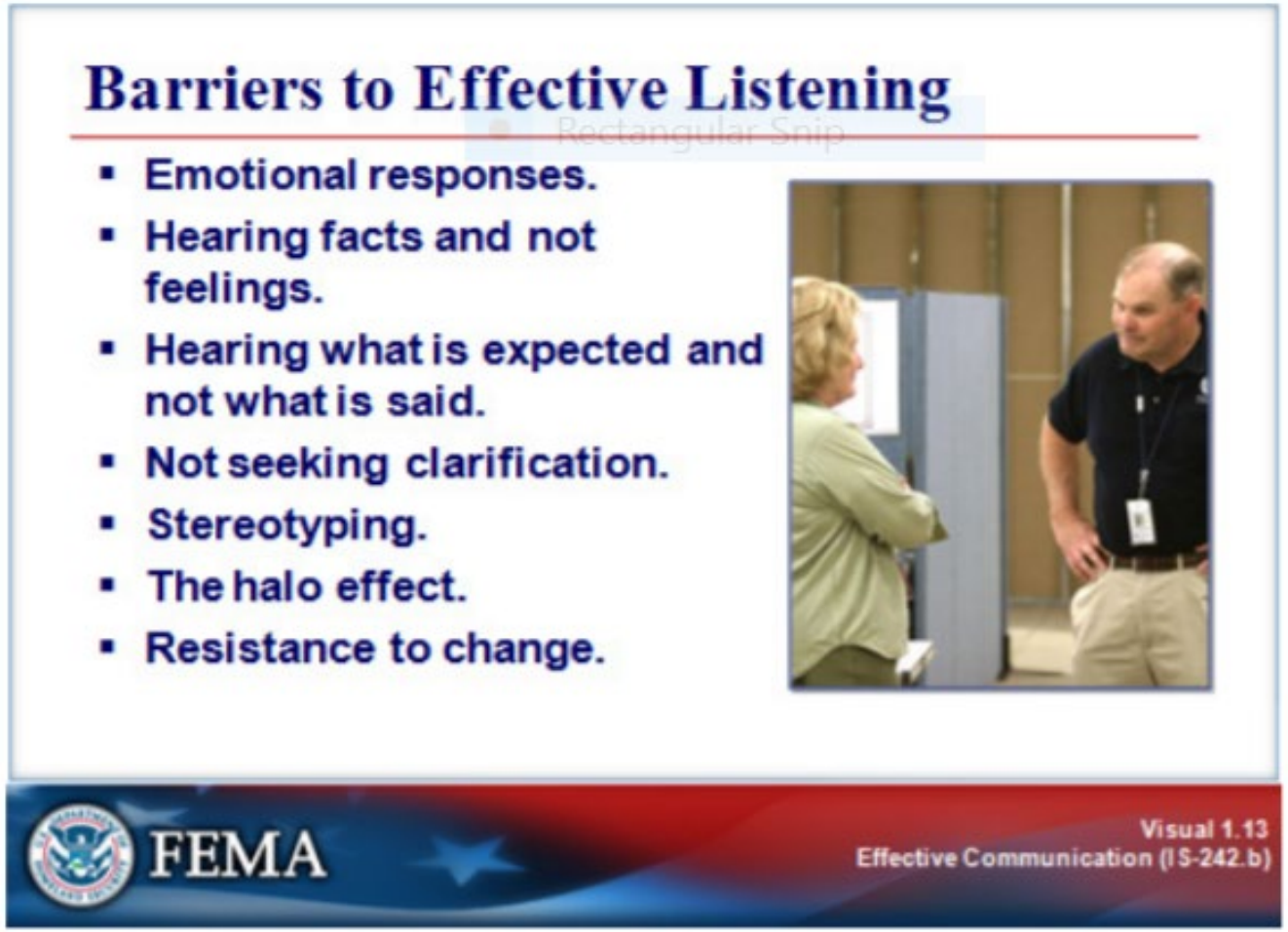
The Team: Specialist and PCP Partnership to Address Utilization

- Care management/coordination
- Consults or referrals (palliative care, pulmonary rehab)
- Patient and caregiver education
- Medication Reconciliation
- Standardizing discharge processes and workflow
- Post discharge follow-up

Communication IS the Foundation for Care Coordination

https://training.fema.gov/emiweb/is/is242b/instructor%20guide/ig_01.pdf

Communication IS the Foundation for Care Coordination



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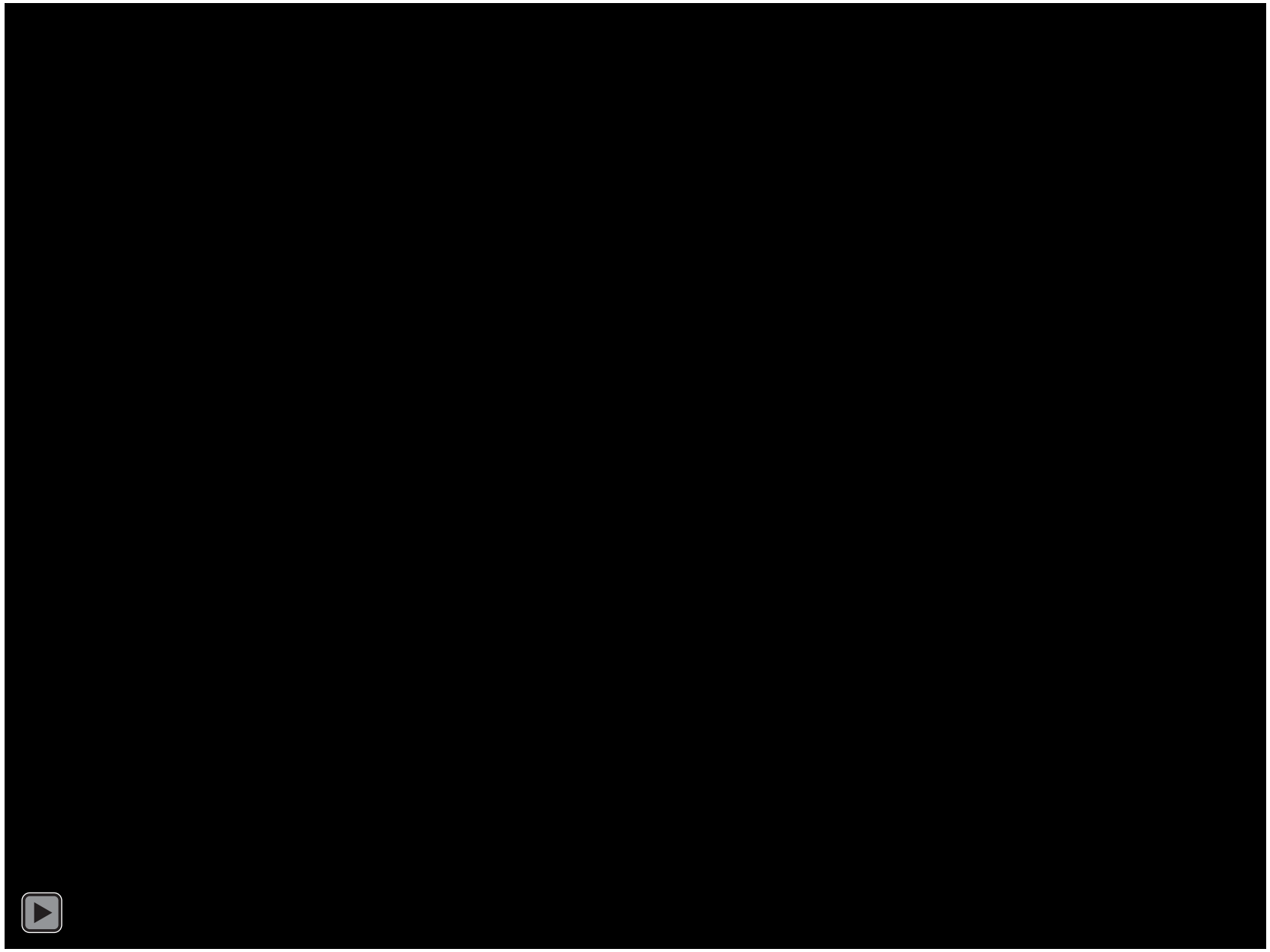
Communicate Clearly?



Communicate Clearly?

