Introduction to Team-Based Care

Participation from learners

Video

Agenda

Topic	Time	Content
Introduction	30 Minutes	
Care Team Model and Team Roles	30 minutes	• Define the team-based model of care • Explain how the team-based care model improves patient outcomes • Identify how to apply these concepts in clinics when acting in the role of care team member
Break	10 minutes	
Care Management Process	60 minutes	• Define key components of the care management process and the impact on team-based care
Outcomes	50 minutes	• Identify, describe how team-based care can impact outcomes measures
Lunch	45 minutes	
Selecting Appropriate Codes to Promote Sustainability	60 minutes	• Demonstrate the selection of appropriate billing codes for daily care team activities to promote sustainability
Break	10 minutes	
Putting it All together	60 minutes	• Examine opportunities to integrate concepts of team-based care into own clinical practice
Wrap Up	30 minutes	

Welcome!

House Keeping

Virtual Etiquette

Meeting participation:

- We will be using the raise your hand feature by clicking on the little blue hand
- We will be using chat function
- When we are taking breaks be sure not to leave the meeting but rather mute your audio and video

Environment:

- Be aware of your backgrounds to not be distracting.
- Position yourself in the light.

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)
Mission of MICMT	The Michigan Institute for Care Management and Transformation will work with Physician Organizations to expand the provider delivered care management model within outpatient primary and specialty care clinics to improve the experience of care, improve the quality of care, and decrease the cost of care for Michigan residents.

MICMT
Michigan Institute for Care Management & Transformation

Successful Completion Introduction to Team-Based Care includes:

- Attend the entire Introduction to 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

- Complete the Michigan Institute for Care Management and Transformation (MICMT) Intro to TBC **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.

Intro to Team-Based Care

Curriculum developed in partnership with:

Ruth Clark, Integrated Health Partners
Kim Harrison, Priority Health
Lynn Klima, Cure-Michigan
Ewa Matuszewski, MedNetOne/PTI
Lisa Nicolaou, Northern Physicians Organization
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MICMT
Michigan Institute for Care Management & Transformation

PriorityHealth
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IHP
Integrated Health Partners

Mi-CCSI
Center for Clinical Systems Improvement

Practice Transformation Institute™

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Introduction to Team-Based Care Curriculum Development

- Please provide the following as an appropriate reference if you use this material:
  - “Material based off of the Introduction to Team-Based Care course developed through a collaborative effort by the following Michigan organizations: BCBSM, Cure Michigan, IHP, MICMT, MiCCSI, MedNetOne, NPO, PTI, Priority Health.”
- Questions about using or replicating this curriculum should be sent to: micmt-requests@med.umich.edu.
- Please follow this link if you are interested in becoming an approved trainer for this curriculum: www.micmt-cares.org

Contact Us

For post test and materials:
micmt-requests@med.umich.edu

Click Here for Training Organizations

Pre-Work

Completion of pre-work material

- Pre-checklist (orientation elements document)

*If you didn’t not have a chance to view the pre-work, please make sure to review

Introductions

- Your name
- Your discipline
- Your practice location
- How long have you been in your role

Group Activity: Question

What's most important for you to learn today?

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Team-Based Care

The provision of health services to individuals, families, and/or their communities by at least two health care providers who work collaboratively with patients and their caregivers, to the extent preferred by each patient, to accomplish shared goals within and across settings to achieve coordinated, high-quality care.

https://pcmh.ahrq.gov/page/creating-patient-centered-team-based-primary-care

The Value of Team-Based Care:
A Patient Perspective

Value

- Improved engagement and satisfaction for patient
- Improved patient health and outcomes
- Decreased visits to the emergency department and hospital
- Improved ability to self manage
- Improved ability to engage with the practice team

The Value of Team-Based Care: *A Practice Perspective*

Value

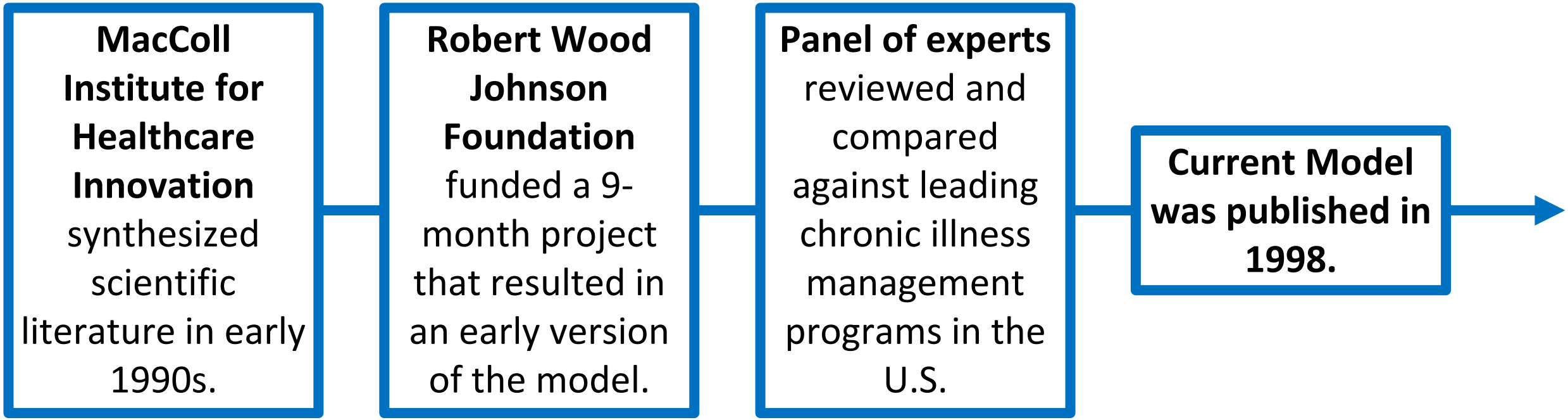
- Improved engagement of practice teams
- Improved patient services
- Improved patient outcomes
- Decreased cost
- Decreased burnout and turnover

The Value of Team-Based Care: *A Payer Perspective*

Value

- Payers support programs that demonstrate improved quality and lower overall costs of care. These things realize health care savings for the payers and the communities they support.
- Outcomes measures, such as A1c, BP, Inpatient Utilization, and ED Utilization demonstrate improved quality and decreased cost of care, making them ideal markers of a successful program.

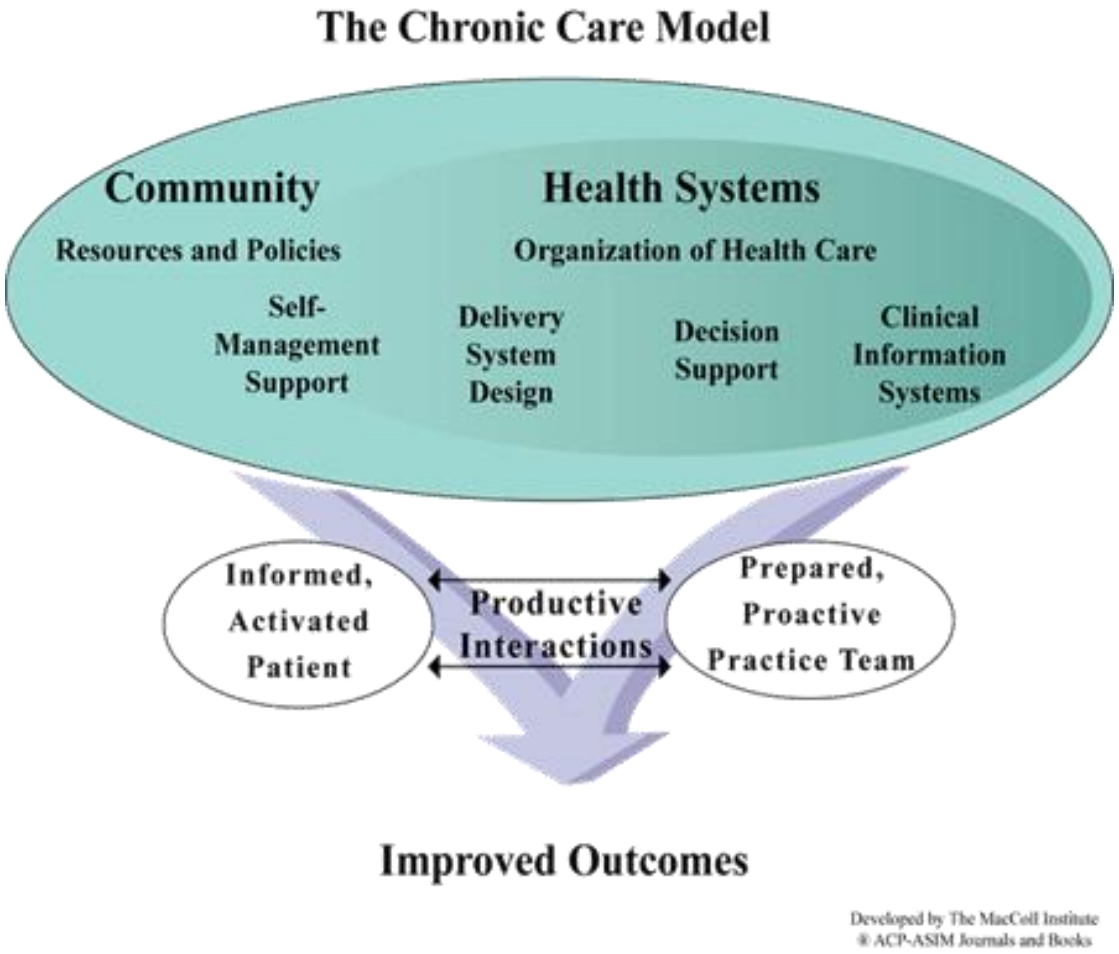
Brief History of Chronic Care Model



The Chronic Care Model

An organized and planned approach to improving patient and population level health:

- Identifies essential elements of a health care system that encourage high-quality chronic disease care.
- Formalized change management process fosters productive interactions.
- Informed patients take an active part in their care.
- Care team has resources, tools and expertise to engage with the patient.

