Thank you for joining!

We will get started promptly at 10:00 am

October 13, 2023

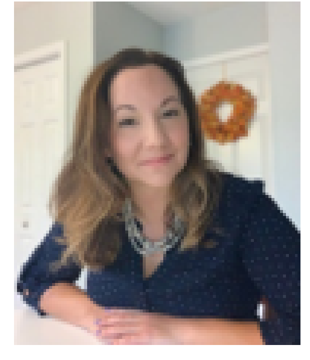
Welcome

Hae Mi Choe, PharmD
Executive Director

Agenda

9:30 – 10:00 AM	**Continental Breakfast/Networking**
10:00 – 10:10 AM	**Welcome & Introduction** *Hae Mi Choe, PharmD, MICMT Executive Director*
10:10 – 11:10 AM	**Building a Healthy Team Culture for Leaders** *April Allen, MA, CAADC, Limited Licensed Psychologist, Pine Rest*
11:10 – 11:35 AM	**MICMT Updates & 2024 Scorecard** *Alicia Majcher, MHSA, MICMT Director of Operations*
11:35 AM – 12:00 PM	**Collaborative Care Model Implementation: Current State** *Kathleen Kobernik, BCBSM* *Susan Blackburn, Trinity Health Alliance of Michigan (Affinia)* *Sara Biag, United Physicians* *Cari Radinski, Huron Valley Physician Association*
12:00 – 1:00 PM	**Lunch**
1:00 – 2:00 PM	**Transitions of Care Approaches** *Sandy Kaltz, McLaren Physician Partners* *Annette Price, Silver Pine Medical Group, United Physician, Inc* *Susan Nason, Bronson Network LLC* *Carissa Cowen, Munson Healthcare Clinically Integrated Network, Northern Michigan Care Partners*
2:00 – 2:30 PM	**Transitions of Care Discussion** • *Open discussion* • *Supporting medication reconciliation education*

Introduction



April Allen, MA, CAADC, Limited License Psychologist

April is a Limited Licensed Psychologist and Certified Advanced Alcohol and Drug Counselor. She has worked at the Pine Rest Caledonia Clinic since 2010. April has a master's degree in counseling from Western Michigan University, and specializes in treatment for anxiety disorders, depression, family therapy, PTSD, trauma, and abuse. April is currently a PhD candidate and is the Training Coordinator for the EAP/CAP/SAP Department.

Building a Healthy Team Culture for Leaders

April Allen, MA, CAADC
Pine Rest

MICMT Updates

Alicia Majcher, MHSA
MICMT, Administrative Director

2023 – Year in Review

Congrats to all on a successful year!

Highlights of the year

- 433 attendees at Team-Based Care Conference
- Re-vamped MICMT website launched
- Community Health Worker, Patient Engagement, & Transitions of Care webinar series
- Chronic kidney disease modules posted
- New PDCM billing video for required training

2023 Training Cycle Summary

- Intro to Team-Based Care
  - Totals:
    - **814 Attendees**
    - 39 Approved Trainers
    - 88 Sessions
- Patient Engagement
  - Totals:
    - **493 Attendees**
    - 32 Approved Trainers
    - 68 Sessions
- Foundational CM Codes & Billing
  - Totals:
    - **155 Attendees**
    - 16 Approved Trainers
    - 28 Sessions

Trainings that occurred between 10/11/22 & 10/10/23.

MICMT

PDCM Outcomes VBR

PO Performance for PDCM (1%, 2 encounters) participating practices. Based on:

- SubPO/PO scores which reflect the performance of all PDCM practices within that SubPO/PO.
- claims incurred in Calendar Year 2022 with a calculated improvement score based on year over year performance for claims incurred in Calendar Year 2021.