Tool: SBAR

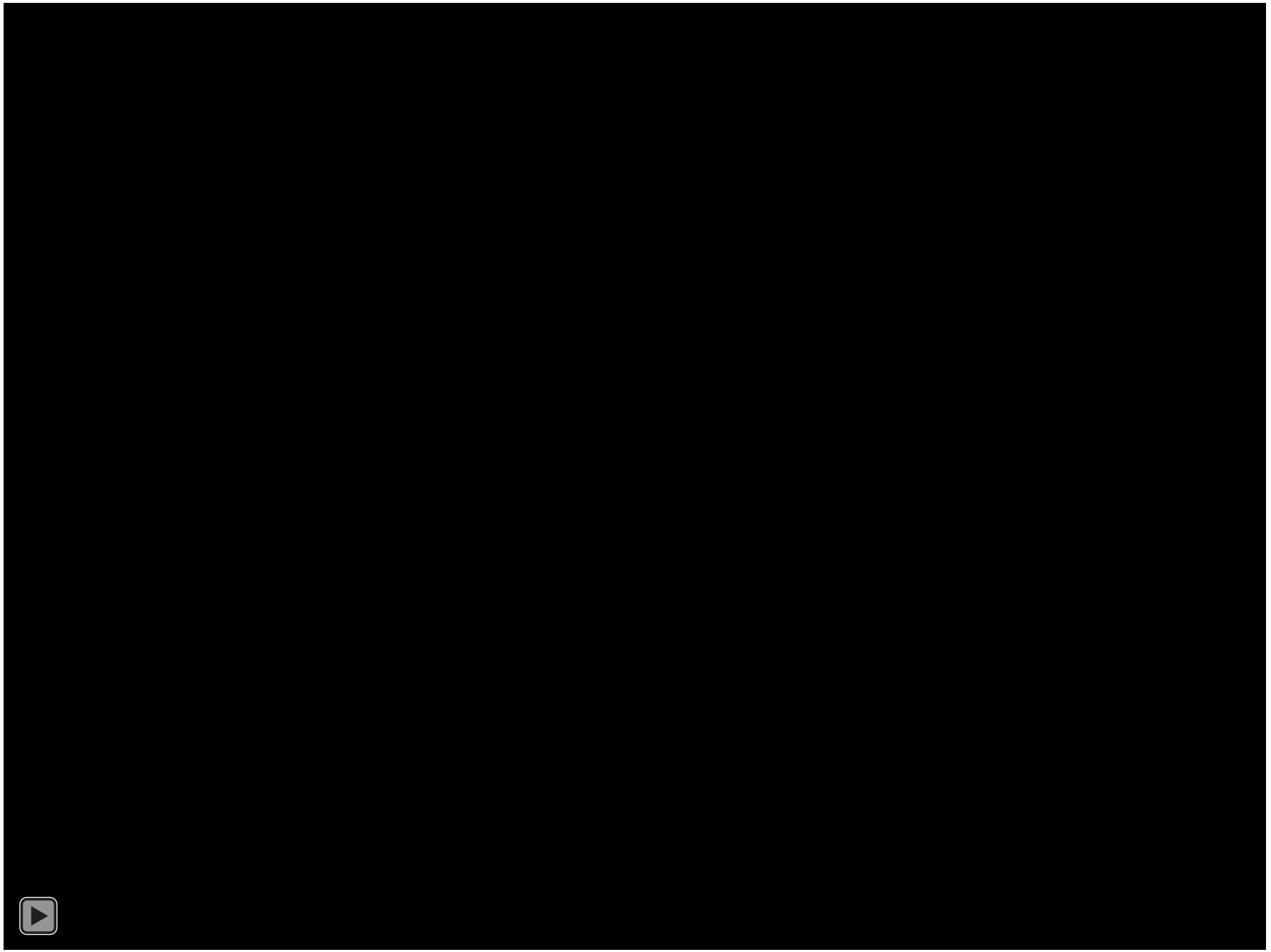
Making Reports and Requesting Action

Reliability Skill: Communicate Clearly

An outline for planning and communicating information about a patient, condition or **any** other issue or problem. It gets to the point!

Situation:	**What is the immediate problem?** **The headline**
Background:	What is the relevant history related to the situation?
Assessment:	What is your view of the situation and your perception of the urgency of the action needed?
Recommendation:	What is your request or recommendation?

Tool: SBAR



Tool: SBAR

Activity: Use SBAR Individually

Prepare an SBAR for one scenario

Situation:	**What is the immediate problem? The headline**
Background:	What is the relevant history related to the situation?
Assessment:	What is your view of the situation and your perception of the urgency of the action needed?
Recommendation:	What is your request or recommendation?

Scenario One: A patient has been discharged from a rehabilitation center and is taking Coumadin. The Coumadin was started during an inpatient hospital stay.

The patient calls the Nephrology CM to state he is not able to locate a Home Health Agency who will draw blood to check his blood clotting time. He is due for this lab test in 2 days.

You decide a next step is to follow up with the PCP office. It is Friday afternoon.

Create your SBAR to discuss with the PCP team member.

Summary

- Strategies to improve coordination across the care continuum
- Effective processes of communication

Resources

- SBAR toolkit - Institute for Healthcare Improvement
- Narayan, M. C. (2013). Using SBAR Communications in Efforts to Prevent Patient Rehospitalizations. Home Healthcare Nurse, 31(9), 504–515. https://doi.org/10.1097/nhh.0b013e3182a87711

Break

Deskercise

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Objective

- Identify two outcome measures that indicate the Specialty team based care is successful.

What are Outcomes Measures?

Outcomes measures are **the reason why** we implement a program.

… they are what payers and organizational leadership can use to **determine** whether or not our **programs are successful**.

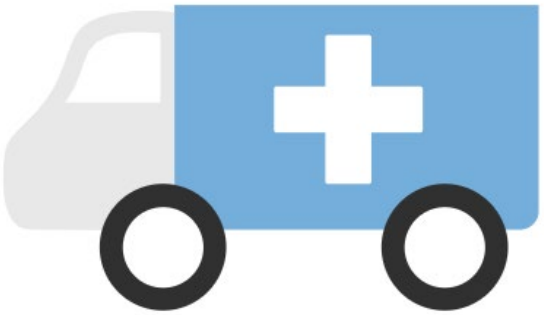
Why

STBC Outcomes Measures

While there are many potential measures that could be used (patient satisfaction, quality of care, etc.), **the ones that determine program success** are:

Inpatient Utilization

Emergency Department Utilization



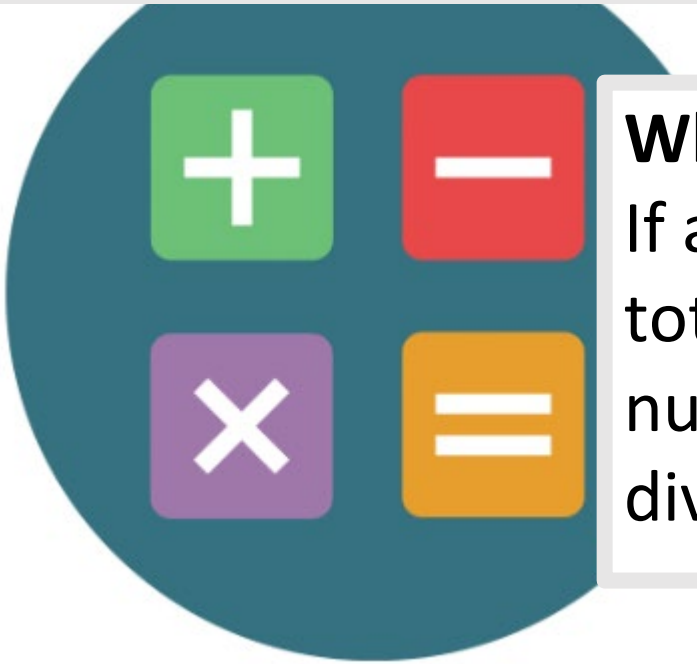
Metric Definitions

What does ED and IP utilization mean?

ED Utilization	The number of times per thousand that the patients attributed to your practice visited the emergency department.
IP Utilization	The number of times per thousand that the patients attributed to your practice were admitted / readmitted.

What is visits per thousand?

For both ED and IP utilization, the metrics are usually calculated as "**visits per thousand**", which allows for comparison across different size populations.



What does this mean?

If a hospital or ED admits/sees 500 patients from a total attributed population of 800 people, the number of admits per thousand is 625 (500 x 1,000 divided by 800 = 625)

Activity

Step 1: Individually
Please take about 30 seconds to think **about a loved one or patient** who had a **difficult experience** with lots of trips to the ER or hospital.

Step 2: Individually
Now, please take 30 seconds to think about how **this role could have changed that experience.**

Step 3: Group sharing
Could at least 2 people share the patient/loved one experience and how they think this role could have helped them?

Tracking Performance

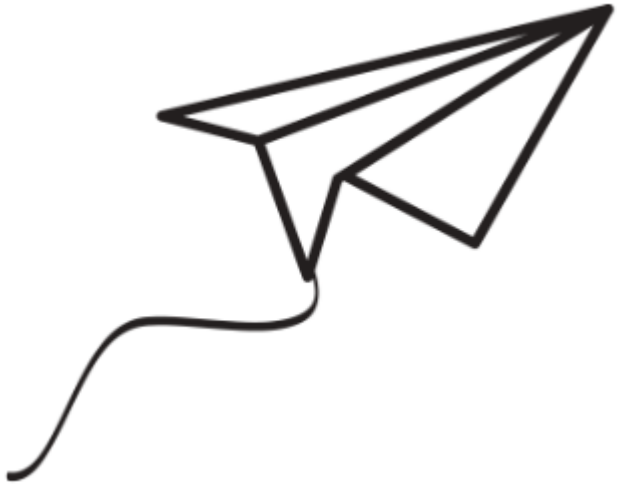
Step 1: Know **who** you're responsible for keeping out of the ED and hospital!