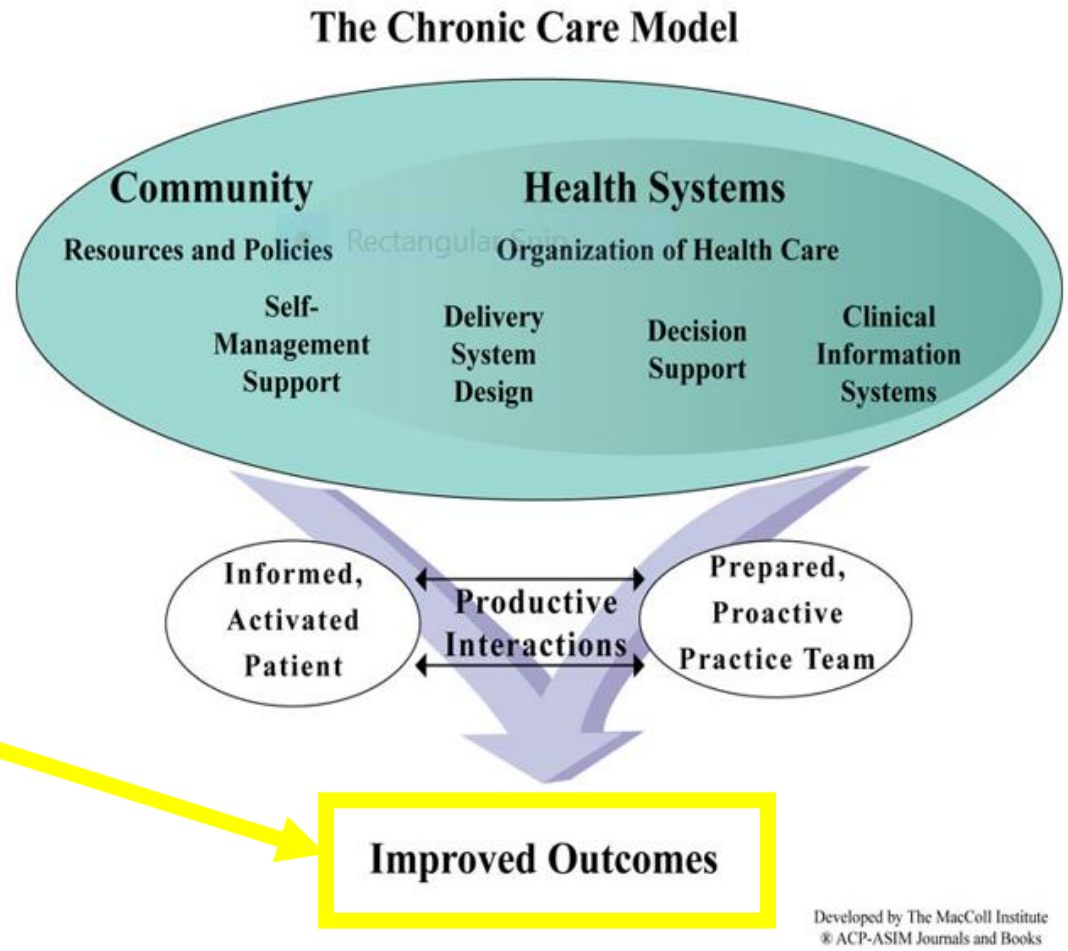


http://www.improvingchroniccare.org/index.php?p=Model_Elements&s=18

Improved Outcomes

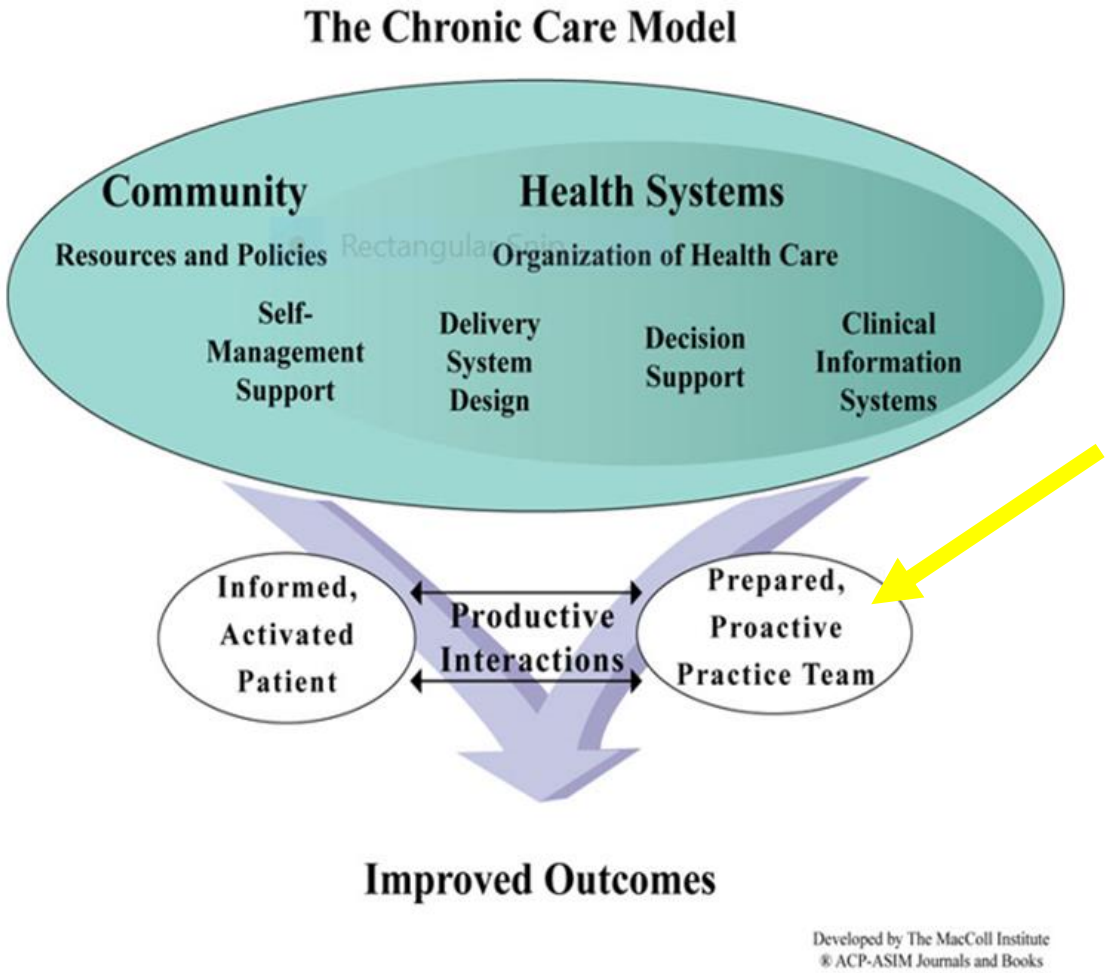
Patient/caregiver is successful with self management of chronic condition(s).

- Improved/stabilized patient quality of life
- Reduced cost of health care
- Patient education: access to Specialty practice, after hours who to call, a tool for decision about ED utilization or not, action plan for chronic condition Medication adherence
- Regular testing and screening
- Healthier lifestyle choices



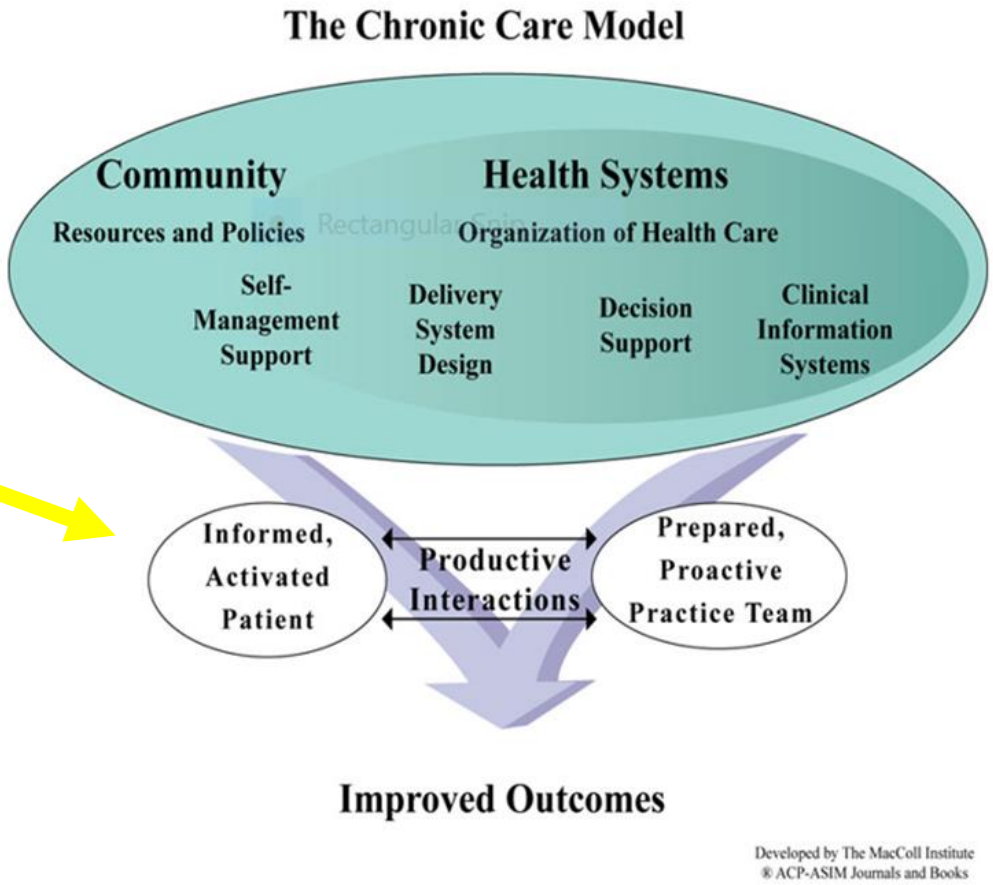
Prepared, Proactive Practice Team

- 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



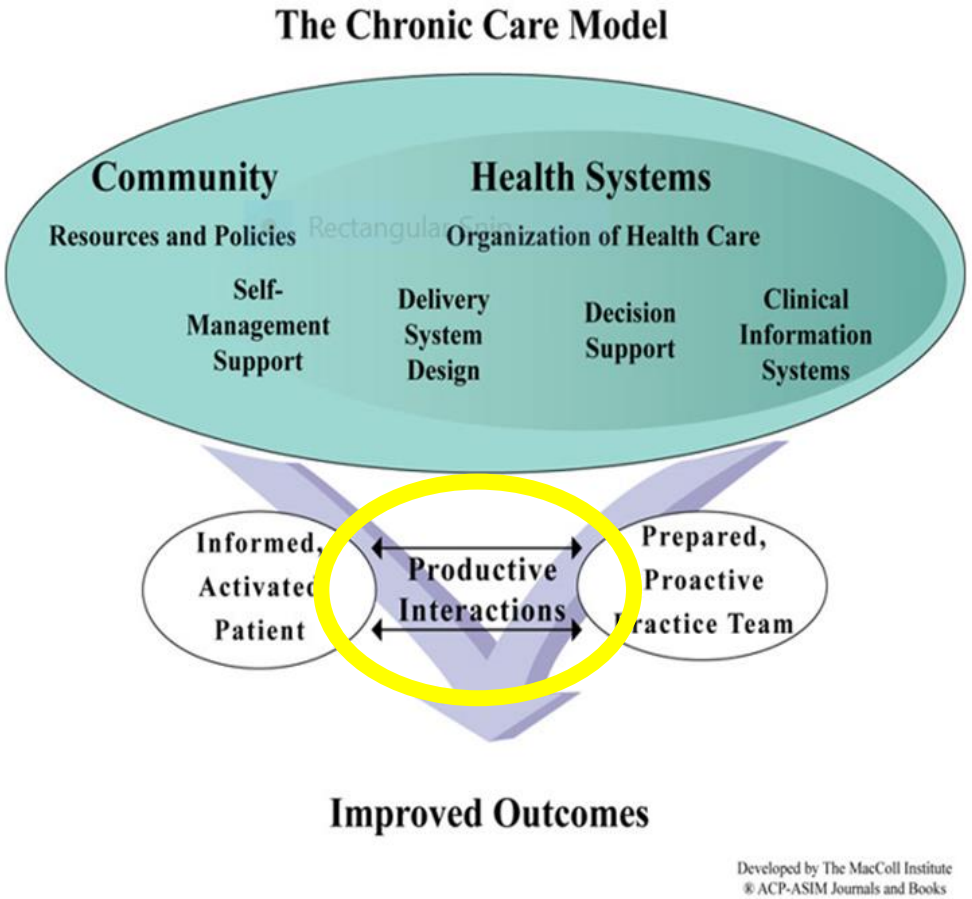
Informed, Activated Patient

- 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



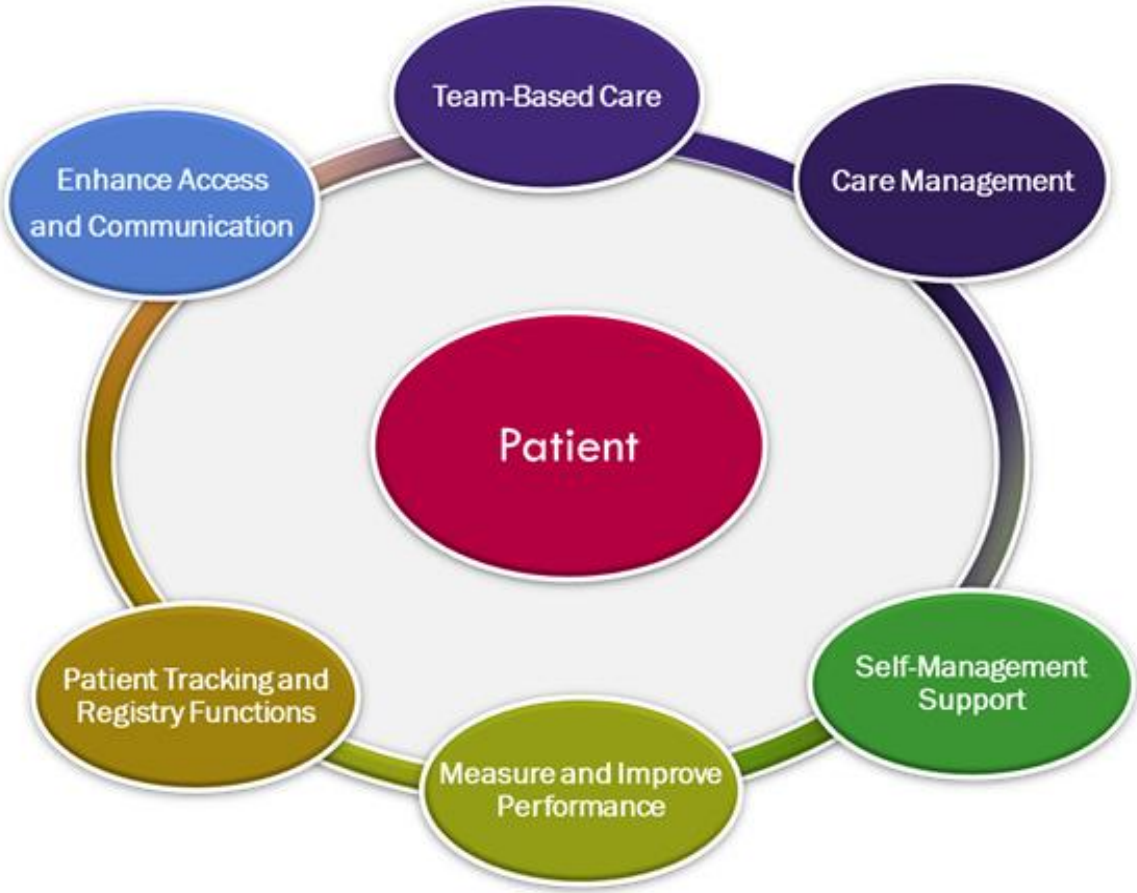
PCMH and Chronic Care Model Alignment

- **Comprehensive Evidence-Based Framework** for improving care delivery and patient-centered chronic condition management across the spectrum of healthcare
- **Recognizes Primary Health Care as the necessary foundation** from which the Community and Health System link to the patient
- **Formal Quality Improvement process**
- **Self Management Support** becomes universally accepted practice to engage patients across the spectrum of care continuum

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

Patient Centered Medical Home (PCMH)

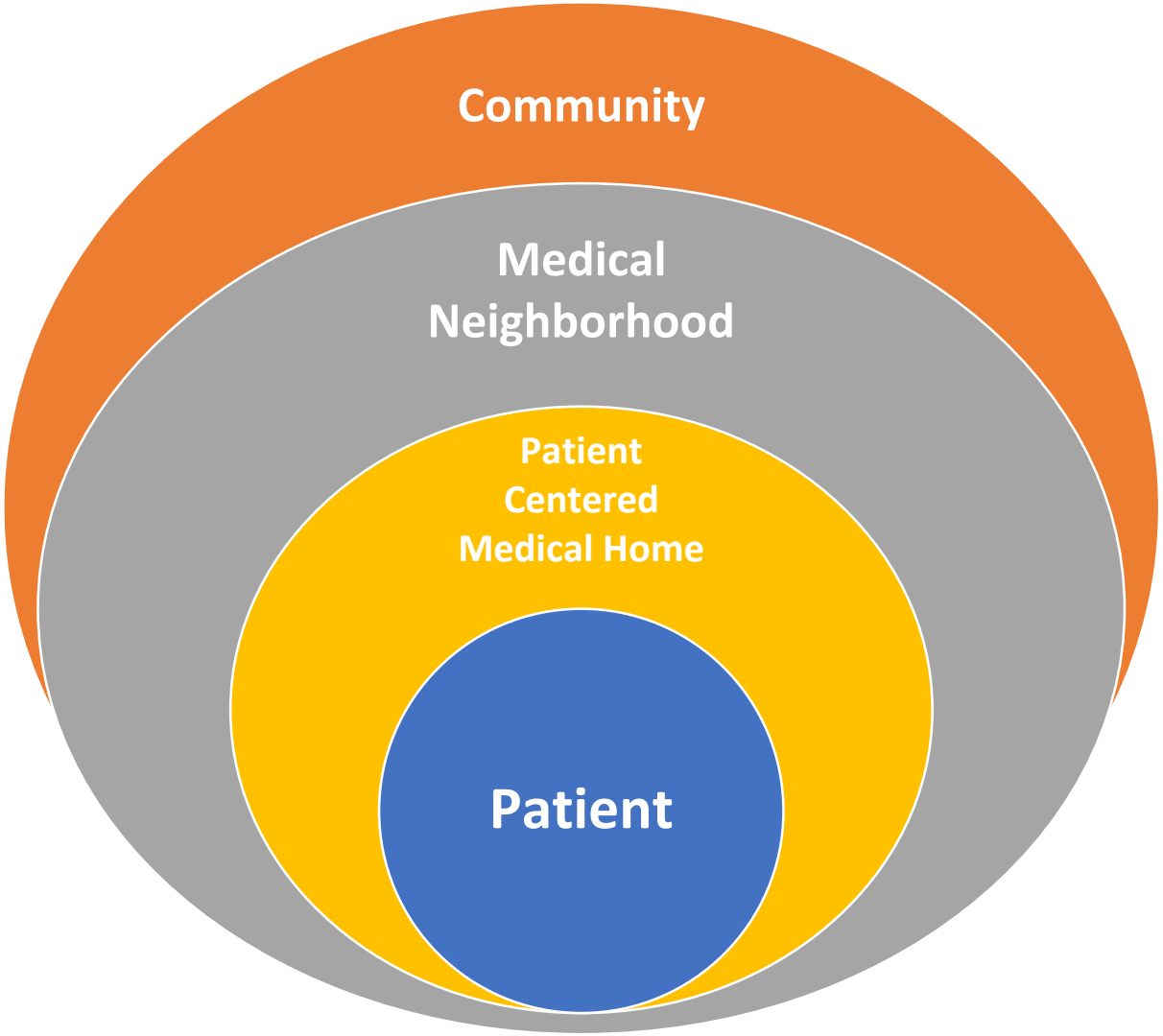
PCMH is a care delivery model in which patient treatment is coordinated through primary care teams to ensure patients receive the necessary care when and where they need it, in a manner they can understand.