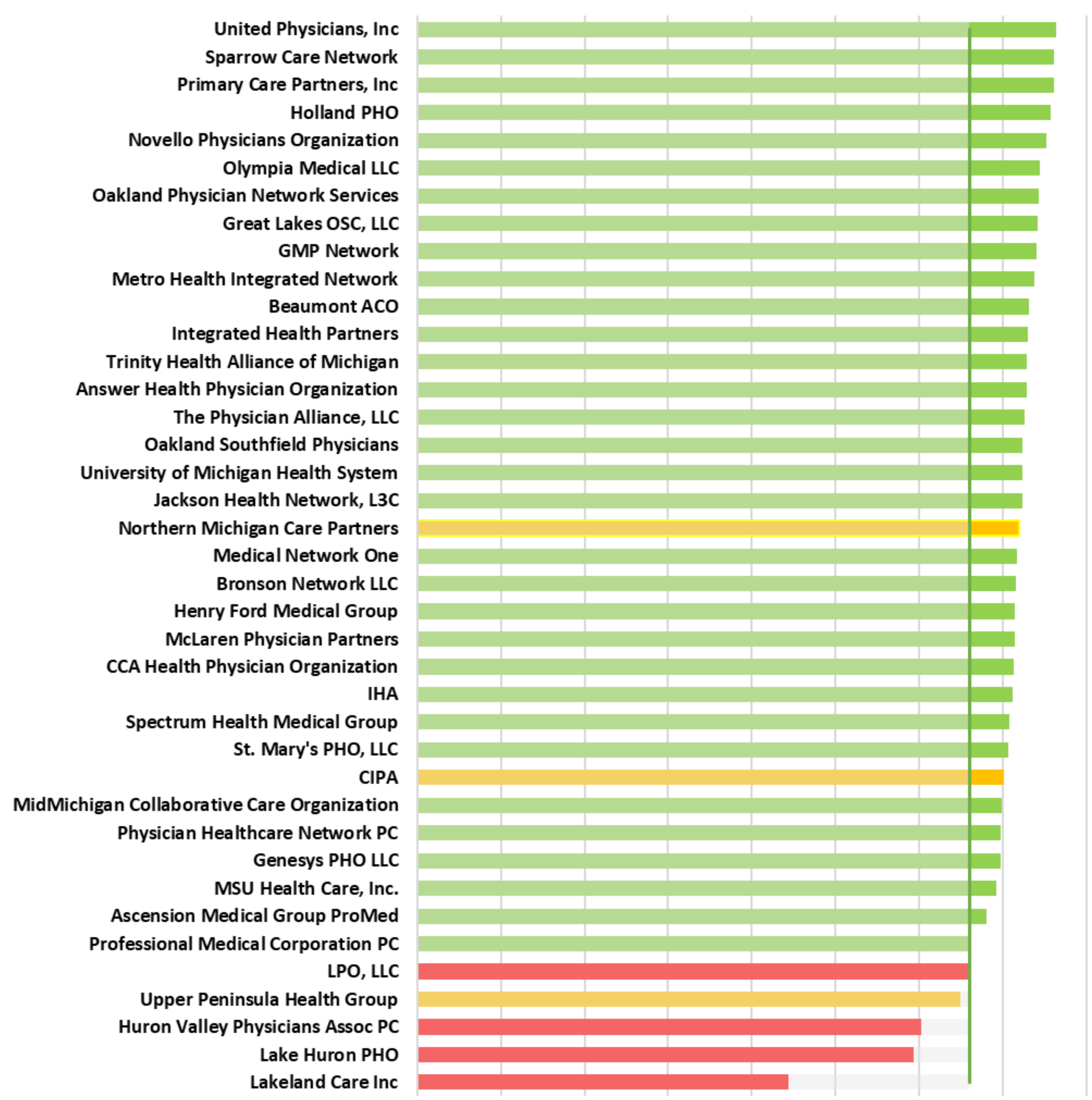
Adult OVBR Summary (N = 39 POs)

	One or more Sub PO earned VBR (Nbr. of POs)	PO earned VBR for improvement (Nbr. of POs)	PO earned VBR for performance (Nbr. of POs)	**Total POs Earning VBR** (Nbr. of POs)	**Change in Total Compared to last year** (Nbr. of POs)
Adult: Comprehensive Diabetes Control: HbA1c < 8%	3	0	32	**35**	**↑2**
Adult: High Blood Pressure	5	1	30	**36**	**↑1**
Adult: ED Encounters (per 1000 members per year)	9	7	3	**19**	**↑8**
Adult: IP Encounters (per 1000 members per year)	9	9	19	**37**	**↑22**

Peds OVBR Summmary
(N = 27 POs)

	One or more Sub PO earned VBR (Nbr. of POs)	PO earned VBR for improvement (Nbr. of POs)	PO earned VBR for performance (Nbr. of POs)	**Total POs Earning VBR** (Nbr. of POs)	**Change in Total Compared to last year** (Nbr. of POs)
Pediatrics: ED Encounters (per 1000 members per year)	1	1	3	**5**	↓ **8**
Pediatrics: IP Encounters (per 1000 members per year)	11	4	8	**23**	↑ **14**
Pediatrics: PEDCOMP1	0	0	5	**5**	↓ **4**
Pediatrics: Pediatric Weight Management	4	2	12	**18**	**n/a**