Work with your **practice administrative** and **clinical leadership** to identify which population of **patients** you should be **focusing on and tracking.**

Activity

Think on your own for a minute

- What population would be considered the highest risk of emergency department and inpatient utilization in your clinics?
- Is there someone who might be able to identify this subset of patients in a registry?

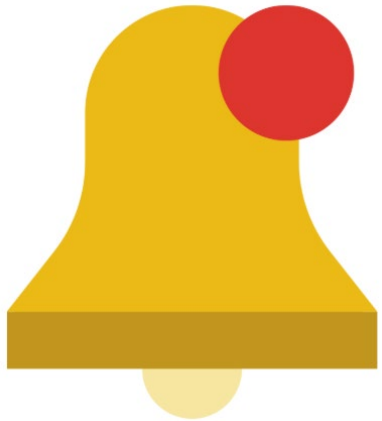


Group discussion

- Describe your patient populations and the type of tracking that is in place.

Tracking Performance

Step 2: Get notifications or find out when high risk patients …



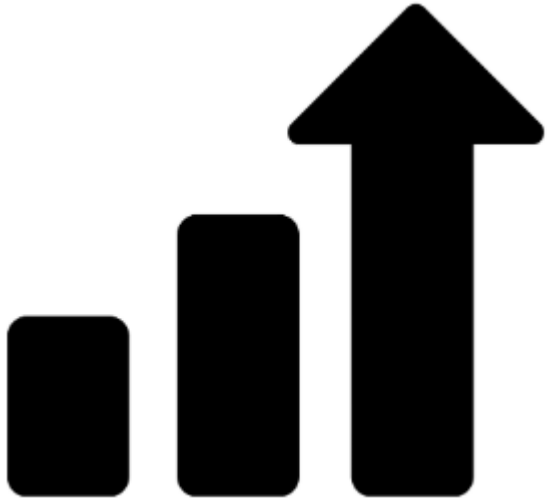
- come into the clinic
- **visited** the ED
- were **admitted** to the hospital

Again, clinic leadership and PO leadership can be helpful!

Impacting Performance: Clinical

While ED and IP utilization are **outcomes measures**, lots of different factors play into whether or not your patient population has **high utilization**:

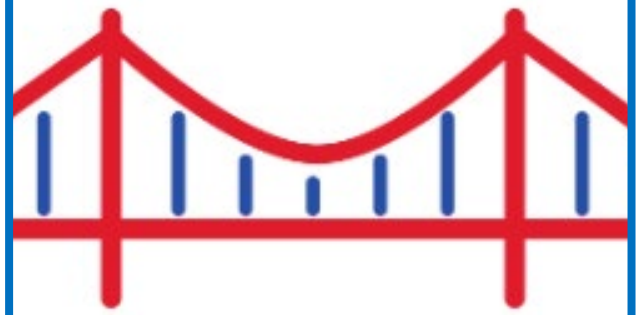
- Medication Adherence
- Multiple diagnoses
- Clinical guidelines
- Symptom Management



- Treating to target
- Quality Metrics
- Health Literacy
- Social Needs

Impacting Performance: Communication and Care Coordination

Communication among team members is key to **achieving the outcomes**.



Coordination with primary care is critical to helping patients/care givers understand why and how to self manage and who to call with concerns and needs.

Impacting Performance: See Enough Patients!

Seeing patients is the way to impact your outcomes! **Seeing enough patients can be the difference between meeting outcomes goals and falling short.**

We suggest at least **4 patients in a half day** in order to see an outcomes impact.

Tracking Performance

Step 3: Trend performance

If you can't track utilization, work with your leadership and PO to identify what you *can* track.

As a care team member, you should find out how your practice/PO tracks admissions - and if there's a dashboard you can view.

Tracking ED and IP Utilization Tools

- If your practice uses **a patient ED and IP utilization tracking tool,** please describe.
- If you have heard of **other practices using a tool to track outcomes**, please describe.

Patient name/identifier	Emergency room visit date	Hospital admission date	30 day Readmission date	Diagnosis	Access to Discharge Summary Y/N
Sally Smith	2.25.20			Dehydration, nausea	no
Joseph Allen		2.26.20		HF	yes

Example: ED and IP utilization tracking tool

Summary

The outcomes measures for team-based care are:

- ED Utilization
- IP Utilization

In order to have the best chance of success:

- Identify your population
- Track your population
- Trend your performance

Questions?

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Outcomes	• Define two outcome measures that indicate the Specialty team-based care is successful
Break	
Care Management Process	• Explain the care management press and actions which address the needs of high risk patients • Illustrate care management interventions to decrease ED utilizations and hospital admissions
Coding and Billing	• Illustrate how to use care management codes for daily care team activities

Objectives

Explain the care management process and actions which address the needs of high risk patients.

Illustrate care management interventions to decrease ED utilizations and hospital admissions.

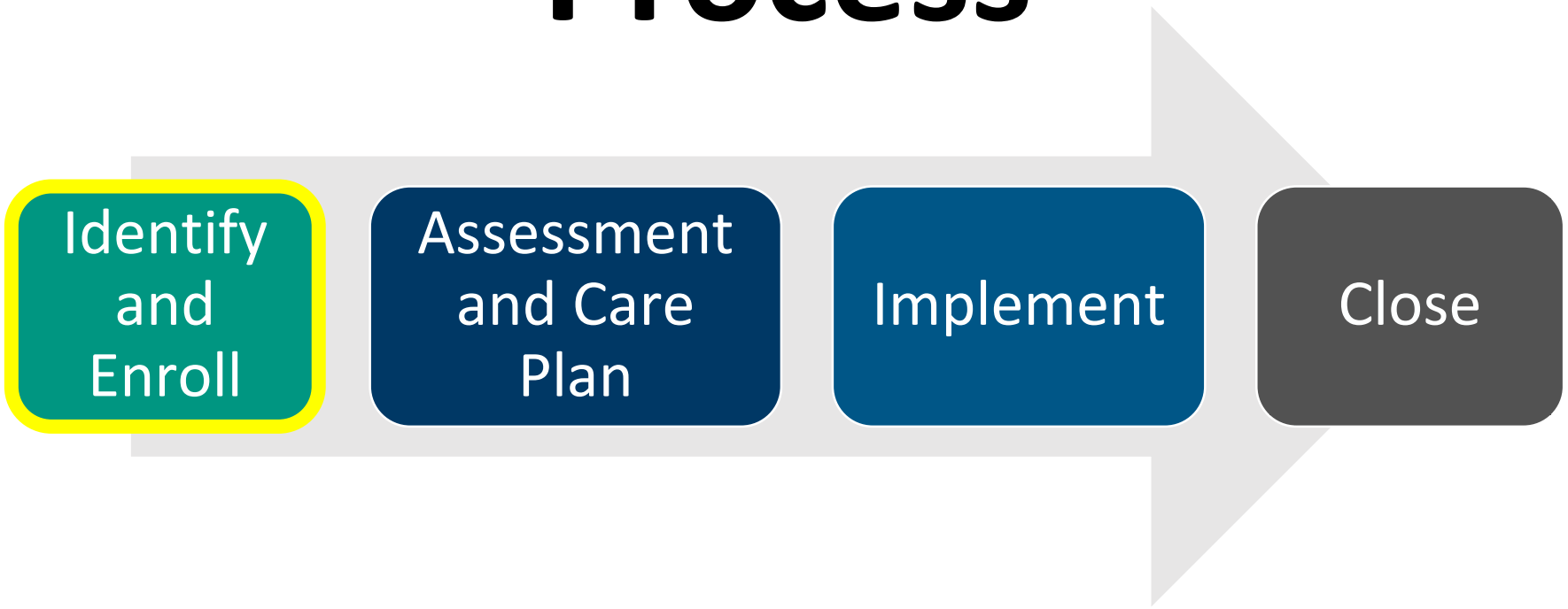
Describe a process for Specialty practice team members to coordinate care with a Primary care practice.

Goal of Care Management

To achieve an optimal level of **wellness** and improve **coordination of care** while providing **cost effective, non-duplicative** services.

Aug 13, 2018, The Center for Health Care Strategies, Inc. (CHCS)

Care Management Process



Identifying Patients for Care Management

Work with your practice team and physician to identify high risk patients.

Clinical Guidelines

Top Outcome Measures:

- **Lower ED Utilization**
- **Lower Inpatient Utilization**

"It is not the number of diagnoses that determines the need for care coordination, but the complexity of health problems, complexity of social situations and complexity manifested by frequent use of healthcare services."