Team Expanded Roles Examples

PCP	RN - CM	SW CM – Behavioral Health Specialist	Clinical Pharmacist Medication Management	Community Health Worker	Office clerical Referral Management	MA Panel Management
• Annual Physical • Orders preventive care • Diagnosis, discussion of treatment options and management of acute and chronic conditions • Coordination of care and care team • Referrals to specialists • On call	• Provide care management for high-risk patients • Chronic illness monitoring response to treatment and titrating treatment according to delegated order sets	• Provide behavioral health services in the practice or by referral • Protocol or (service may be in the practice or at another site) • Urgent BH patient need	• Medication review for patents • Review prescribing practices • Assist patients with problems such as non-adherence, side effects, cost of medications, understanding medications, medication management challenges • Titrate medication for selected groups of patient under standing orders • Manages chronic conditions according to Collaborative Practice Agreements	• Provides self-management support • Coordinates care by helping patients navigate the healthcare system and access community services	• Assist with outreach to help patient establish overdue appointments • Assist patients with obtaining referral appointment, having preauthorization orders, and obtaining follow-up reports	• Collaborate with providers in managing a panel • Outreach on preventive services • Provides services to chronically ill patients such as self-management coaching or follow-up phone calls • Scrub chart, provides pre-visit screenings • Reviews medication list
	Quality Improvement Activities Team conducts QI activities to monitor quality measures and improve metrics with involvement of patient and families Team monitors program targets and make changes to improve					

Community Team Members



Teams and Patient Outreach

Typical day

- Scheduled appointments
- Urgent appointments
- Active outreach for follow-up

Types of Outreach Activities

- Health Coaching Call
- Medication Management Call
- Symptom Management Assessment
- Planned Visit Preparation
- Outreach on Gaps in Care
- Follow up to determine barriers
- Adjustment of the care plan
- ED follow up call
- Transitions of Care Calls

Let's Talk Team Communication

Communication is:
A taken-for-granted human activity that is recognized as important only when it has failed.

Complex Setting

Complex Patients

TBC Case Study: Focusing on John

John is a 64-year-old male with a diagnosis of COPD. He has had COPD for the last 10 years.
Current findings:

- John was recently hospitalized last month due to shortness of breath.
- John is a smoker even though his physician has educated him on the problems associated with smoking.
- He also has high blood pressure which at this time is borderline.
- He currently takes Symbicort and albuterol for management of his COPD.
- He is currently not on any medication for his blood pressure although when discussed John refuses to be on any medication.
- John lost his wife one year ago and is on his own.
- The closest family he has lives out of state.
- He is on a fixed income and sometimes has difficulty paying his bills or putting food on the table.

Enhancing Team Communication

It’s about relationship and engagement with team members:

- Seek out opportunities for interactions
- Shadow and reverse shadow team members
- Be curious
- Recognize common goals and values
- Recognize there may be differences in communication style
- Seek to understand-address proactively
- Assume the best

Team Communication Challenges

These are normal human challenges

Personal

- Memory limitations
- Stress/anxiety
- Fatigue, physical factors
- Multi-tasking
- Flawed assumptions
- New role/new team

Environmental

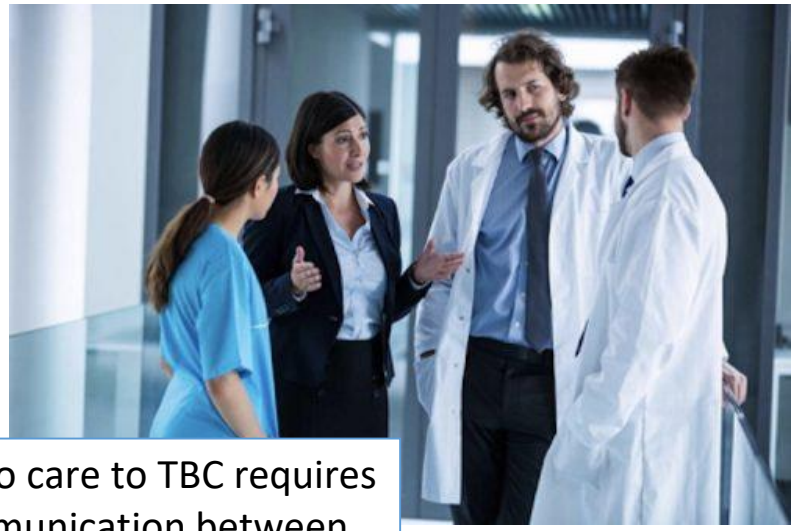
- Many modes communication
- Rapid change
- Time pressure
- Distractions
- Interruptions
- Variations in team culture

Communication is a Critical Skill for High-Functioning Teams

- Providers
- Internal team members
- External team members
- Patients
- Family members
- Caregivers

Care Team Members: Communicating with Providers

- Communication between provider and care team
  - Huddle: Clinical and Operations
  - Team Conference Complex patients, outcomes, ID of cases
  - Patient update: part of both
- Quick and focused



Moving from solo care to TBC requires increased communication between the provider, patient and team. The communication is best when it is efficient and focused.

Team-Based Care Communication Examples

Huddle	Meeting
Short, patient centered	Has an agenda, operational
Frequent, even daily	Less frequent, but scheduled regularly or ad hoc
Goal is to discuss arising situations that need multi-disciplinary support and are complex enough for a conversation: • High risk patients, complex care plans • ED or IP visits • Requests for different referrals • Concerns for a patient	Goal is to improve the overall program performance: • Review operational opportunities, such as scheduling or standing agreements/orders • Review process for referrals • Review outcomes measures / performance
Participants include the individuals directly involved with the huddle topics	Participants expanded to include all involved with the process on the agenda: front and back office, billing, PCP, Care Team, MA, Office Manager

Communication Tools

Spontaneous Communication Tools:

- SBAR (Situation, Background, Assessment, Recommendation)
- Clear patient encounter documentation in the EHR
- Messaging
- Huddles

Standing Communication Tools:

- Collaborative Practice Agreements
- Standing Orders
- Order Sets

High functioning teams have communication tools and processes that support the team to provide efficient effective care
Examples include:

- SBAR communication
- Team documentation visible to all team members
- Instant messaging between team members
- Huddles

SBAR

Situation:
What is the concern?
A very clear, succinct overview of pertinent issue.

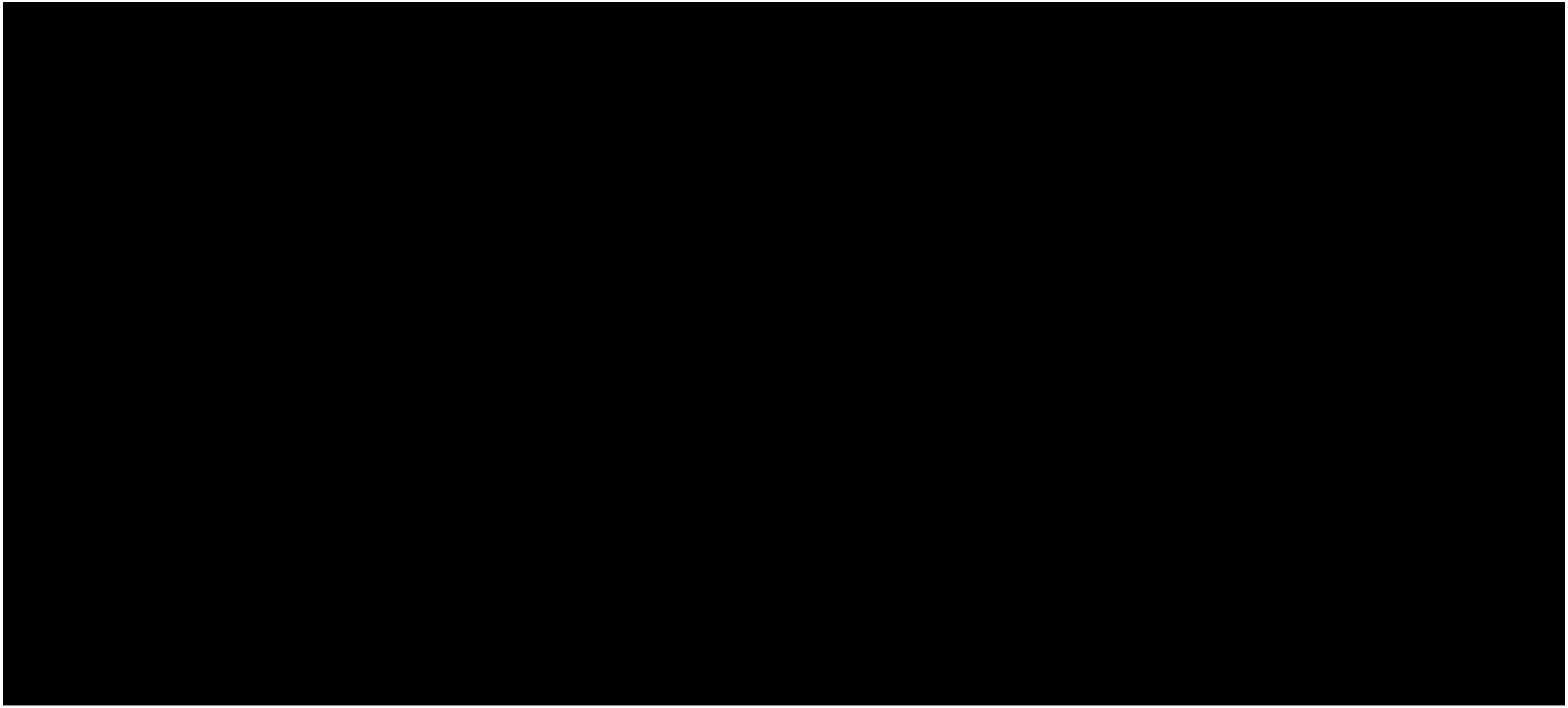
Background:
What has occurred?
Important brief information relating to event. What got us to this point?

Assessment:
What do you think is going on? Summarize the facts and give your best judgement.

Recommendation:
What do you recommend?
What actions do you want?

SBAR Ineffective Communication

SBAR Effective Communication



SBAR: Your Turn!

Kathy is 28 years old and pregnant (32 weeks). She has recently moved to Ypsilanti from Flint to share an apartment with her sister and her 2 children. Kathy has not set up OB care yet. She has just run out of her Toprol to control her blood pressure. She is asking for an appointment and medications to cover her until she can be seen. She has no means of transportation.

- **Situation:** What is the concern?
  A very clear, succinct overview of pertinent issue.
- **Background:** What has occurred?
  Important, brief information relating to event. What got us to this point?
- **Assessment/Analysis:** What do you think is going on?
  Summarize the facts and give your best judgement.
- **Recommendation:** What do you recommend?
  What actions do you want?

Other Communication Modalities

- **Chart Documentation**: Communicate progress
  - Maintain regulatory, practice scope and system requirements
- **Messaging**: Communicates urgent recommendation for action
  - How does the team knows what happened, what is needed and planned with follow up?

Standing Orders/Agreements

- **Standing Orders/Agreements** facilitate team-based care by giving blanket agreement for proactive outreach by the care team

- **Standing orders examples**:
  - Transitions of Care phone calls
  - Calling patients for gaps in care / other preventive care
  - Immunizations procedures
  - Enrollment into chronic care management

https://cepc.ucsf.edu/standing-orders; https://www.jabfm.org/content/25/5/594

Team Roles: Collaborative Practice Agreements

- A legal agreement that formally defines the relationship between the physician and care team member (usually used with Pharmacists) that expands the role of the care team member beyond the normal licensure confines.
- For pharmacists, this frequently gives the ability to provide medication management through titration of meds and ordering supplies.

Let's Talk About Teamwork in Your Practice

- **Introduce** yourself and your role in your practice.
- **Describe** how your role differs from others on the team and how the team compliments and assist in providing good care. Who are other team members and their expanded roles?
- **Identify** any tools your practice uses:
  - Evidence-based guidelines
  - Standing orders, protocols
  - Collaborative practice agreements
  - Others
- **Describe** your team's communication process.

Key Takeaways

- Team-based care provides value to the practice, patients, and payers
- The Chronic Care Model visualizes an organized and planned approach to improving patient health
- Regular, clear team communication is an integral part of team-based care

Break Time

10 minute break!