Adult: Comprehensive Diabetes Control: HbA1c < 8%
Program Year 2023 Performance = 66% / Improvement = 10%

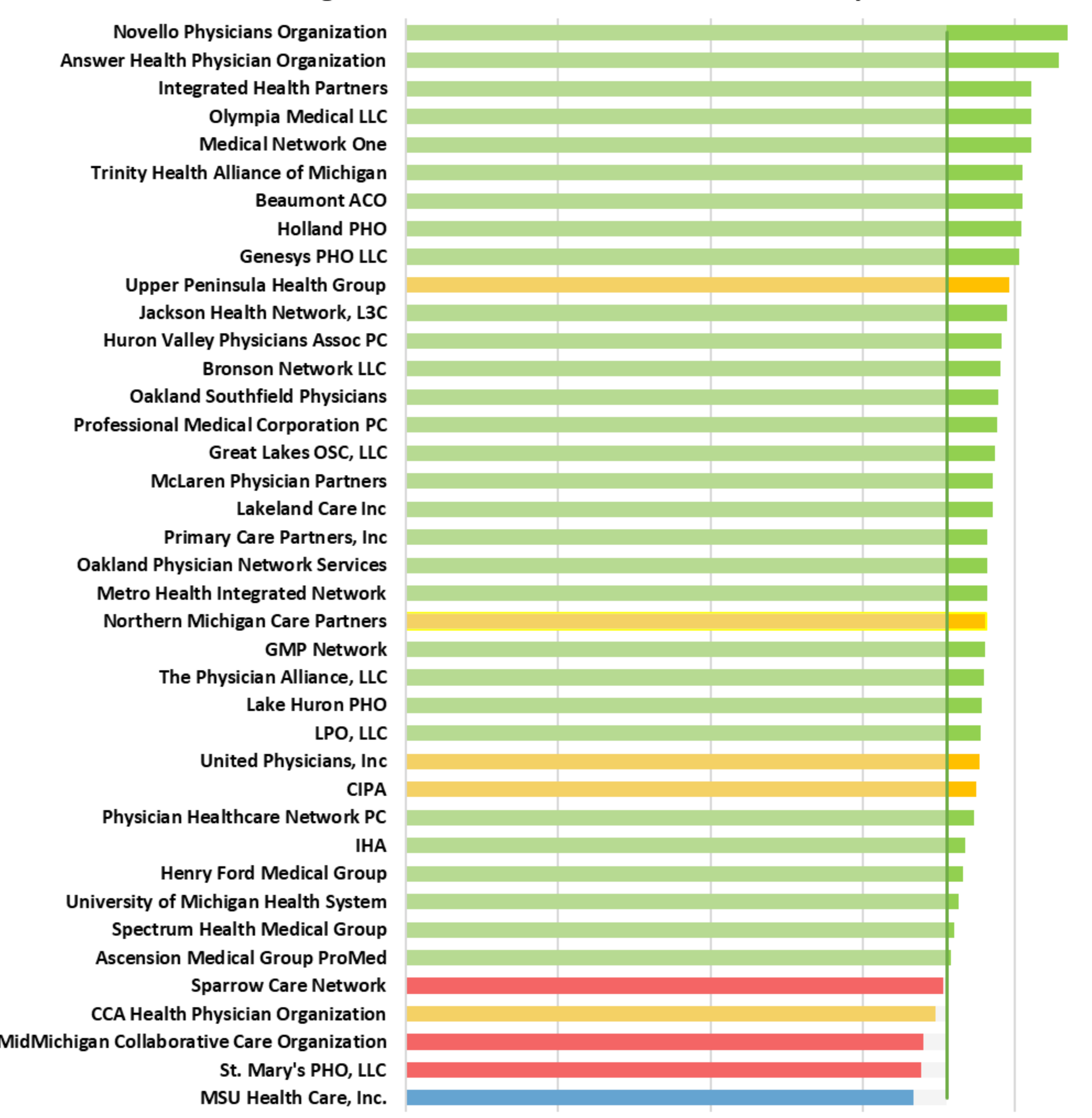


PO earned VBR for performance target

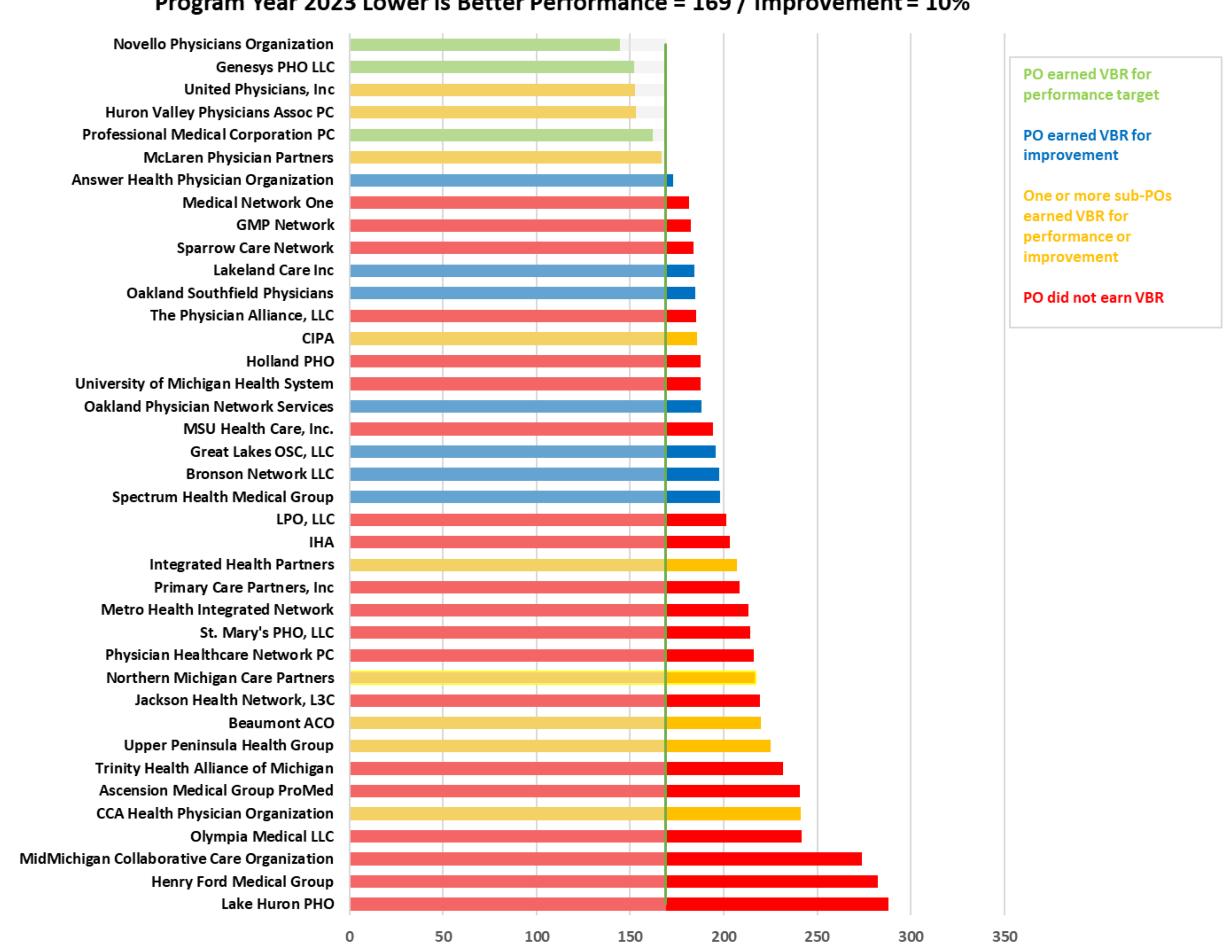