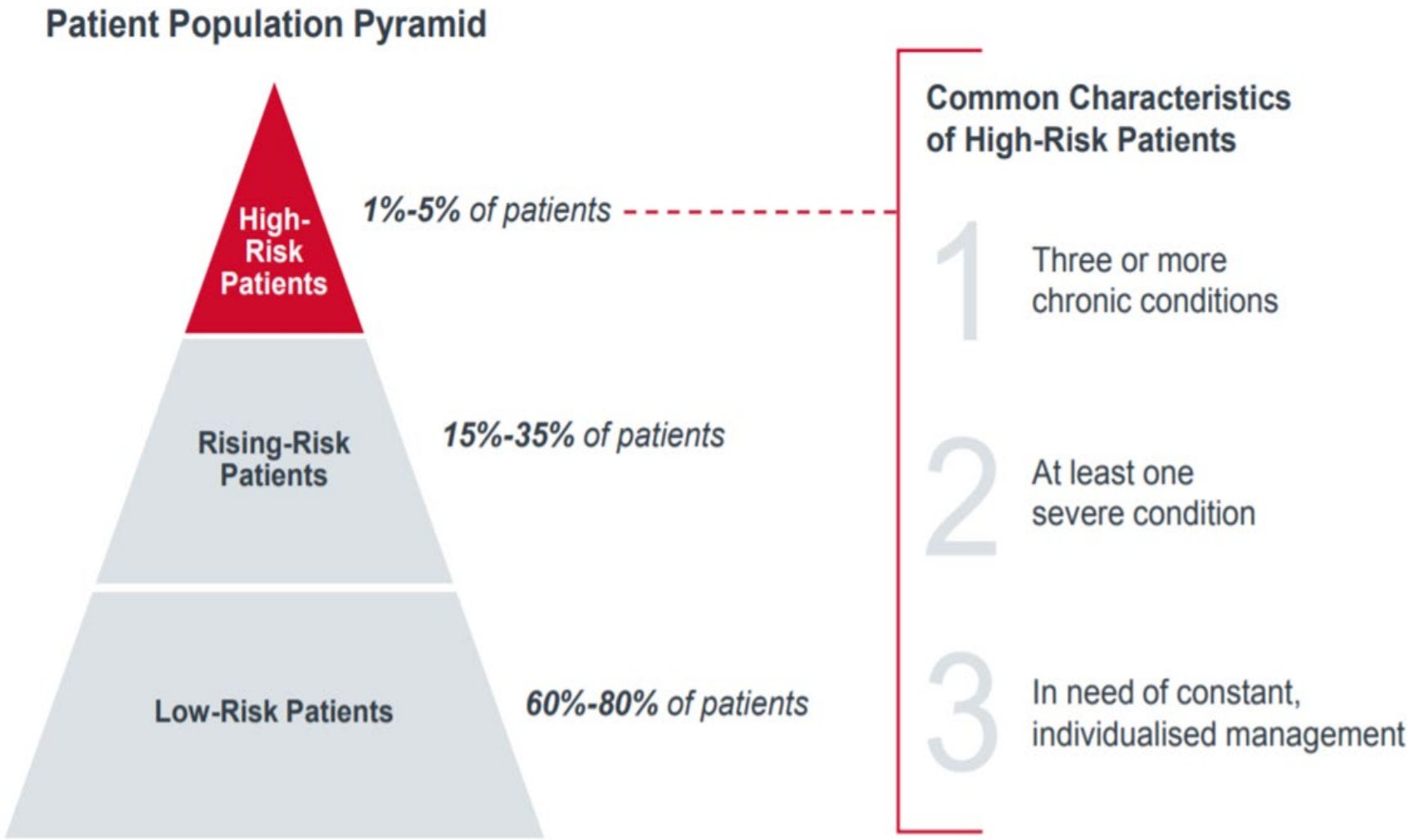
Predicting use of nurse care coordination by older adults with chronic conditions. (2017). Western Journal of Nursing Research. https://doi.org/10.1186/s12913-019-2016-5

Risk Stratification

Risk stratification is ideally an intentional, planned and proactive process carried out at the practice level to effectively target clinic services to patients.

http://www.njafp.org/sites/ethos.njafp.org/files/risk_strat_peskin_distribution_final.pdf

High Risk: the Initial Focus!



SOURCE: “Mind the Gap", The Advisory Board Company.
https://www.advisory.com/-/media/Advisory-com/Research/PHA/Research-Study/2017/Mind-the-Gap-Managing-the-Rising-Risk-Patient-Population.pdf

Identify High Risk Patients

Identify the population of patients to work with: predicting risk in *specific* patients to reduce hospital admission or recurrent, unnecessary ED visits.

- Physician identification
- ADT alerts
- Medical record review – how many admission and/or ED visits in past 6 months? In the past year?
- Risk score
- Care Sensitivity

Discussion: Who is the high risk patient population in your practice?

Proactive Outreach and the Provider Discussion

- The provider often has knowledge of patient's circumstances - psychosocial, readiness for change.
  - Provider input saves time!
- The provider can help you identify a group of people who he/she considers important for outreach, and write a standing order - this allows you to provide outreach proactively!
- Setting up a regular time for discussion of patients is not only helpful, but billable (more to come later).

If you can't enroll the patient, who else can provide support?

If you can't support the patient because of insurance, they don't meet the qualifications of high risk, or any other reason, the best option for the patient is a referral to a community resource that *can* support them. Often, payers have centralized care teams that can also provide support.

- For **Blue Cross Health and Wellness**: call 800-775-2583

- For Coordinated Care Program **Blue Cross and BCN:** call 1-800-845-5982
- For Coordinated Care Program **Blue Cross Complete:** call 888-288-1722

Priority Health Outpatient Care Management Contacts

LOB	Name	Role	Phone #	Email
ACA Individual	Bethany Swartz	Manager	616-575-7338	Bethany.Swartz@priorityhealth.com
	Julie Reynolds	CM/Referral Lead	616-464-0438	Julie.R@priorityhealth.com
Commercial	Debbie Collins	Manager	616-464-8132	Deb.C@priorityhealth.com
	Maria Knoppers	Supervisor	616-464-8415	Maria.K@priorityhealth.com
Medicaid	Bethany Swartz	Manager	616-575-7338	Bethany.Swartz@priorityhealth.com
	Nichol Scholten	Supervisor	616-355-3261	Nichol.S@priorityhealth.com
	April Sydow	Supervisor	616-464-8186	April.S@priorityhealth.com
Medicare	Stacey Ottaway	Supervisor	616-575-5833	Stacey.O@priorityhealth.com
	Susan Molenaar	Supervisor	616-355-3247	Susan.M@priorityhealth.org
Behavioral Health	For urgent/emergent concerns related to Behavioral Health, contact the PH Behavioral Health Dept. at 1-800-673-8043			
Home Health	For questions about Home Health Care call the Home Health Care Management Line at 616-464-9437			

How to Start the Conversation

Introducing care management to patient/caregiver

What is your elevator speech?

What are your concerns and what would you like to work on?

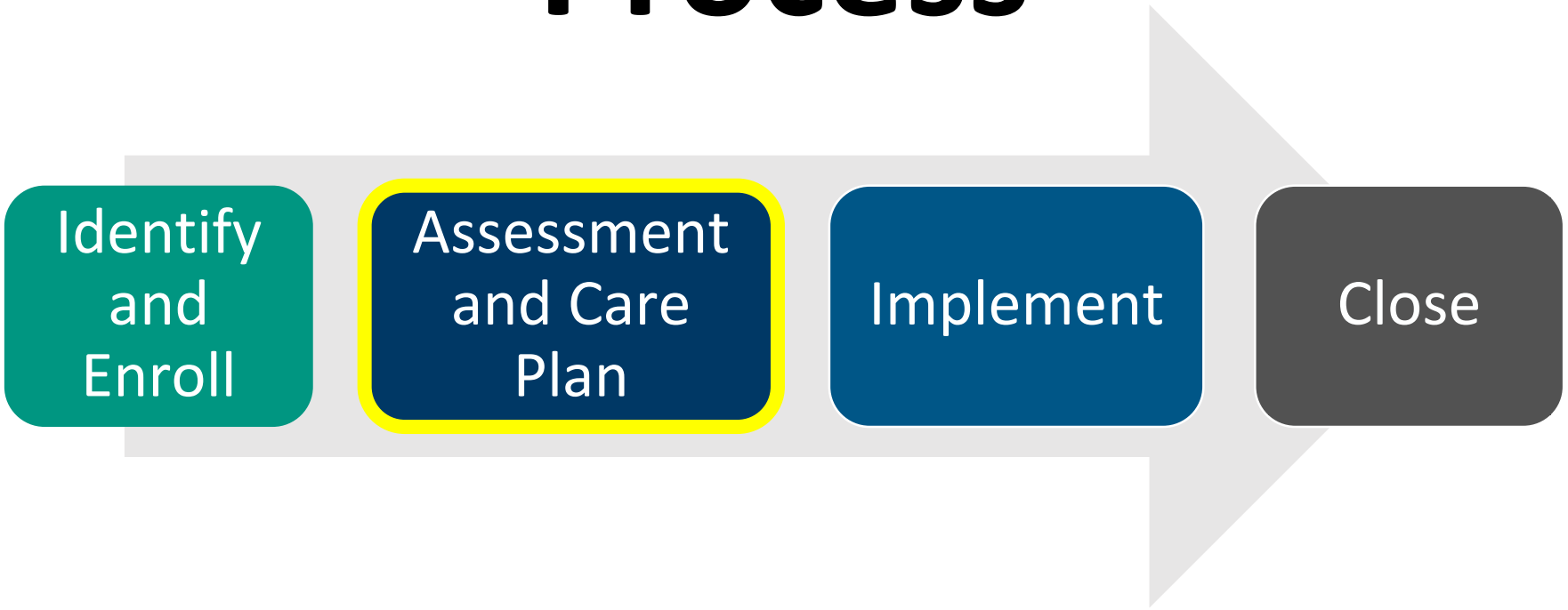
Asking patient/caregiver

Patient Agreement to Care Management Services

What is **agreement**?