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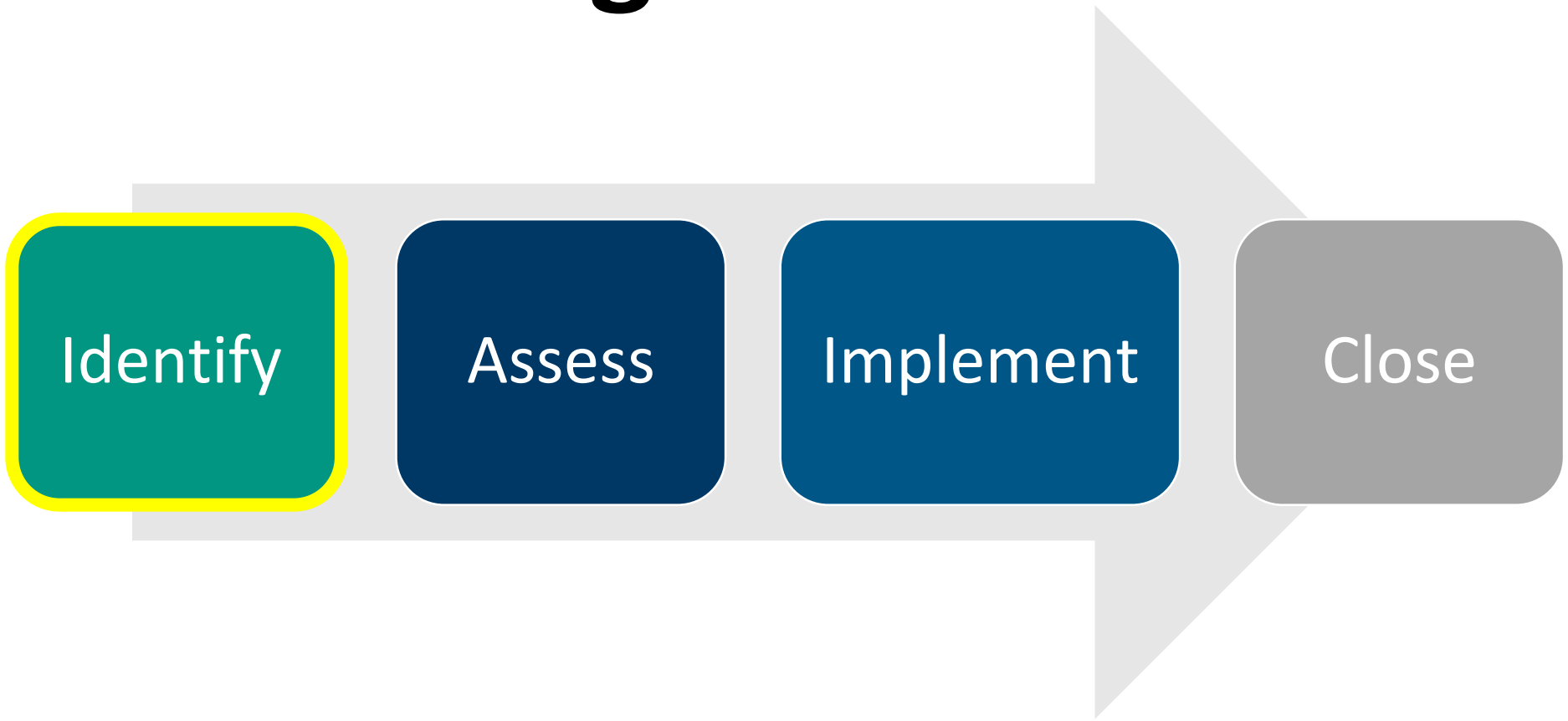
Care Management Process

Care Management Process



How to Identify Patients

- **What's important to your clinic or health system**
  - Your PO, clinic, or health system's strategic plan
  - Populations served
  - Who is on the team
- **Focus for quality improvement**
  - High level of social needs
  - At risk for COVID-19
  - Elevated HbA1c
  - Elevated blood pressure
  - High emergency room use
  - Frequent inpatient hospitalizations

Identifying Patients for Care Management

Work with your practice team and physician to identify patients who need support to improve the key outcomes measures.

Evidence-based Guidelines

Top Outcome Measures:

- Lower ED Utilization
- Lower Inpatient Utilization
- A1c in Control
- BP in Control

"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

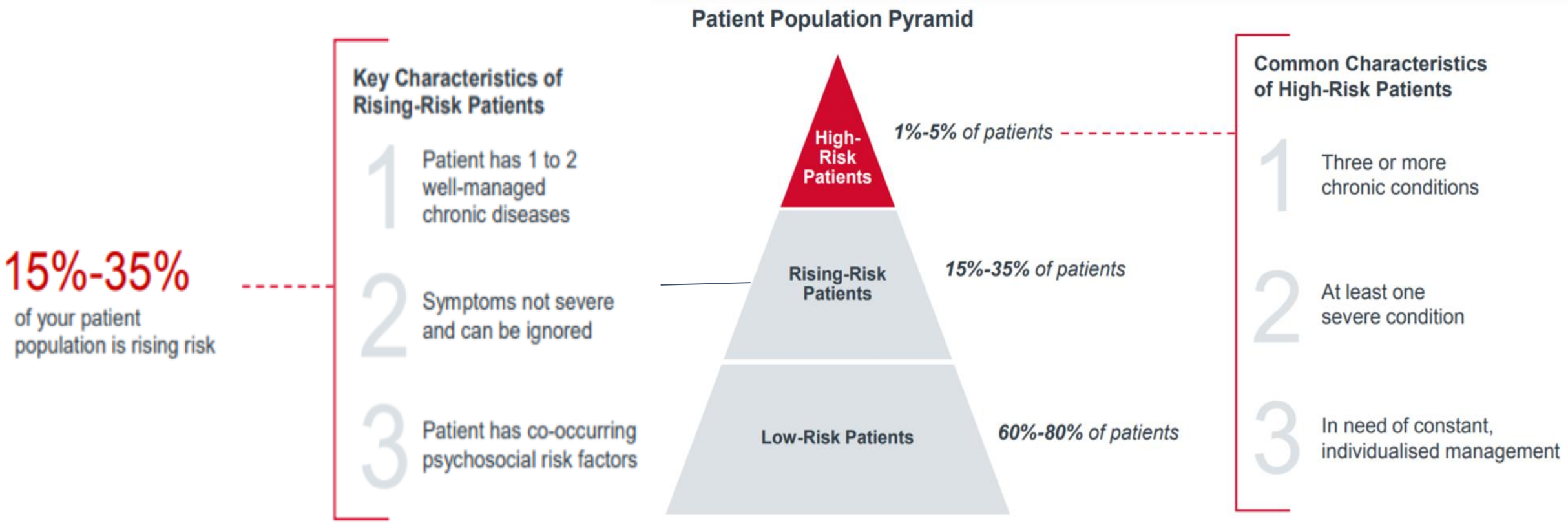
Proactive Identification: A Critical Step!

It is difficult to build a big enough panel to impact outcomes if you're waiting for patients to be sent to you.

Registry: All POs and Payers have lists of patients who are 'out of control' for A1c and BP. These can be great target lists!

Admission / Discharge / Transfer (ADT) Notifications: Your PO / practice will have a way of knowing when somebody is discharged from the hospital / ED; usually on a daily basis, if not in real time!

Using Risk to Identify Patients



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

Passive vs. Proactive Patient Identification

Passive: receiving patients into your panel because somebody else wants you to support the patient.
Main Process:

- Physician or care team referrals

Proactive: finding patients who would have better outcomes if you were involved and helping the patient self-manage. Reaching out to patients who have not been into the office.
Main Process:

- Identify 'lost to follow up' patients:
  - Have an 'out of control' quality metric - such as high A1c or BP
  - Calling patients after an ED or IP admission.
  - High risk/ rising risk patient list

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)	Other inpatient settings

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

Why are Transitions of Care 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.
- Helps to mitigate risk and to improve patient care.

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 Transition 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

Your Transition of Care Experience: Poll

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

Engage With Providers

Providers are important parts of the care team, and they direct the patient-level care. They should be engaged in every step of the process.

Input:
Provider often has knowledge of patient's circumstances: psychosocial, readiness for change. Provider input saves time.

Outreach:
Providers should be engaged in defining proactive outreach attempts, and care team members should have agreement from providers before engaging in proactive outreach based on specific patient parameters.

Activity: Identifying Patients

Other than a physician / team-member referral, how might you in your current practice, identify patients who you think you could help?

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

If you can't support the patient in the practice because of decisions related to care management capacity and/or insurance coverage, the patient does not meet criteria for high or rising risk, or for any other reason, the best option for the patient is a referral to a community resource that is able to provide support. If the patient has insurance that provides centralized care management, that is also an option.

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

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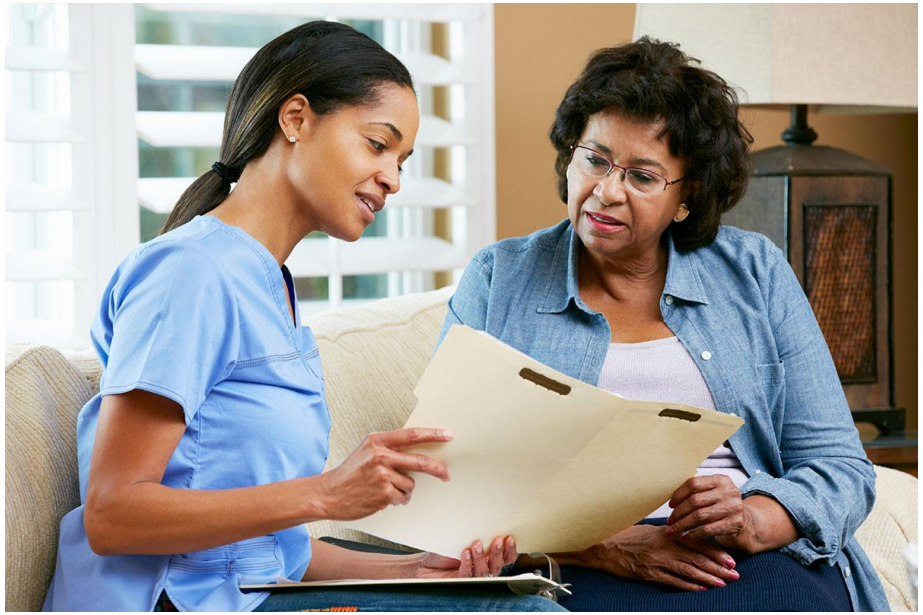
Commercial	Debbie Collins	Manager	616-464-8132	Deb.C@priorityhealth.com
	Maria Knoppers	Supervisor	616-464-8415	Maria.K@priorityhealth.com
Medicaid	Bethany Swartz	Manager	616-575-7338	Bethany.Swartz@priorityhealth.com
	Nichol Scholten	Supervisor	616-355-3261	Nichol.S@priorityhealth.com
	April Sydow	Supervisor	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			

Engaging the patient

Introducing care management to patient/caregiver: Elevator speech

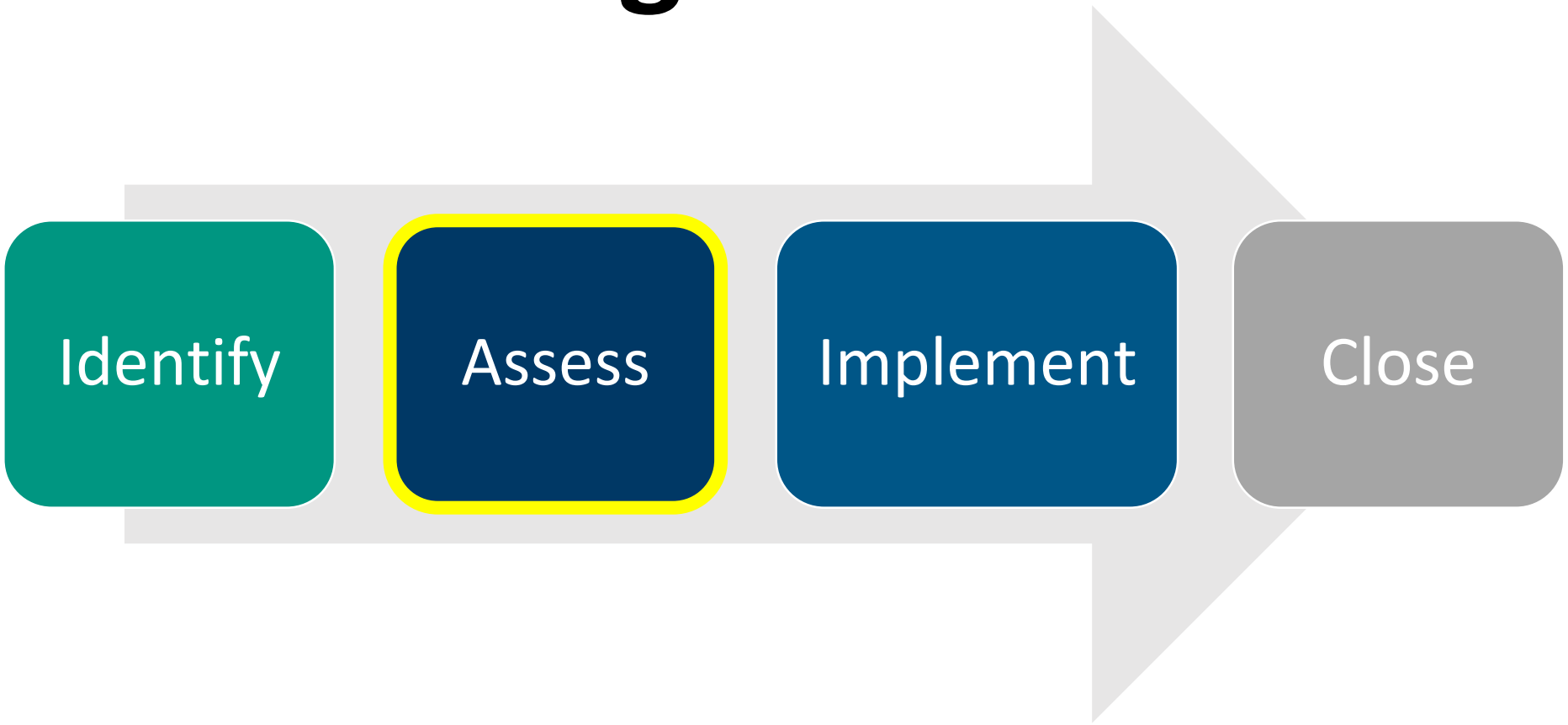
Asking patient/caregiver: What are your concerns and what would you like to work on?



Key Takeaways

- Using evidence based guidelines can help meet established outcome measures
- Coordinating transitions of care can help to mitigate risk and improve patient care
- Effective interactions start with meeting the patient where he or she is

Care Management Process



Assessment and Care Planning

Assessment provides patient context and supports development of the Patient Self-Management Plan and use of Action plans for symptom management.