PO earned VBR for improvement

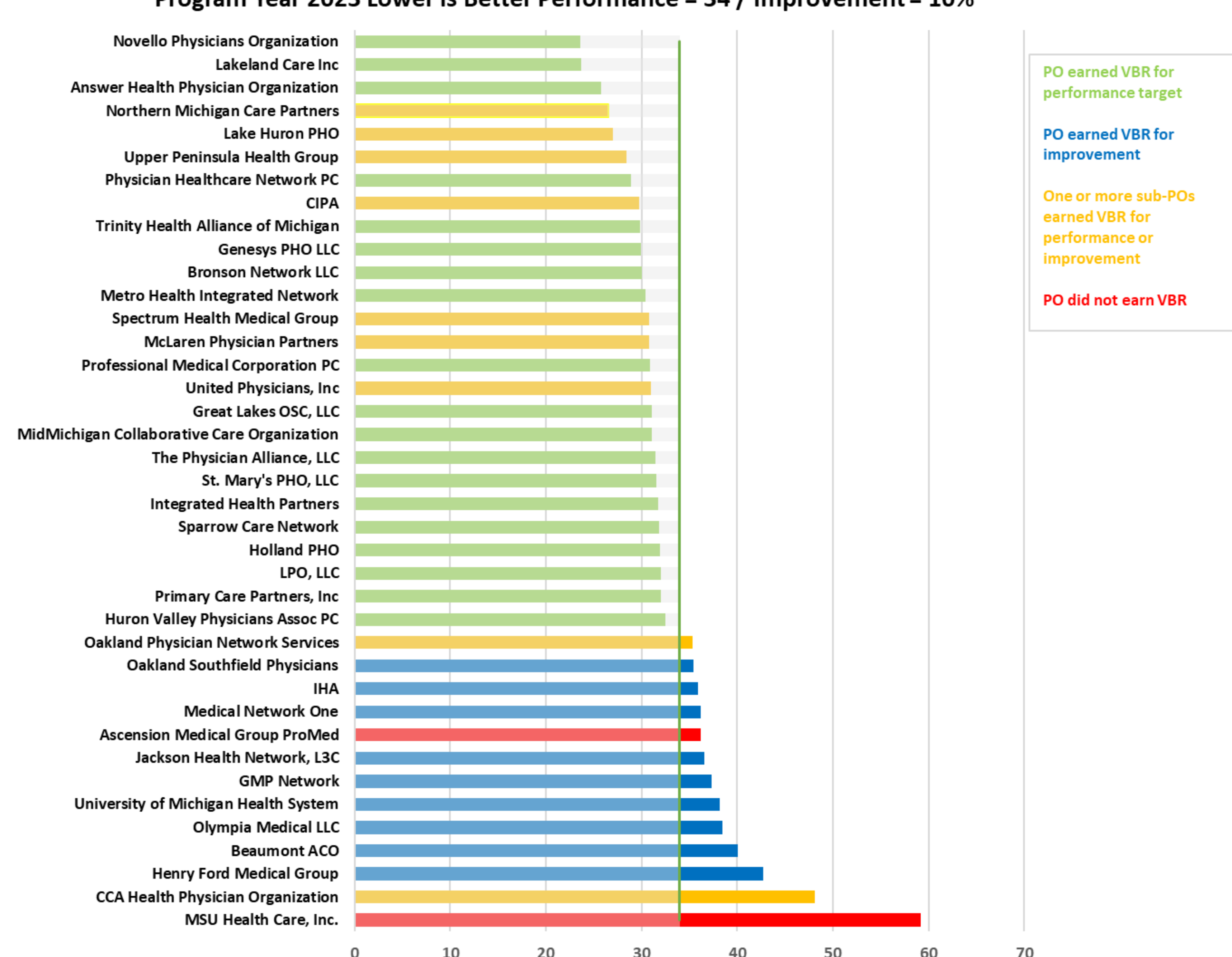
One or more sub-POs earned VBR for performance or improvement