How do you **document agreement**?

Care Management Process



Assessment and Care Planning

Assessment provides patient context and supports development of the individualized Patient Care Plan and use of Action plans for symptom management.

Assessments and Screenings

Key Area of Focus	Screening tools / methods
Medical	• Chronic conditions • Functional status • Utilization • Who else is on the care team? Is there a PCP care manager?
Behavioral	• PHQ-9 • GAD-7 • Cognitive status
Social	• Social Needs Assessment • Nutritional Status • What is the support level? Does the patient have a caregiver?
Patient ability / Desire	• Discussion about ideal state / goals • Confidence in achieving goals
Patient / Caregiver Understanding	• Teach-back processes

Care Plan:

For High Risk Patients Episodic vs. Longitudinal

Determine Care Management services to match needs of patient:

Episodic: Short-term, goal oriented

- Exacerbation of condition and has confidence/knowledge to self manage
- Social needs, short term and need can be addressed
- Lack of knowledge regarding accessing care (how to reach Specialist care team weekends and after hours)
- Elective surgery

Longitudinal:
High Risk, goal oriented

- Frequent use of healthcare services
- Combination of multiple comorbidities
- Complexity of health problems
- Complexity of treatment regimens
- Behavioral and social risks

Patient Plan and Goals: Shared Decision Making

The patient plan and goals:

Conversations with the *patient* to develop goals and interventions

Cover plan areas:

Symptom management: ex. stop light action plan; when to call and who to call

Medication management

Planned interventions

Community and other resources or referrals

Follow-up schedule, calls with CM Team members, planned visits

To guide care, evaluate during follow up and refocus as needed - basing changes on patient desire and ability.

Activity: Practice creating a Care Plan

1. **Enter into the comments:** What types of screenings does your practice use?
2. **Now, please enter into the comments:** What might you add to support your patients more holistically and create care plans that align with improving utilization?
3. **Discussion:** How might you use these assessments to help the patient create goals that would decrease their need for ED / IP use?

Communicate the Plan to the Care Team

1

Confirm with patient/caregiver: "Who is the person you work with the most at your PCP practice?"

2

Let the PCP know your Care Plan:
If patient has a PCP care team member (the person patient identifies), call PCP care team member to coordinate.

- Discuss how to work together to address patient's health concerns
- Share assessment findings

"I work with Dr. Smith and he asked that I call/meet you. He mentioned your [ ] is something we could work on together to address your health concerns…"

Care Plan Summary

The care plan is collaboratively developed by the patient and care team to identify clinical plan and set mutual goals and actions for the patient.

Components include

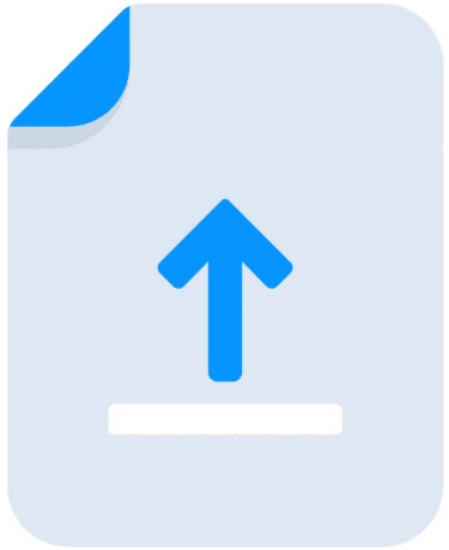
- Symptom Management
- Medication Management
- Education and coaching to self-manage condition/health
- Planned interventions: tests, procedures
- Follow up schedule: planned visits, phone calls
- Coordination of care across settings: Primary care, Specialists, Community

Care Management Process

Implementation and Follow Up

The follow-up plan is based on patient level of:

- Risk
- Safety issues
- Changes in condition or care (new diagnosis or medication)
- Treatment to target goals/trend
- Self-management abilities
- Support needed to accomplish their goals



Symptom Management

Stoplight Tools

- Used by patients to recognize and monitor their symptoms and collaborate with providers to recognize early systems and manage condition with office to prevent ED and hospital.
- Symptom to be aware of and actions to take at each level.

Green: Goal

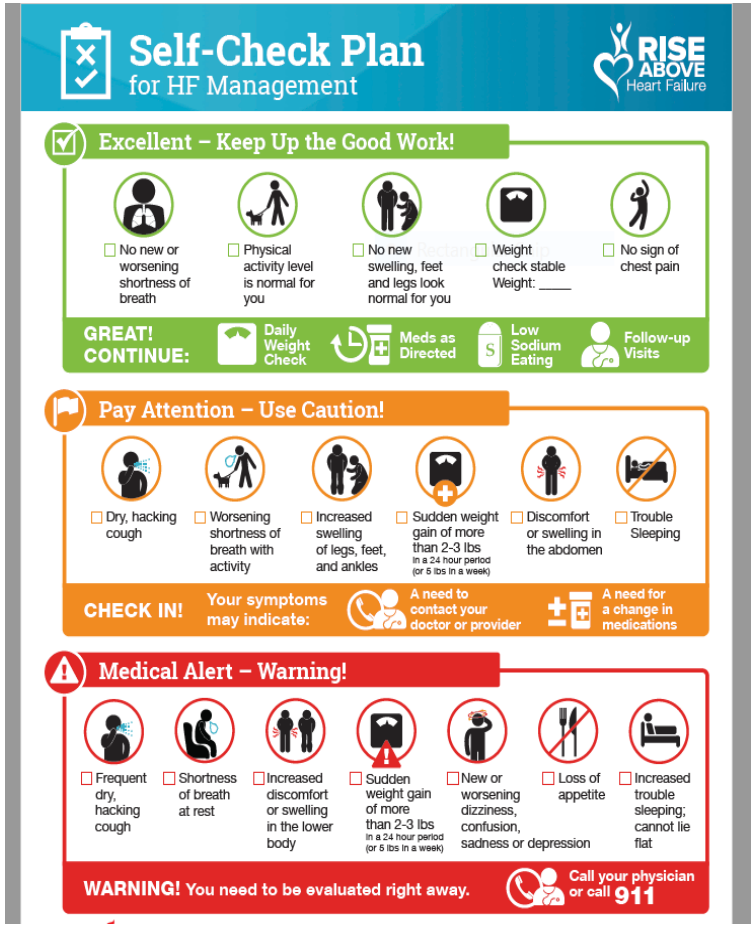
Yellow: Warning when to call provider/office

Red: Emergency symptoms

Patient Education:
Proactive Action Plans

Emergency Room Utilization

Symptom Management



Definition of Transitions of Care (TOC)

A set of actions designed to ensure the coordination and continuity of health care as patients transfer from hospital to home.

. . .TOC services are provided after a patient is discharged from one of these inpatient settings

- Inpatient acute care hospital
- Hospital outpatient observation
- Skilled nursing facility (SNF)
- And other inpatient settings

https://apps.who.int/iris/bitstream/handle/10665/252272/9789241511599-eng.pdf;jsessionid=15B79538FFD509D36F09E059C4CD6BB2?sequence=1

Your Transition of Care Experience: Poll

Please rate your experience in working with patients to address Transition of Care.

Why is TOC Important?

20% of patients experience an adverse event (66% drug related).

"US health care spending **increased 4.6%** to reach $3.6 trillion in 2018, a faster growth rate than the rate of 4.2% in 2017 but the same rate as in 2016." (Health Affairs, January 2019)

20% of Medicare patients are readmitted within 30 days of discharge.

Analysis conducted by the Medicare Payment Advisory Committee (MedPAC) US data
Reference: Schall M, Coleman E, Rutherford P, Taylor J. How-to Guide: Improving Transitions from the Hospital to the Clinical Office Practice to Reduce Avoidable Re-hospitalizations. Cambridge, MA: Institute for Healthcare Improvement; June 2013. Available at www.IHI.org.
https://healthinsight.org/outpatient-clinicians/strengthening-primary-care/transitional-care-management
National Health Care Spending In 2017," *Health Affairs,* January 2019

Goals for a Positive Transitions of Care

Patient receives the continuity of care they need to keep condition stable or recognize warning signs and actions to take

Health outcomes are consistent with patient's wishes

Avoid hospital readmission

Patient and family's experience and satisfaction with care received.

Providers have the information they need to understand and bridge care.