- Performed by licensed care team professionals, in compliance with payer and licensure scopes of practice
- Supported by non-licensed professionals through provision of screenings, documentation, and other information gathering processes

Getting started:
Scrub the Record / Pre-Screening

Key Area of Focus	Screening tools/Methods
Patient or Caregiver's Ability / Desire	• Discussion about ideal state / goals • Confidence in achieving goals • Evaluate patient's understanding of his/her health
Medical	• Chronic conditions • Functional status • Utilization • Who else is on the care team? Is there a PCP care manager? • Patient's risk score
Behavioral	• PHQ-9 • GAD-7 • Cognitive status
Social	• Social Needs Assessment • Nutritional Status • What is the support level? Does the patient have a caregiver?

Comprehensive Assessment

Identify the barriers that support development of a Patient Care Plan:

- Medical
- Social
- Behavioral

A comprehensive assessment must review all three domains in order to be successful.

An Effective Comprehensive Assessment

Familiarize yourself with your organization's tool/assessment

Behavioral

Medical

Social

- Assessing each and incorporating barriers from these 3 areas results in a comprehensive assessment.
- With this, incorporate the patient desire and ability.
- Combined, results in an effective care plan.
- One without the others is incomplete.

Conducting the Assessment with a Focus on Patient-Centeredness

- Use of open-ended questions
- Demonstrating interest in the patient
- Active listening

<u>Key Areas of Focus</u>

- Linguistic and Cultural Needs
- Health Status
- Psychosocial Status/Needs
- Patient Knowledge/Awareness/Ability

Group Activity: Create an open-ended question for one of the Key Areas of Focus

Medical Concerns and Interventions Identified

- 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: specialists, community

Psychosocial: Cultural and Linguistic Needs

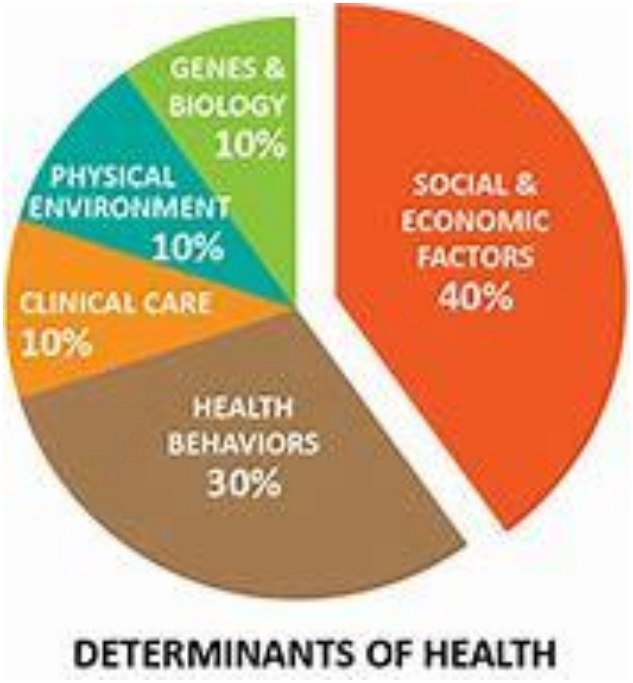
Agency for Health Research and Quality

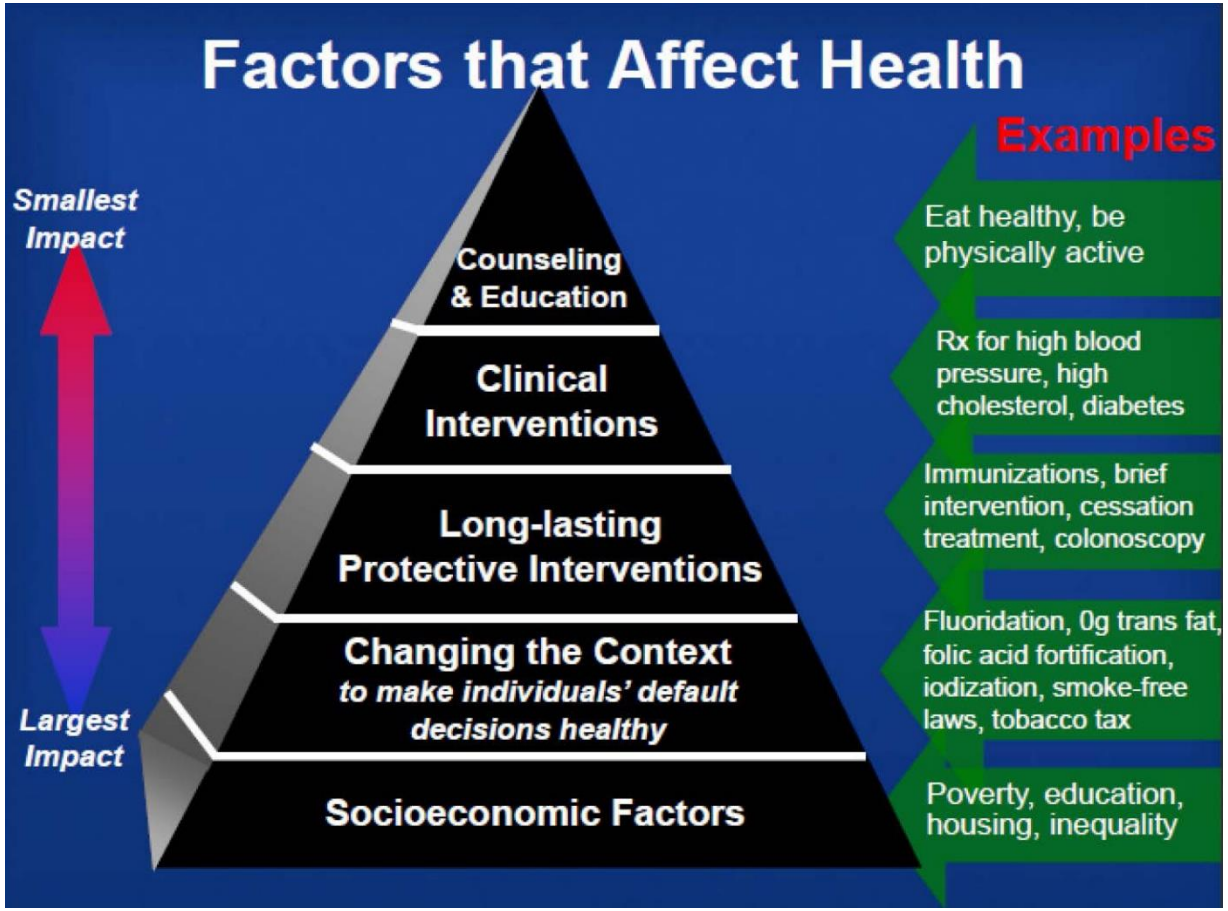
- **Linguistic Competence:** Providing readily available, culturally appropriate oral and written language services to limited English proficiency
- Examples:
  - Bilingual/bicultural staff
  - Trained medical interpreters
  - Qualified translators
- **Cultural Competence:** A set of congruent behaviors, attitudes, and policies that come together in a system or agency or among professionals that enables effective interactions in a cross-cultural framework.

- **Cultural and Linguistic Competence:** The ability of health care providers and health care organizations to understand and respond effectively to the cultural and linguistic needs brought by the patient to the health care encounter.

Note where the responsibility and accountability are in this statement

According to the Center for Disease Control





Social Needs

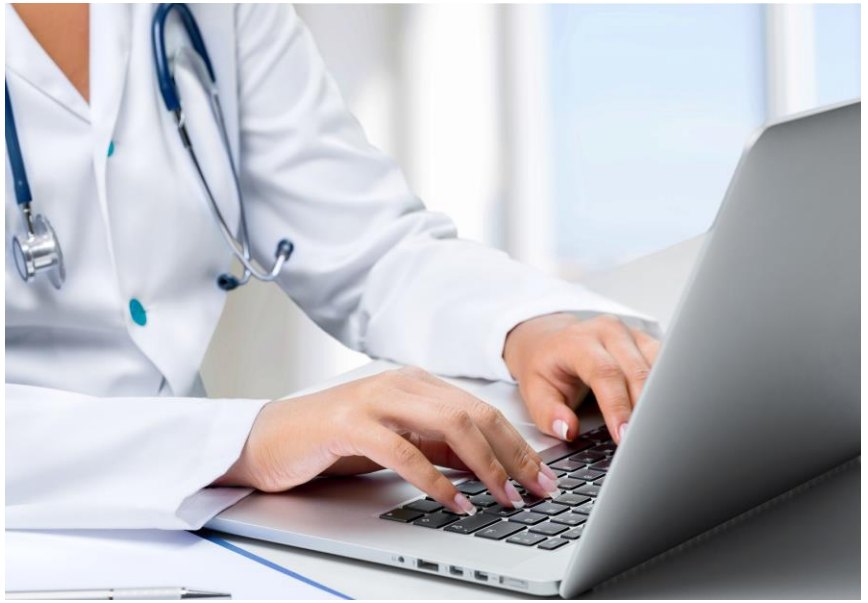
Behavioral Needs

Screenings conducted to identify patients with risk

- Depression Screening (PHQ-9)
- Anxiety Screening (GAD-7)

Workflows

- Documentation
- Confirm diagnosis
- Treatment plan



Patient Self Management Plan

- Developed by the patient with support from the care team to set mutual goals and actions for the patient care plan
- Generally supports the medical plan set by the physician
- It is derived from the medical assessment and plan:
  - Identified barriers (medical, behavioral, social)
  - Patient abilities and desired goals

Components can 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: specialists, community

Introduction of an Action Plan

Provided by the clinician and used by patients to recognize and monitor their symptoms. Providers share these tools to:

- Assist patients in recognizing early symptoms with the goal of avoiding risk
- To be better informed and prepared to manage the condition
- To prevent unnecessary emergent situations and risk and hospitalizations
- Symptom to be aware of and actions to take at each level

Symptoms to be aware of and actions to take at each level

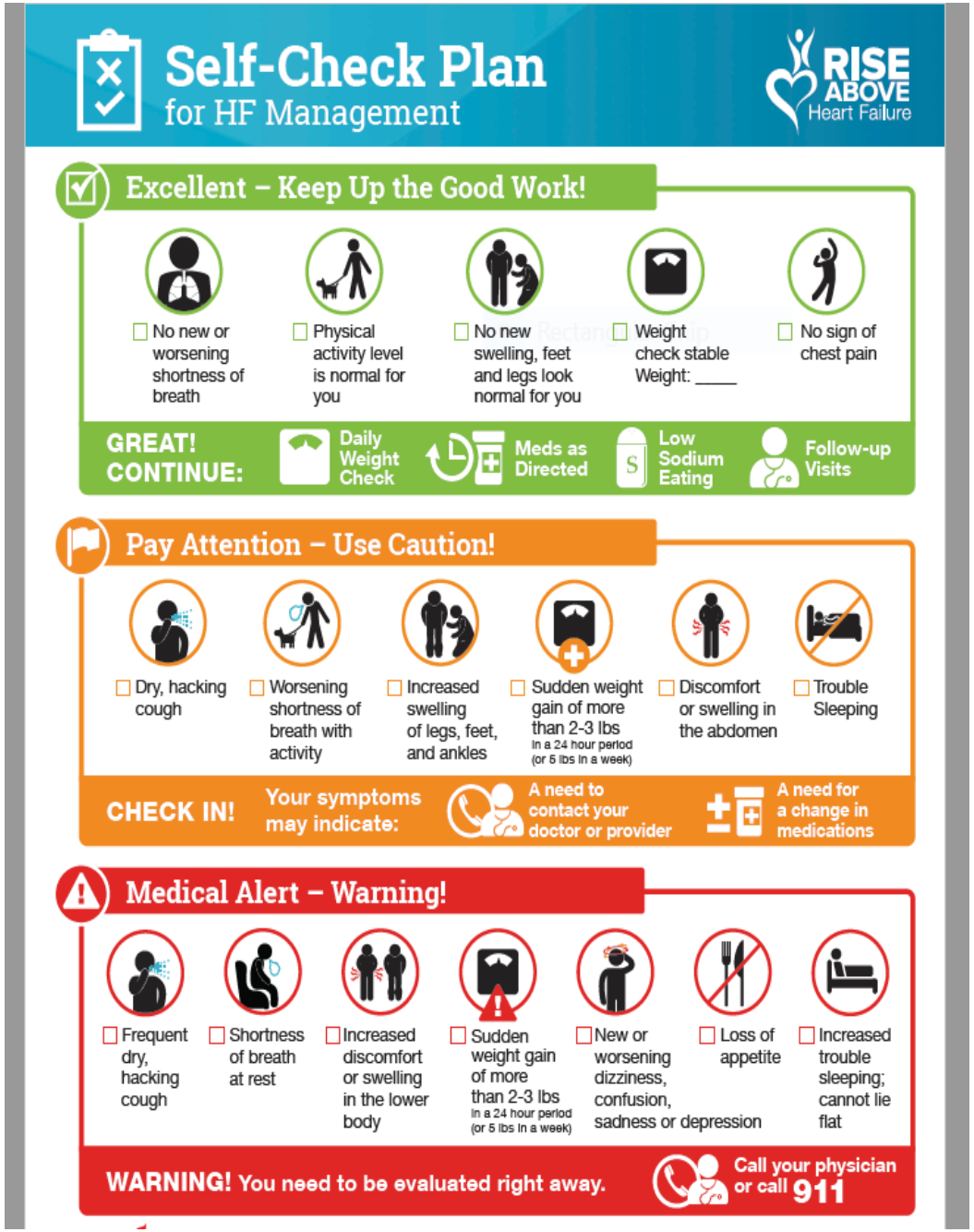
- **Green**: Maintaining Goal(s)
- **Yellow**: Warning when to call provider/office
- **Red**: Emergency symptoms

Action Plan:

Emergency Room Utilization

Action Plan:

Symptom Management



Follow-Up and Next Visit

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

Schedule follow-up call

Episodic vs Longitudinal

Episodic

- Otherwise stable patients going through Transitions of Care (TOC)
- New or unstable chronic condition
- Short-term, goal oriented

Longitudinal

- Combination of multiple comorbidities
- Complex treatment regimens
- Behavioral and social risks
- Ongoing relationship