Nielsen GA, Bartely A, Coleman E, Resar R, Rutherford P, Souw D, Taylor J. *Transforming Care at the Bedside How-to Guide: Creating an Ideal Transition Home for Patients with Heart Failure.* Cambridge, MA: Institute for Healthcare Improvement; 2008. Available at http://www.ihi.org

TCM Element: KEY Identify **who is LEAD:** Specialist or PCP?

Call patient within 2 days of discharge	Visit Prep (Same day as provider visit or prior to)	TCM Visit	Follow Up Support	Bill
Unlicensed Team Member	Licensed Team Member -LEAD	Provider- LEAD	Unlicensed / Licensed Team Member-LEAD	Office Staff - LEAD
• Obtain and Review discharge information • Confirm LEAD: office visit scheduled with PCP or Specialist (7 business days complex, 14 business days moderate) • LEAD: communicate with appropriate PCP/Specialist team members • LEAD: Identify if patient has urgent needs prior to F2F visit: ex. SDOH, clinical needs – connect patient with appropriate PCP team member to address SDOH	• Complete medication reconciliation • Discuss patient's goals and concerns • Provide relevant education • Conduct screenings • Coordinate Specialists, Primary care, community resources, other care plan needs.	• Address medical treatment plan • Assess for complications • Review need for and/or follow up on pending tests/treatments • Interact/coordinate with Specialists • Educate patient/caregiver • Discuss patient's goals and concerns • Discuss care team member support opportunities	• Regularly check in with high risk / moderate risk patients to review care plan, self-management goals, and any patient concerns. • Goal is to avoid readmission.	• Bill the TCM if the practice is assured that there have been no readmissions within 30 days. • 99495 = Visit completed within 14 days. • 99496 = Visit completed within 7 days.

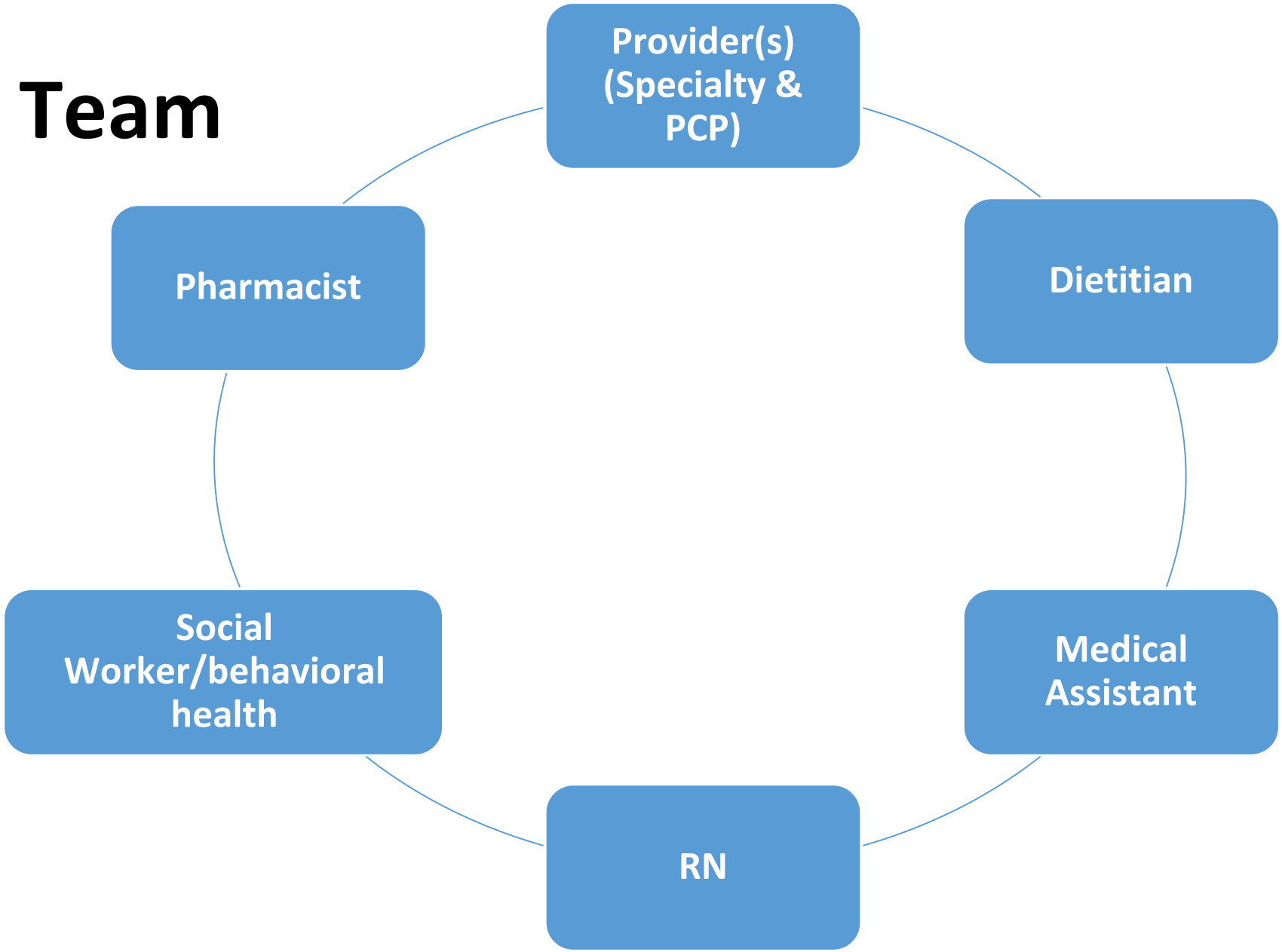
TOC Case Study: Mary

- Mary is an 80 year old African American female with diagnoses of Heart Failure, Congestive Obstructive Pulmonary Disease, Diabetes Type II, and Hypertension. In the past 6 months, Mary had 3 ER visits and 2 Hospital admissions.
- Yesterday Mary was discharged from the hospital with a diagnosis of ketoacidosis.
- Mary is a widow and lives alone; her daughter lives nearby.
- After speaking with Mary and her daughter you gather:
  - Daughter notices her Mom is more and more isolated and has observed a decline in her Mom's memory.
  - Mary shares she is having difficulty affording medication and food.
  - Most days Mary has anxiety.
    - Takes 8 prescription medications daily.
    - Meals consist of canned and prepared food.
    - Understanding of self management for her chronic conditions is limited.

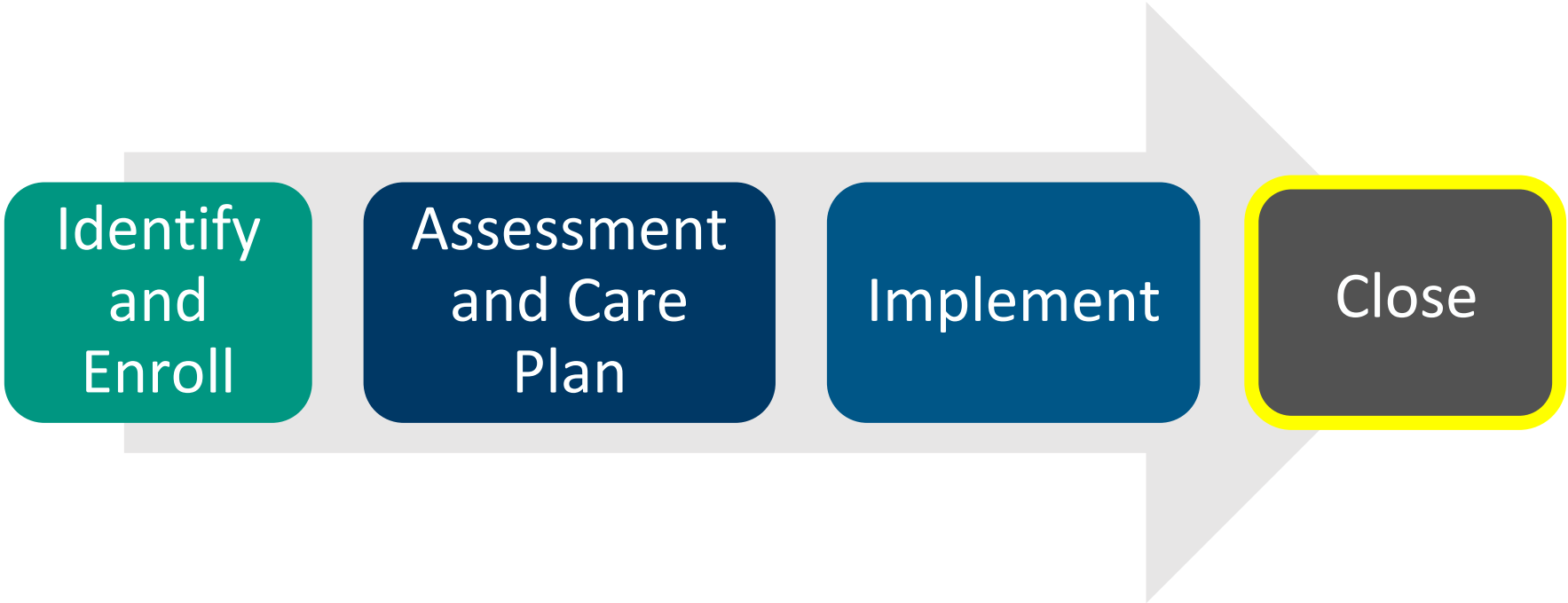
TOC Activity:

Identify Mary's Team

Think about your role and scope



Care Management Process



Case Close and Evaluation

Reasons for case close and discharged from care management services:

- Patient /caregiver successful and confident with self management
- Patient moves out of region/state
- Patient is admitted to Skilled nursing facility, hospice care
- Patient declines further services
- Patient expires

Patient Met Goals

Prepare for transition back to team monitoring

Prepare patient for ongoing self-management and relapse prevention*

Keep door open for support that may be needed in the future

*__Note__: Patients with longitudinal needs will benefit from periodic follow up by the care management team.

Summary

The care management process describes the **method** care team members use to **collaborate with the patient and care team** to support improved patient self-management and outcomes.

Resources

- MQIC Guidelines
- https://www.ahrq.gov/evidencenow/tools/standing-orders.html
- https://www.cdc.gov/diabetes/prevention/pdf/postcurriculum_session11.pdf
- Relapse Prevention Strategies
- Essential Steps of Shared Decision Making, AHRQ
- Patient Engagement - a variety of resources - www.micmt-cares.org
- Tools
  - Care Management Flyer
  - Care Management Introduction Phone Script
  - Symptom Management Stoplight tool Emergency room visit decision - GDHAC Tool
  - Symptom Management Stoplight tool Heart Failure – Chronic conditions
  - Introducing Care Management – script follow up TOC call

Questions?

Break

Deskercise

Agenda

Topic	Objectives
Introductions	
Chronic Care Model	• Explain how a prepared, proactive team contributes to positive patient outcomes • Describe how the components of the Chronic Care Model support the practice team
Team Based Care and Care Coordination	• Describe strategies to improve coordination across the care continuum • Describe effective processes of communication
Outcomes	• Define two outcome measures that indicate the Specialty team-based care is successful
Break	
Care Management Process	• Explain the care management press and actions which address the needs of high risk patients • Illustrate care management interventions to decrease ED utilizations and hospital admissions
Coding and Billing	• Illustrate how to use care management codes for daily care team activities

Objective

Illustrate how to use the Care Management codes in daily care team activities.

Different payers, Different rules!

Not all of the payers interpret/pay for these codes in the same way. As we discuss each code, please refer to the **Multi-Payer handout** for additional detail regarding how the two main payers (Priority Health and BCBSM) interpret these codes and who they pay to deliver service.

Billing resources are posted on MICMT website:
https://micmt-cares.org/bcbsm-billing

Different payers, Different rules!

BCBSM

- BCBSM removed the distinction between lead care managers and qualified health professionals – now they simply have “physicians” and “care team members,” and those care team members are either licensed (e.g., social workers, nurses) or unlicensed (e.g., MAs, CHWs).
- The care team can be comprised of any health care or behavioral health professional the provider believes is qualified to serve on the care team.

Priority Health

- QHPs include: RNs, certified NPs, PA-Cs, licensed Master social workers (LMSWs), psychologists (LLPs and PhDs.), certified diabetes educators (CDEs), Registered Dieticians, Masters'-trained nutritionists, clinical pharmacists and respiratory therapists.

PH: https://www.priorityhealth.com/provider/manual/services/medical/care-management
BCBSM: March, 2020 FAQ document

Care Management Codes for Care Team Members

BCBSM		Priority	
Licensed	X	QHP	X
Unlicensed MA, CHW			

Face to Face w/ patient

G9001: Initiation of Care Management (Comprehensive Assessment)
G9002: Individual Face-to-Face Visit

Group Visits w/ patient

98961: Education and training for patient self-management for 2–4 patients; 30 minutes
98962: Education and training for patient self-management for 5–8 patients; 30 minutes

End of Life Counseling Advanced Directive

S0257: Counseling and discussion regarding advance directives or end of life care planning and decisions

Provider liability if patient does not have the Care Management Benefit.

G9001 Comprehensive Assessment Code

BCBSM		Priority	
Licensed	X	QHP	X
Unlicensed MA, CHW			

The **Comprehensive Assessment** (**G9001**) is a face to face meeting which results in a patient centered care plan that the care team and the patient agree upon and follow.

- The comprehensive assessment is a holistic approach and involves screenings (ex. SDOH, PQ 2), understanding and discussion of patient's concerns/goals and the medical treatment plan.
- The care plan:
  - Guides the patient and caregiver towards **self-management**
  - Requires **monitoring and evaluation** of the effectiveness of the plan over time
  - **Adjust goals and interventions as needed**, until goals are met

G9001 Comprehensive Assessment Code

BCBSM		Priority	
Licensed	X	QHP	X
Unlicensed MA, CHW			

BCBSM

- Individual, face to face (or video for commercial)
- One per patient per day

Priority Health

- Individual, face to face
- May be billed once annually for patients with ongoing care management.

G9002 Face-to-Face

BCBSM		Priority	
Licensed	X	QHP	X
Unlicensed MA, CHW			

BCBSM (Commercial and Medicare Advantage):
Quantity Billing

- Individual, face to face or video
- If the total cumulative time with the patient adds up to:
  - 1 to 45 minutes, report a quantity of one; 46 to 75 minutes, report a quantity of two; 76 to 105 minutes, report a quantity of three; 106 to 135 minutes, report a quantity of four.

Priority Health (Commercial, Medicare Advantage, Medicaid):
No Quantity Billing

- In person visit with patient, may include caregiver involvement.
- Used for treatment plan, self management education, medication therapy, risk factors, unmet care, physical status, emotional status, community resources, readiness to change.

BCBSM: 2P Modifier for G9002- Payable when contact is made with patient to discuss the program and patient does not enroll in care management.

Face to Face or Video Codes

BCBSM		Priority	
Licensed	X	QHP	X
Unlicensed MA, CHW			

G9001 Comprehensive Assessment

- A face to face or video meeting
- Duration at least 30 minutes, that results in a care management plan that all care management team members and the patient will follow.
- This is a **holistic, encompassing** type of patient visit that helps define a significant change in how the patient approaches managing their health: new diagnosis, transition of care, addressing a symptom that requires a significant change to the previous care plan.

G9002 Patient Visit

- A face to face or video meeting that is focused on addressing a piece of the care management plan.
- This type of visit should additionally address patient goals and a follow up plan.

98961, 98962
Group Education Code

BCBSM		Priority	
Licensed	X	QHP	X
Unlicensed MA, CHW			

98961 Group Education

- 2-4 patients for 30 minutes
- Face to Face with patient or caregivers
- Quantity bill per 30 minutes

98962 Group Education

- 5-8 patients for 30 minutes
- Face to Face with patient or caregivers
- Quantity bill per 30 minutes

S0257 End of Life Counseling Advanced Directive Discussion Code

BCBSM		Priority	
Licensed	X	QHP	X
Unlicensed MA, CHW			

Individual face to face, video or telephone

BCBSM: one per patient per day

Priority: no quantity limits

S0257 End of Life Counseling Advance Directive Discussion Code

BCBSM		Priority	
Licensed	X	QHP	X
Unlicensed MA, CHW			

Discussion with patient/caregiver may include one of the following:
Share information and answering questions: "what is an advance directive?", "what is advance care planning? what is Physician Orders for Life Sustaining Treatment (POLST)?
Patients wishes:

- Types of medical care preferred
- Comfort level that is preferred
- Identify a person to make decisions for the Patient if the Patient cannot speak for him or herself
- How the patient prefers to be treated
- What the patient wishes others to know

Individual face to face, video or telephone

- **BCBSM:** one per patient per day
- **Priority:** no quantity limits

Care Management Codes for:
QHPs, Licensed, and Unlicensed

Telephone with patient	**98966:** Telephone visit 5-10 minutes of medical discussion **98967:** Telephone visit 11-20 minutes of medical discussion **98968:** Telephone visit 21-30 minutes of medical discussion
Care Coordination (not with patient or provider)	**99487:** First 31 to 75 minutes of clinical staff time directed by a physician or other qualified healthcare professional with no face-to-face visit, per calendar month **99489:** Each additional 30 minutes after initial 75 minutes of clinical staff time directed by a physician or other qualified healthcare professional, per calendar month. (An add-on code that should be reported in conjunction with 99487)

Provider liability if patient does not have the Care Management Benefit for BCBSM.

98966, 98967, 98968 Phone Service Codes

BCBSM		Priority	
Licensed	X	QHP	x
Unlicensed MA, CHW	X		

Call with patient or caregiver to discuss care issues and progress towards goals.

98966 for 5-10 minutes

98967 for 11-20 minutes

98968 for 21-30 minutes

BCBSM: 2P Modifier for 98966, 98967, 99868 - Payable when contact is made with patient to discuss the program and patient does not enroll in care management.

99487, 99489
Care Coordination Codes

BCBSM		Priority	
Licensed	X	QHP	X
Unlicensed MA, CHW	X		

Call on behalf of the Patient to coordinate care.