Case Study: Mary

Mary is an 65 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

Activity: Case Study

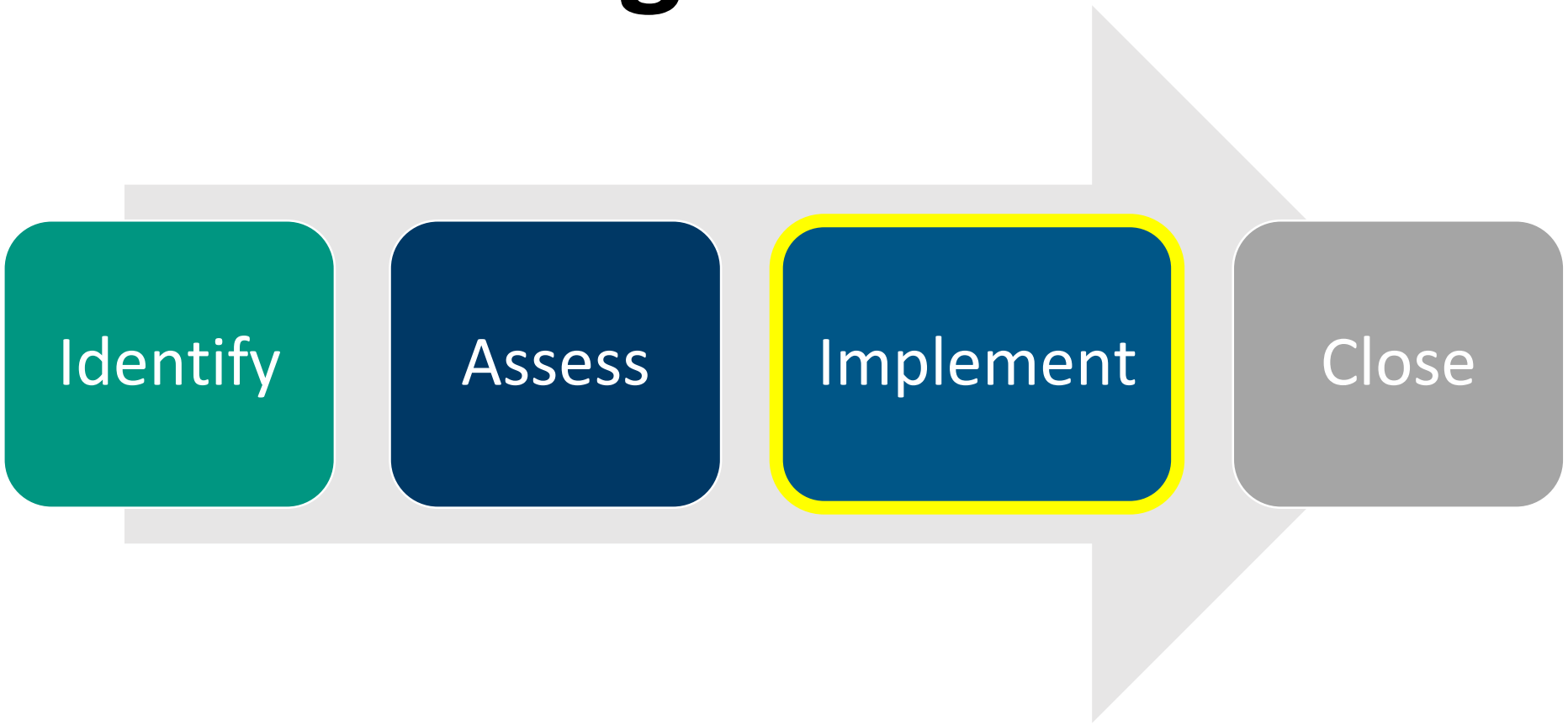
- Dr. Sheila Gordon's practice is small. Dr. Gordon's team includes a Physician Assistant, a part-time Social Worker, 2 Medical Assistants, and a front desk clerk.
- Maria Jones is a 54 year old woman who is overweight and has diabetes. She has struggled with her weight for years, and her diabetes is starting to spiral out of control.
- Ms. Jones has set a self-management goal to increase activity by walking around her block every Monday, Wednesday, and Friday.

What role can each of the care team members play in supporting Maria Jones with her self-management goal?

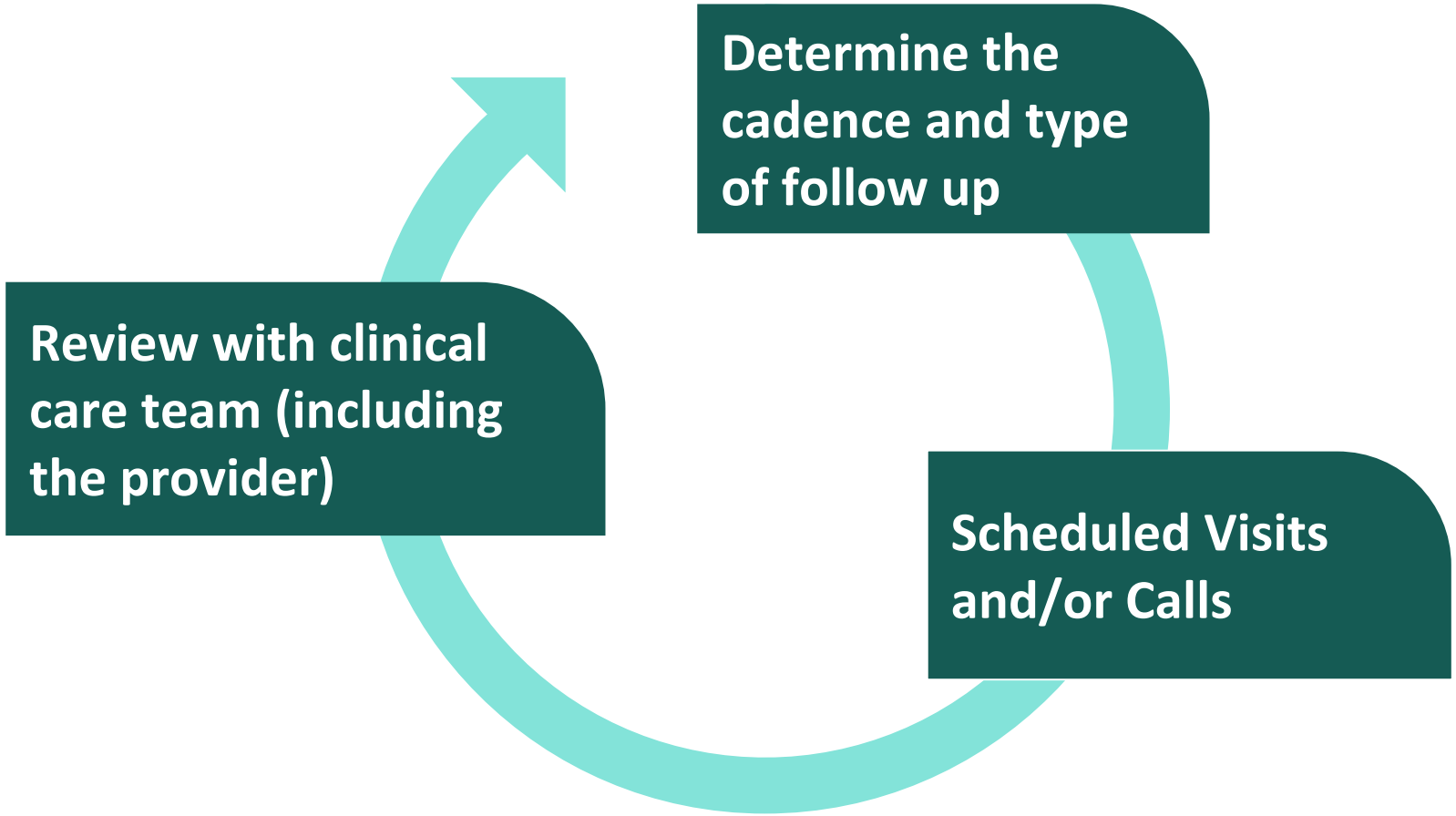
Key Takeaways

- Assessment is critical to the development of the patient's self-management plan
- Action plans are designed to help patients identify what to do when faced with a change in their health, i.e. an exacerbation of their COPD
- Care management may be episodic or longitudinal, depending on the patient's status

Care Management Process



Implementation: Follow Up and Monitoring



http://www.cmbodyofknowledge.com/content/case-management-knowledge-2

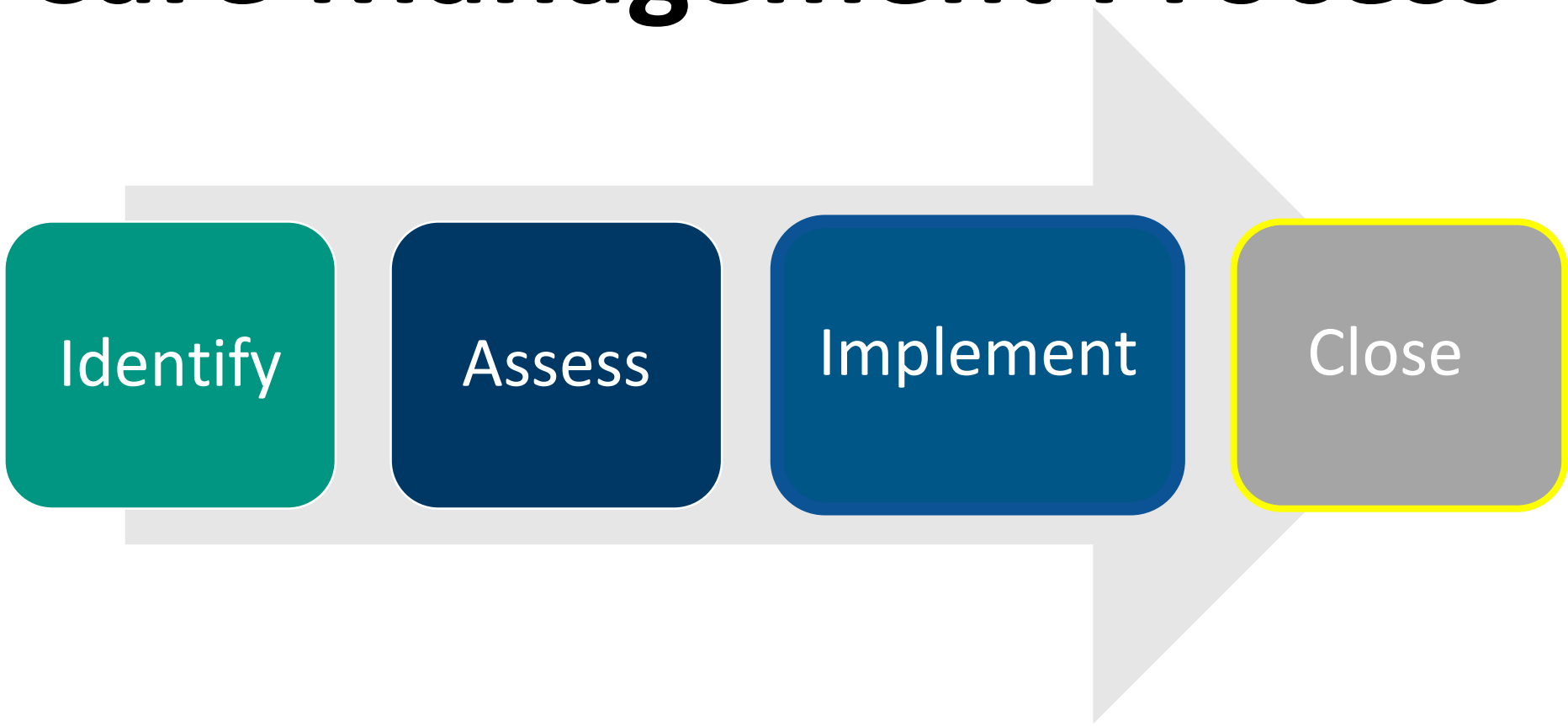
Reassessing when patients don’t meet goals…

- Treat to target
- Not the right goals; refocus
- Not engaging
- Not progressing; identify barriers
- Transition to another level of care
- Different service or specialty

Key Takeaways

- Follow up and monitoring are key to help prevent the patient from relapsing
- Following up and monitoring are pieces of a continuous flow to ensure that patients are staying on track with their self management

Care Management Process



Case Closed and Evaluation

Reasons for case closure and discharged from care management services:

- Patient has met his/her goals
- Patient moves out of region/state
- Patient is admitted to hospice care
- Patient declines further services
- Patient expires

What are other reasons?

Communicating Case Closure

- Notify the patient verbally (whenever possible)
  - Follow up with a letter that identifies how to get back in touch, as needed
- Notify the provider - ideally with a discussion that outlines reasons for closure
- Document within the record
- Evaluate the impact of care management:
  - Did the patient get to target?
  - Lessons learned, process improvement opportunities
  - Internal self-assessment for patient engagement skills

Always keep the door open! The patient may need your services again

Patient “Exit Plan”

Transition

- Transition to care within the Patient-Centered Medical Home

Continuous Monitoring

- Monitoring to assure that the patient is receiving evidence-based care and determining if the patient would benefit from care management in the future

Key Takeaways

- There are many reasons a patient may discontinue care management services
- You must have an exit plan for the patient
- Keep the door open

Agenda

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Wrap Up	30 minutes	

Outcomes Measures

- In healthcare, our primary objective is to help patients.
- Improving patient outcomes is why we practice in a team-based care model.
- Outcomes measures tell us if we have truly made a difference in patient care.

Common Outcomes Goals

Quality

Controlled HbA1c
Controlled Blood Pressure

Utilization

Decreased emergency department visits
Decreased hospital admissions

Outcomes Goals:
Be Part of the Strategy

Care Team:

- **Learn** their PO's strategy and core measures focus
- **Develop** a plan for how they will also impact the selected goals
- **Monitor** impact of strategies they implement and continuously improve

BCBSM 2020 Targets

Metric	Performance Threshold	Performance Source	Improvement
ED Encounters (per 1000 members per year)	175 encounters (per 1000 members per year)	Milliman Loosely Managed Benchmark (2018)	10%
IP Encounters (per 1000 members per year)	45 encounters (per 1000 members per year)	Milliman Loosely Managed Benchmark (2018)	8%
HbA1c Control < 8%	70%	NCQA 75th percentile (2018)	10%
High Blood Pressure	70%	NCQA 50th percentile (2018)	10%

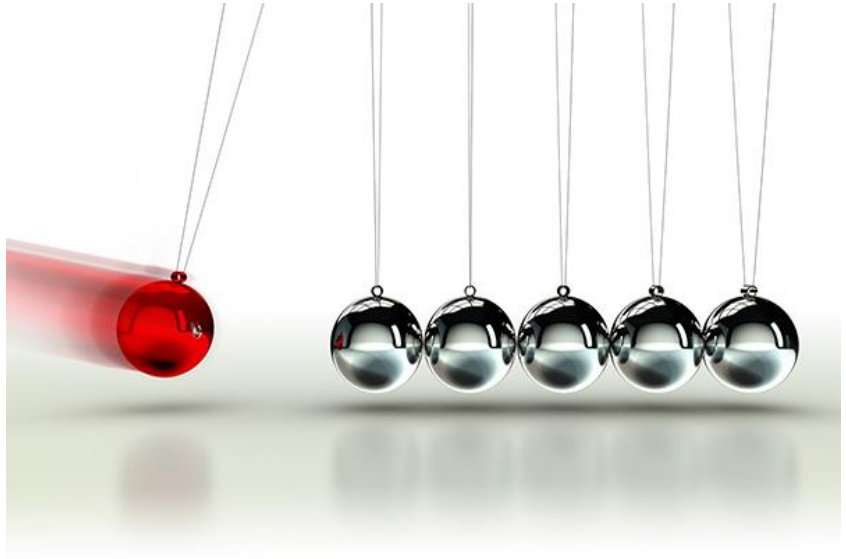
- VBR = Value-Based Reimbursement; it's essentially an increase in payment on every office visit and PDCM code paid in a primary care office.
- These are subject to change every year – **so keep in touch with your PO for updates!**

Quality Metrics: A1c <8%

- Patients aged 18-75
- Have a diagnosis of diabetes
- The last A1c measure of the year must be less than or equal to 8
- Your goal should be to help your practice have at least 70% of your diabetic population with an A1c<8

Impact of Unmet Outcomes

Activity:
What is the impact of outcome measures being “out of control”?