- **99487** for first 31 to 75 minutes of clinical staff time working on behalf of the patient with someone other than the patient or provider.
  - Examples: coordinating DME for a patient; reaching out to a community resource to help support a SDOH need.
- **99489** for each additional 30 minutes after 75 minutes per calendar month.

Care Management Codes for Providers / Physicians

Care Team Member and Provider Discussion	**G9007:** Coordinated care fee, scheduled team conference
Physician discussion with patient, other physicians, extended care team members not part of the care team.	**G9008:** Physician Coordinated Care Oversight Services (Enrollment Fee)
End of Life Counseling Advanced Directive	**S0257:** Counseling and discussion regarding advance directives or end of life care planning and decisions

Provider liability if patient does not have the Care Management Benefit.

Provider Code:
G9007 Team Conference Code

- PCP and a care team member formally discuss a patient's care plan.
- Can be billed once per day per patient regardless of time spent.
- May be billed by a physician or APP.

Physician Code:
G9008 Physician Coordinated Care Oversight Services (Enrollment Fee)

BCBSM – Physician only

- **No quantity limit.**
- May be conducted face to face, via video, or by telephone.
  - This does not include email exchange or EMR messaging.
- Communication with paramedic, patient, other health care professionals not part of the care team when consulting about patient who is engaged in care management.

Priority Health – Physician only

- **One time per practice.**
- Only be conducted face to face.
- Can only be billed when the physician has discussed the care plan with the patient and if the licensed care team member has had a face to face with the patient on or before the day of the physician's discussion with the patient.

Coding Examples

Specialist Team Based Care Management

Before we start…

- The following series of examples are intended to show a couple of common situations for using the billable codes. They are NOT comprehensive.
- Resources offered by BCBSM
  - Monthly Billing Q&A session
    1st Thursday of every month at noon
  - Questions on specific situations
    valuepartnerships@bcbsm.com

High Risk Patient

Identify the codes:

- Oncology practice Care Manager (RN) reviews patient's recent screenings (SDOH, PHQ-9), problem list, medications, and ED/hospital utilization history. The patient is identified as High Risk:
  - Patient has transportation issues
  - Financial barriers including not being able to afford prescription medications to manage nausea/side effects of chemotherapy
  - Patient has been seen in the ED twice in the past 3 months and was admitted to the hospital each time due to dehydration and uncontrolled nausea
- Care Manager obtains referral from provider and meets with the patient.
- During the face to face visit, the patient agrees to care management. The Care Manager completes the comprehensive assessment and plan of care.
- Care Manager then discusses the care plan with the provider who agrees with the care plan.

GOAL: Reduce ED and hospital utilization

Face to Face Visit and Follow Up Plan

Note how this is different from the G9001!

- Patient has an appointment with the Pulmonologist regarding diagnosis of end stage COPD. During the appointment the provider discusses with the patient the benefits of care management.
- Provider and patient discuss a care plan building on the patient's goals.
- Patient agrees to participate in care management; provider introduces the patient to the Care Manager
- Care Manager meets with the patient and identifies patient
  - ✓ lacks understanding of COPD
  - ✓ reports increased difficulty with shortness of breath (SOB), coping, and feels discouraged about limited activities
- Care Manager initiates the care plan
  - ✓ discusses referral to home care agency to arrange for a respiratory therapist to teach breathing techniques, Care Manager conducts a medication review and provides education to ensure patient is safe with the current medication plan
- Provider and patient discuss and agree with the action plan
- Care Manager and patient agree to follow-up in one week via a phone visit

NOTE: PH also includes in person with patient and CM with CM/PCP direct involvement on a separate occasion.

Coordination of Care

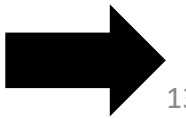
Identify the code:

- Care Team Member contacts the home health agency to schedule in-home visits and conduct a safety assessment. Includes Respiratory Therapist and Occupational Therapist in home visits.
- In addition, a call was made to the DME provider to arrange for delivery of home O2.
- Time spent coordinating care was 35 minutes.

Multidisciplinary Team

Identify the code:

- Patient with diagnosis of diabetes, end stage COPD, HTN, completed a comprehensive assessment with the MSW care manager one week ago.
- A multidisciplinary team conference was held with the Clinical Pharmacist, MSW and Specialty Provider to discuss the initial plan of care with the team, which includes:
  - The MSW to schedule a virtual face to face visit with the patient regarding the lack of caregiver support and social isolation, which is linked with hospital admissions.
  - The Clinical Pharmacist to follow up with the patient on the ability to afford medications and the chronic diseases management also linked to frequent ED visits.
  - Both MSW and Clinical Pharmacist follow up with the team at their regular huddle.



Advance Directives End of Life

- Care Team Member conducts a 20 minute in person visit* meeting with a patient regarding their advance directives.
- During the visit, discussion occurs and written information about advance directives is shared.
- Care Team Member and Patient discussion includes:
  - How the patient prefers to be treated.
  - What the patient wishes others to know.
- Care Team Member and patient agree to follow up via a phone call in 2 weeks.

Identify the code:

***Note: this code allows for phone visit, face to face visit or video and may be with the patient, caregiver, or family member.**

Identify the code:

Reducing ED visits

- Follow up each ED visit with a call to identify issues, coordinate follow up care, and encourage seeking care through the practice rather than the ED when appropriate. **Often, this can be performed by a Medical Assistant.**
- Medical Assistants, operating under a protocol, may call patients:
  - Example: MA asks if the ED physician recommended follow up care, coordinates the needed care, transfers to clinician for issues requiring immediate medical assessment or guidance, and encourages the patient to bring in all medications to office visit.
  - **Call takes between 5 and 10 minutes.**
- Proactive patient education examples:
  - Call Specialist related to disease focus needs/concerns: ex. Call Oncologist for chemotherapy side effects
  - Call PCP care team for mild cold symptoms, new onset
  - Suggest nearby urgent care, or ED for true emergency

Phone Service

Identify the code:

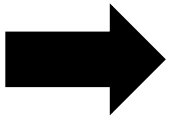
- Pulmonologist Care Team Member speaks conducts a patient phone visit
- Care Team Member:
  - Discusses patient's COPD action plan with patient; reviews "in control", "worsening symptoms" and "exacerbation."
  - In reviewing patient with Pulmonologist, the CM understands: Pulmonologist introduced the benefits of having an advance directive at the last visit. Following up, CM asks the patient about interest in meeting with Specialist practice team member to discuss Advance Directive. Patient indicates interest and CM sends referral to Specialist team member.
  - Also reinforced when to call the office.
- CM and patient agree on follow up in one week via in person visit at the office.
- Phone visit = 20 minutes.

Group Education Visit

Identify the codes:
3 patients:
6 patients:

Patient has a new diagnosis of Chronic Kidney Disease.

- Patient and caregiver indicate interest in Chronic Kidney Disease Group Education class.
- Patient attends with caregiver and with 3 other patients for 30 minutes.
- Patient attends a second class with 6 other patients for 60 minutes.



Medical Community

Identify the code:

- Primary Care Physician calls a Pulmonologist to discuss a joint treatment plan for a patient with diagnosis of severe Pulmonary Hypertension.

Summary

The Care Management codes in daily care team activities

Resources – Billing and Coding Care Management Services

BCBSM

- https://micmt-cares.org/billing-resources

Priority Health

- https://www.priorityhealth.com/provider

Centers for Medicare & Medicaid

- Chronic Care Management
- Behavioral Health Integration

Michigan Institute for Care Management and Transformation

- www.micmt-cares.org

BCBSM Monthly Billing Q & A

BLUE CROSS BLUE SHIELD OF MICHIGAN MONTHLY BILLING Q & A

Billing Resource Q&A Presentation Information »

Provider Delivered Care Management (PDCM)
High Intensity Care Model (HICM)

On a monthly basis, Blue Cross Blue Shield of Michigan will conduct a question and answer session via WebEx relating to questions you may have after you've completed the online Billing/Coding course regarding these programs. They are scheduled for the first Thursday of each month from 12:00 – 1:00 for 2020. For a list of dates and access to the conference call **Click Here**

Topics: Billing
Resource Type: Billing

To access the dates for the BCBSM Q & A:
https://micmt-cares.org/billing-resources

Appendix: At a Glance Resources

- https://micmt-cares.org/training/specialty-team-based

Communication and Telehealth Visits

Medicare March 2020 Expansion of Telehealth Visit Reimbursement:

- Includes a range of providers, such as doctors, nurse practitioners, clinical psychologists, and licensed clinical social workers, who can offer a specific set of telehealth services.
- The specific set of services beneficiaries can get include evaluation and management visits (common office visits), mental health counseling, and preventive health screenings.
- This change broadens telehealth flexibility without regard to the beneficiary's diagnosis.

Note: Due to COVID-19, many Health Plans have activated telehealth visit coding and billing. Check with your manager for details.

Medicare Telemedicine Health Care Provider Fact Sheet

CMS Medicare Learning Network March 2020 - Telehealth Services

Questions?

MICMT Team Mailbox: micmt-requests@med.umich.edu