What Are Evidence Based Care Guidelines?

Evidence-based care guidelines are a set of interventions that have been proven to improve patient outcomes.

Outcomes measures are derived from evidence-based guidelines as a way of measuring whether or not a program is actually improving population health.

Evidence-based Guidelines: Michigan Quality Improvement Consortium (MQIC)

- The Michigan Quality Improvement Consortium (MQIC) is a diverse group of physicians, payers, researchers, quality improvement experts, and specialty societies.
- MQIC was formed to establish and implement consistent, evidence-based clinical practice guidelines and performance measures with a focus on improvement and positive health outcomes.

http://www.mqic.org/guidelines.htm

MQIC Guideline: Example

Michigan Quality Improvement Consortium

Michigan Quality Improvement Consortium Guideline

June 2015

Management of Diabetes Mellitus

The following guideline applies to patients with type 1 and type 2 diabetes mellitus. It recommends specific interventions for periodic medical assessment, laboratory tests and education to guide effective patient self-management.

Eligible Population	Key Components	Recommendation and Level of Evidence	Frequency
Patients 18-75 years of age with type 1 or type 2 diabetes mellitus	Periodic assessment	Assessment should include: Height, weight, BMI, blood pressure **[A]** Assess cardiovascular risks (tobacco use, hypertension, dyslipidemia, sedentary lifestyle, obesity, stress, family history, age > 40) Comprehensive foot exam (visual, monofilament, and pulses) **[B]** Screen for depression **[D]** Dilated eye exam by ophthalmologist or optometrist **[B]**, or if no prior retinopathy, may screen with fundal photography **[B]**	• Perform periodic assessment at least annually • Record BP at every visit • In the absence of retinopathy repeat retinal eye exam in 2 years
	Laboratory tests	Tests should include: A1C **[D]** Urine microalbumin measurement **[B]** (unless already on ACE or ARB) Serum creatinine and calculated GFR **[D]** Lipid profile **[B]**, preferably fasting Consider TSH and LFTs **[D]**	• A1C every 3-6 months based on individual therapeutic goal; other tests annually
	Education, counseling and risk factor modification	Comprehensive diabetes self-management education and support (DSME and DSMS) from a collaborative team or diabetic educator if available Education should be individualized, based on the National Standards for DSME[1] **[B]** and include: - Importance of regular physical activity including interrupting sedentary periods at least every 90 minutes with physical activity, and a healthy diet **[A]**, and working towards an appropriate BMI - Assessment of patient knowledge, attitudes, self-management skills and health status; strategies for making health behavior changes and addressing psychosocial concerns **[C]** - Description of diabetes disease process and treatment; safe and effective use of medications; prevention, detection and treatment of acute and chronic complications, including prevention and recognition of hypoglycemia - Role of self-monitoring of blood glucose in glycemic control **[A]** - Cardiovascular risk reduction - Tobacco cessation intervention[2] **[B]** and secondhand smoke avoidance **[C]** - Self-care of feet including nail and skin care and appropriate footwear **[B]**; preconception counseling **[D]**; encourage patients to receive dental care **[D]**	At diagnosis and as needed
	Medical recommendations	**Care should focus on tobacco cessation, hypertension, lipids and glycemic control:** - Medications for tobacco dependence unless contraindicated - Treatment of hypertension using up to 3-4 anti-hypertensive medications to achieve adult target of 140/90 mmHg **[A]** (see *MQIC hypertension guideline)*. Mortality increases if diastolic is < 70. - Prescription of ACE inhibitor or angiotensin receptor blocker in patients with chronic kidney disease or albuminuria **[A]**[3] - Moderate intensity statin[4,5] therapy for primary prevention against macrovascular complications (e.g. simvastatin 20-40 mg, atorvastatin 10-20 mg) - For patients with overt CVD, high intensity statin (e.g. atorvastatin 40-80 mg) - Anti-platelet therapy **[A]**: low dose aspirin for adults with cardiovascular disease unless contraindicated. - Individualize the A1C goal[6]. Goal for most patients is 7-8%. Mortality increases when A1C is > 9% **[B]**. - Assurance of appropriate immunization status [Tdap or Td, influenza, pneumococcal vaccine (PCV13 and PPSV23), Hep B] **[C]**	At each visit until therapeutic goals are achieved

[1] National Standards for Diabetes Self-Management Education and Support

[2] There is no evidence that e-cigarettes are a healthier alternative to smoking or that e-cigarettes can facilitate smoking cessation

[3] Consider referral of patients with serum creatinine value > 2.0 mg/dl (adult value) or persistent albuminuria to nephrologist for evaluation

[4] Diabetes Care, January 2015: Cardiovascular Disease and Risk Management

[5] 2013 ACC/AHA Blood Cholesterol Guideline Table 5. High-, Moderate-, and Low-Intensity Statin Therapy

[6] Diabetes Care, Volume 38, Supplement 1, January 2015, S37, Table 6.2

Levels of evidence for the most significant recommendations: A = randomized controlled trials; B = controlled trials, no randomization; C = observational studies; D = opinion of expert panel

This guideline lists core management steps. It is based on the American Diabetes Association Standards of Medical Care in Diabetes - 2015; Volume 38, Supplement 1, Pages S1-S93 (http://care.diabetesjournals.org). Individual patient considerations and advances in medical science may supersede or modify these recommendations.

Approved by MQIC Medical Directors June 2008, 2010, 2012, 2013, 2014, 2015 **MQIC.ORG**

Quality Metrics: Blood Pressure < 140/90

- "In control" means blood pressure less than 140/90 in both systolic and diastolic readings
- Outcomes measure is based on the last blood pressure taken in a calendar year
- BCBSM's goal is to have at least 70% of the hypertensive patient population in your practice with BP below 140/90

Blood Pressure Categories

American Heart Association | American Stroke Association

BLOOD PRESSURE CATEGORY	SYSTOLIC mm Hg (upper number)		DIASTOLIC mm Hg (lower number)
NORMAL	LESS THAN 120	and	LESS THAN 80
ELEVATED	120 – 129	and	LESS THAN 80
HIGH BLOOD PRESSURE (HYPERTENSION) STAGE 1	130 – 139	or	80 – 89
HIGH BLOOD PRESSURE (HYPERTENSION) STAGE 2	140 OR HIGHER	or	90 OR HIGHER
HYPERTENSIVE CRISIS (consult your doctor immediately)	HIGHER THAN 180	and/or	HIGHER THAN 120

https://www.health.harvard.edu/heart-health/reading-the-new-blood-pressure-guidelines

Hypertension is often called the "silent killer"

Impacting Outcomes

While A1c, BP, ED and IP utilization are **outcomes measures**, lots of different factors play into whether or not your patient population meets targets:

- Medication Adherence
- Multiple diagnoses
- Clinical guidelines
- Symptom Management
- Treating to target
- Quality Metrics
- Health Literacy
- Social Needs

Review internal processes for opportunities to improve

Impacting Outcomes: Productive Interactions

- Effective interactions with patients is how you impact patient outcomes.
- Reaching targets for productive interactions can be the difference between meeting outcomes goals and failing short.

- It is suggested at **least four (4) productive interactions with patients** in a half day in order to see an outcomes impact.

Productive interactions are those that support the patient to take actions between visits that accomplish their self-management goals, with the overall end goal of accomplishing the Care Plan that was designed by the provider.

Tracking Quality to Evaluate Success

- **Metrics resources:**
  - **EHR** can provide a report on practice level performance
  - **Registry** can provide a report on metrics
    - List by payer or practice.
    - List of patients who are not in control or who are missing evidence-based care
- **Payer reports and websites** will additionally show your performance and the list of patients with a ‘gap’ in their care

Activity: How is your practice doing?

Tracking Utilization

- Admission/Discharge/Transfer notifications can be tracked over time.
- Payer Reports can be used both as a way to identify patients and to follow performance over time.

BCBSM: Consolidated Dashboard, a PO level report, twice a year

BCN: HealtheBlue (HeB), provides a utilization report

Priority Health: File Mart on the Priority Health website

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.

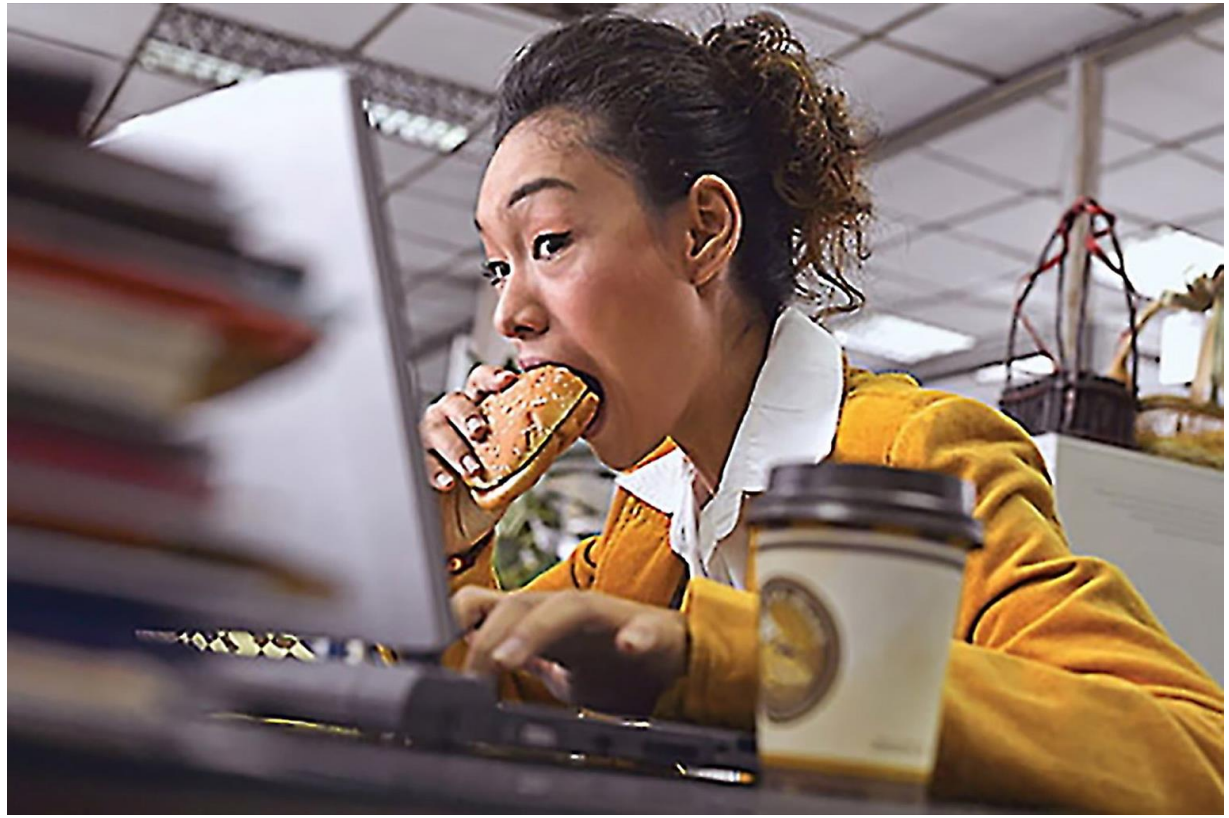
Step 2: Individually
Now, please take 30 seconds to think about how this role could have changed that experience.

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

Key Takeaways

- Care teams can impact outcomes by using evidence-based care and the care management process
- Common outcome goals include A1c, BP, ED utilization, and inpatient utilization
- Impacting outcomes requires productive interactions

Lunch



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Why is billing important?

- Billing for services and being paid for services places value on the patient care that you provide.
- Billing, along with care management incentive programs, is how team-based care can be sustainable.
- Sustainability comes from:
  - Seeing enough patients in a day
    - Minimum of 4 on average per half day
    - Could include telephone, initial comprehensive assessments, or other virtual/face to face follow ups
  - Billing consistently for all billable services.

Incentive Programs

BCBSM

Value Based Reimbursement (increase on every E&M code and PDCM code)

PDCM Touches – Tiered Model (measured at practice level) for attributed population:

- 4% with 2 touches = 5% VBR
- 5% with 2 touches = 7% VBR
- 6% with 2 touches = 9% VBR

Outcomes VBR (measured at subPO level):

- HbA1c control VBR = 1%
- Blood pressure control VBR = 1%
- Pediatric quality composite VBR = 2%, comprised of:
  - Medication Management for people with asthma
  - Follow-up after ED visit for mental illness w/in 7
  - Follow-up care for children prescribed ADHD medication (continuation and maintenance phase)
- ED encounters/1000 VBR = 1%
- Inpatient encounters/1000 VBR = 1%

To be eligible to earn outcomes VBR, practices must meet 1% outreach with 2 touches

Priority Health

- Annual PMPM incentive payment if outreach achieved for 2- 5% of the patient population. 5% available for CPC+ Track 2 practices only.
- 2 billed codes on different dates of service.
- Fee For Service on all codes billed.
- No patient co-pay.

CPC+ isn't specific in its funding.

Minimum of (8-10) Interactions with Patients per Day Needed for Sustainability and to Impact Outcomes

Week-Long Review	
Pre-Work Start of Week	Review schedule and identify patients based on payer, risk, diagnoses. Review patients with provider.
Target (15) minutes with Provider after enrollment.	Review complex patients and face to face patients from that week (12 patients; 12 G9007 codes).
Target interacting with (1-4) new patients per week.	(1-4) G9001 or G9002 codes
Target interacting with (3-4) existing patients in face to face visits per week.	(3-4) G9002 codes
Target follow up phone calls at least (4-6) phone calls per day with the patient.	(20-30) patient phone calls a week (98966-98968)
Target follow up phone calls for coordination of care – accumulated time billed monthly	

That sums to **36 - 50 codes** per week!

- Look at a month, as a day/week is too variable.
- Review the example it shows how you might get up to 10 billable type activities per day or 50 per week.

Telehealth and Virtual Visits

- Due to COVID, there has been a shift in the modality of care management visits to telehealth
  - Early indications of improved ability to connect with patients
- While this isn't universally true, there is significant opportunity with telehealth and virtual visits:
  - One Michigan organization saw a decrease in no show rates from 34% to 11% on average.
  - Another Michigan organization saw an increase of up to 39% increased use of virtual face to face codes.

Activity/Billing Progress Reports

- Each payer program sets benchmarks for number of patients receiving care management services at the practice level.
- Each payer also sends a progress report to the PO:
  - BCBSM sends through the EDDI mailbox on approximately a quarterly basis.
  - Priority Health sends through Filemart to PO Representatives on a monthly basis.
- Work with your PO to devise a best strategy for tracking progress towards program goals.

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”
  - 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
  - PA-Cs
  - Licensed Master Social Workers (LMSWs)
  - Psychologists
  - Certified Diabetes Educators (CDEs)
  - Certified Asthma Educators (CAEs)
  - Registered Dieticians
  - Clinical Pharmacists

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

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.

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

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.

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 Activity

The following series of examples are intended to practice a couple of common situations for coding. They are NOT comprehensive.
For more information on specification situation:

- **BCBSM:** Monthly Billing Q&A session (1st Thursday of every month at noon) and Commercial and MA Billing Guidelines
- **Priority:** Kim Harrison Priority Health

High Risk Patient

Identify the codes:
G9007, G9001

- Patient is flagged as high risk by a payer list.
- Care manager discusses overall care plan goals with provider, and it is determined the patient is appropriate for care management.
- Care manager reviews the chart, recent screenings (SDOH, PHQ-9), problem list, medications, and utilization history.
- Care manager sees the patient in a face to face visit, patient agrees to care management. CM evaluates the patient's current ability to steward completing the comprehensive assessment.
- Patient develops a SMART goal, and the care manager connects the patient with various resources that address identified barriers.
- Care manager discusses care plan with the provider. Provider agrees with the care plan.
- Patient and care manager agree on a follow up plan.
- Care manager documents in the chart and adds the appropriate billing codes.

Face to Face Visit and Follow Up Plan

Identify the codes:
G9002, G9008

- A patient comes into the office to be evaluated by their PCP. After the evaluation the PCP introduces the patient to the care manager (CM).
- During the conversation with the patient the CM assesses that there is not a clear understanding about asthma management.
- CM conducts a medication review, teaches how to use peak flow and keep a log, provides an asthma action plan.
- CM and patient agree to follow up in one week via a phone visit.
- This initial visit with the patient was 60 minutes.
- PCP and patient discuss and agree with the action plan.
    - The PCP does teach back with the patient about use of asthma medications and reinforces the importance of keeping a log. The patient agrees to participate in care management. A follow up appointment with the PCP is scheduled in 4 weeks.

Note how this is different from the **G9001!**

*PH G9008 is billed one time per practice, during the time the patient is a member of the practice.

Coordination of Care

Identify the code:
99487

- Care manager contacts the home health agency to schedule in-home visits and conduct a safety assessment.
- In addition, a call was made to the DME provider to arrange for delivery of home O2.
- Time spent coordinating care was over 30 minutes.

Gaps in Care

Identify the code:
98968 BCBSM

- RN notices during chart review that several of the patients who are enrolled in care management have not received their cancer screenings, even though the RN and provider reminded them.
- RN shows the list to the Medical Assistant.
- Per the Standing Agreement that has been put in place with the physician, the Medical Assistant calls the patient enrolled in care management to discuss gaps in care and facilitate closing the gaps. Time more than 31 mins.

Multidisciplinary Team

Identify the codes:
G9007, G9001, G9002

- Patient with diagnosis of diabetes, COPD and HTN has a comprehensive assessment completed by the pharmacists and SW CM.
- Patient screens positive for SDOH – food insecurity, struggling to afford medications, lacks caregiver support during face-to-face visit with SW.
- An multidisciplinary team conference was held with the Clinical Pharmacist, SW CM and PCP to discuss the initial plan of care with the team, which includes:
  - The SW CM to schedule a virtual face to face visit with the patient regarding the lack of caregiver support and social isolation, which is linked with 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 SW CM and Clinical Pharmacist follow up with the team at their regular huddle.

Advance Directives End of Life

Identify the code**: S0257**
*Note: this code allows for phone visit and meeting may be with the patient, care giver, or family member.

- CM conducts a 20 minute in person meeting with a patient regarding their advance directives.
- During the discussion, information is given to the patient to review regarding advance directives.
- Discussion includes:
  - How the patient prefers to be treated.
  - What the patient wishes others to know.
- CM and patient agree to follow up via a phone call in 2 weeks.

Reducing ED visits

Identify the code:
98966 BCBSM

- Proactive patient education to consider the PCMH practice first for acute healthcare needs, suggesting nearby urgent care, or ED for true emergency.
- 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, ask if the ED physician recommended follow up care, coordinate the needed care, transfer to clinician for issues requiring immediate medical assessment or guidance, and encourage the patient to bring in all medications. Call takes 10 minutes.

Phone Service

Identify the code:
98967

- CM speaks with a patient via the telephone.
- CM reviews the patient's asthma action plan and reviews the symptoms that indicate worsening symptoms and asthma exacerbation.
- This is also reinforced when to call the office.
- In addition, CM asks the patient about interest in attending an asthma group visit. Patient indicates interest and CM provides the information regarding the asthma group visit.
- CM and patient agree on follow up in one week via in person visit at the office.
- This meeting takes 20 minutes.

Identify the code:
G9002

Patient Visit Face to Face

- The patient returns to the office one week later to meet with CM.
- During the visit, CM and patient discuss symptoms, medications, and SMART goals.
- Patient states he/she has not needed to use the rescue inhaler and feels they now have a better understanding of how to care for his/her self. You again review the action plan and state you will follow up in one month.

Group Education Visit

Identify the codes:
3 patients 98961
6 patients 98962

- Patient and caregiver indicate interest in Asthma Education class.
- Patient attends with caregiver with 3 other patients for 30 minutes.
- Patient attends a second class with 6 other patients for 30 minutes.

Identify the code:
G9008 BCBSM

Medical Community

- Physician calls a Pulmonologist to discuss a joint treatment plan for patient's asthma.

Summary

In this module we:

- Demonstrated how to use the billing codes to create a sustainability program and earn available incentive dollars
- Reviewed definitions of billing codes and scenarios of when the codes might used in daily care team activities

Break Time

10 minute break!

Agenda

Topic	Time	Content
Introduction	30 Minutes	
Care Team Model and Team Roles	30 minutes	• Define the team-based model of care • Explain how the team-based care model improves patient outcomes • Identify how to apply these concepts in clinics when acting in the role of care team member
Break	10 minutes	
Care Management Process	60 minutes	• Define key components of the care management process and the impact on team-based care
Outcomes	50 minutes	• Identify, describe how team-based care can impact outcomes measures
Lunch	45 minutes	
Selecting Appropriate Codes to Promote Sustainability	60 minutes	• Demonstrate the selection of appropriate billing codes for daily care team activities to promote sustainability
Break	10 minutes	
Putting it All together	60 minutes	• Examine opportunities to integrate concepts of team-based care into own clinical practice
Wrap Up	30 minutes	

What have we discussed?

We have covered:

- The Chronic Care Model framework and how to use it successfully in a team-based care practice model so that we can improve patient outcomes
- The care management process; how to identify, assess and collaboratively create a self-management plan; and how to implement that plan

Recap: what have we discussed?

We have covered:

- How to know whether or not our efforts are making a difference in the health of the whole population of patients
  - Tracking targeted outcome measures: A1c, BP, ED utilization, and IP utilization
- How to bill and keep the program sustainable over time

What will you start using in your role as care team member tomorrow?

What is your elevator speech?

Agenda

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Wrap Up	30 minutes	

Homework: Questions to take back to your practice

- Does your practice conduct virtual and telehealth visits?
- What screening tools does your practice use?
- What clinical guidelines is the practice following?
- What outcome measures are your practice's area of focus?
- What role do you play in ensuring the metrics are being met?
- Shadow your team members

Successful Completion of Introduction to team-based Care includes:

- Completion of the one day in-person/virtual training.
- Completion of the Michigan Institute for Care Management and Transformation (MICMT) post-test and evaluation.
- Achieve a passing score on the post-test of 80% of greater.
  *If needed, you may retake the post-test.

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

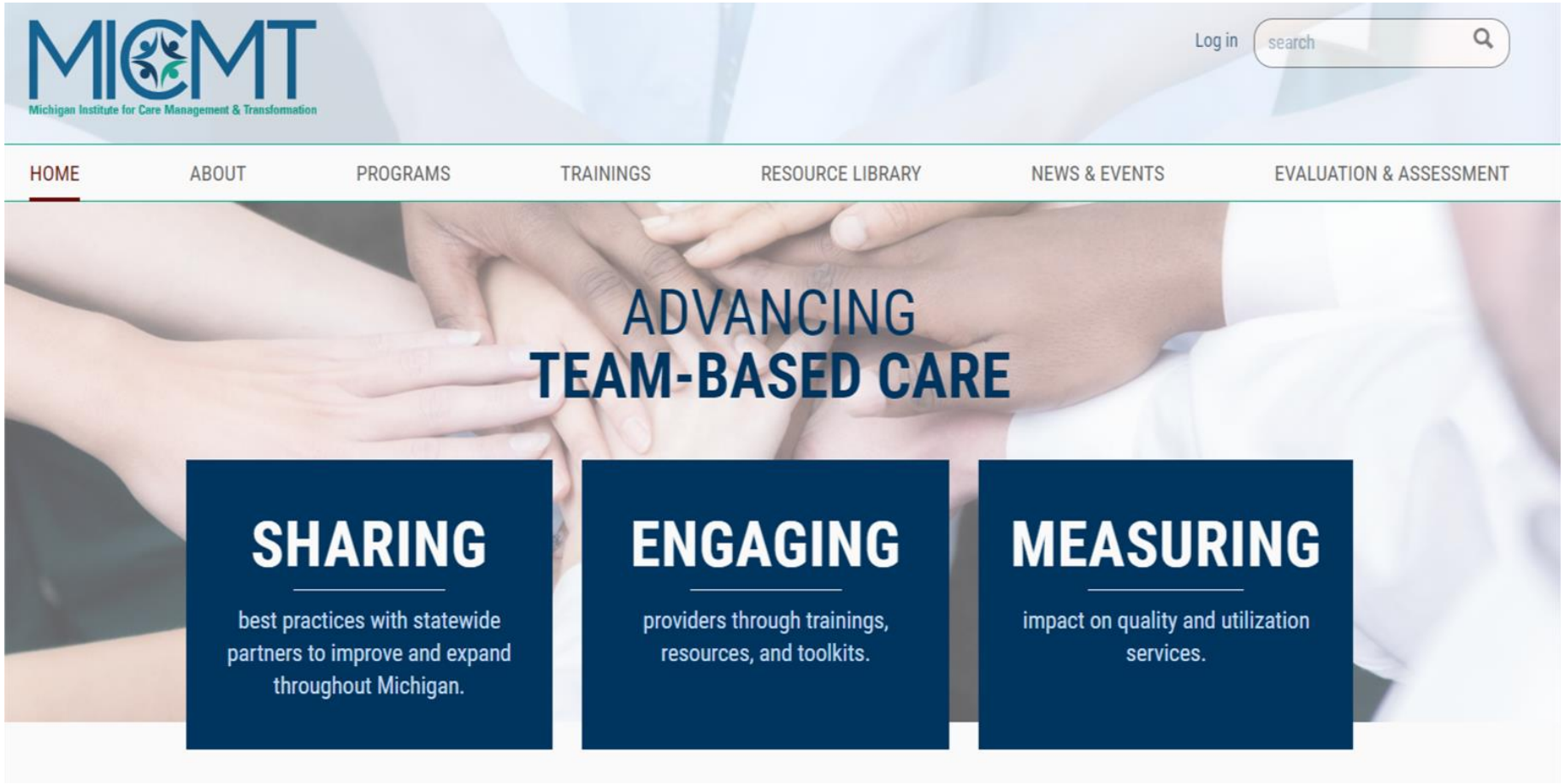
Contact Us

micmt-requests@med.umich.edu

Resources

MICMT Resources

https://micmt-cares.org/



Additional Resources on Huddles and Meetings

Creating Patient-centered team-based Primary Care
https://pcmh.ahrq.gov/sites/default/files/attachments/creating-patient-centered-team-based-primary-care-white-paper.pdf

UCSF Center for Excellence in Primary Care- Healthy Huddles
https://cepc.ucsf.edu/healthy-huddles

Huddles: Improve Office Efficiency in Mere Minutes
https://www.aafp.org/fpm/2007/0600/p27.html

IHI Optimize the Care Team Communication
http://www.ihi.org/IHI/Topics/OfficePractices/Access/Changes/IndividualChanges/UseRegularHuddlesandStaffMeetingstoPlanProductionandtoOptimizeTeamCommunication.htm

MICMT Website Online Resources

- Care Manager Introduction Phone Script
- Care Management Explanation Flyer
- Share the care: Assessment of Team Roles and Task Distribution
- Michigan Community Resources
- MDHHS Community Mental Health Services Programs
- Michigan 2-1-1 Informational Guide

Resources: Care Management Services

- Michigan Institute for Care Management and Transformation
- BCBSM
  - PDCM Billing online course
  - PDCM Billing Guidelines for Commercial
  - Medicare Advantage
- Priority Health
- Centers for Medicare & Medicaid
  - Chronic Care Management
  - Behavioral Health Integration