PO did not earn VBR



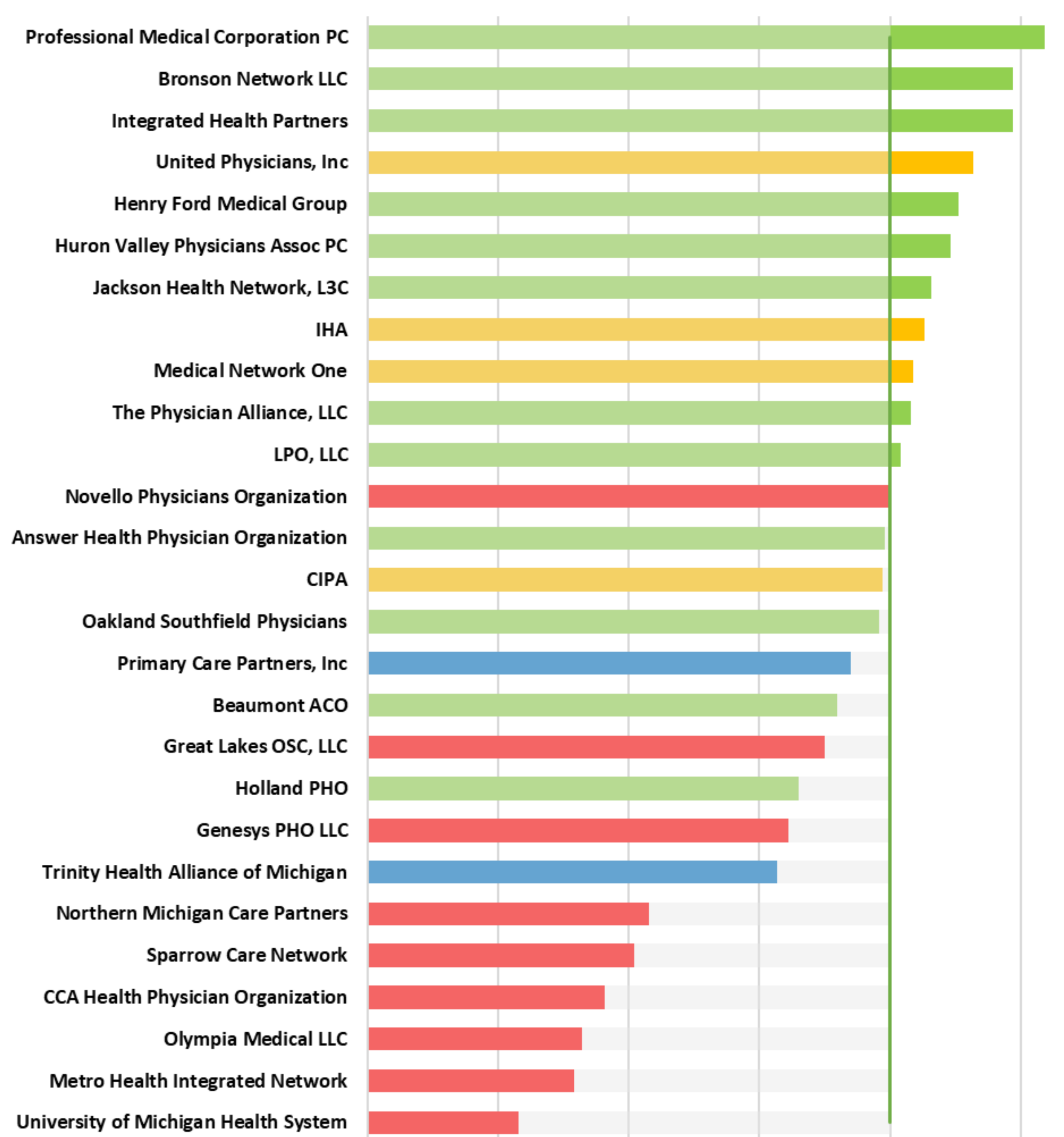
Adult: High Blood Pressure
Program Year 2023 Performance = 71% / Improvement = 10%
Novello Physicians Organization
Answer Health Physician Organization
Integrated Health Partners
Olympia Medical LLC
Medical Network One
Trinity Health Alliance of Michigan
Beaumont ACO
Holland PHO
Genesys PHO LLC
Upper Peninsula Health Group
Jackson Health Network, L3C
Huron Valley Physicians Assoc PC
Bronson Network LLC
Oakland Southfield Physicians
Professional Medical Corporation PC
Great Lakes OSC, LLC
McLaren Physician Partners
Lakeland Care Inc
Primary Care Partners, Inc
Oakland Physician Network Services
Metro Health Integrated Network
Northern Michigan Care Partners
GMP Network
The Physician Alliance, LLC
Lake Huron PHO
LPO, LLC
United Physicians, Inc
CIPA
Physician Healthcare Network PC
IHA
Henry Ford Medical Group
University of Michigan Health System
Spectrum Health Medical Group
Ascension Medical Group ProMed
Sparrow Care Network
CCA Health Physician Organization
MidMichigan Collaborative Care Organization
St. Mary's PHO, LLC
MSU Health Care, Inc.
0%
20%
40%
60%
80%
100%
PO earned VBR for performance target
PO earned VBR for improvement
One or more sub-POs earned VBR for performance or improvement
PO did not earn VBR


Adult: ED Encounters (per 1000 members per year)
Program Year 2023 Lower is Better Performance = 169 / Improvement = 10%
Novello Physicians Organization
Genesys PHO LLC
United Physicians, Inc
Huron Valley Physicians Assoc PC
Professional Medical Corporation PC
McLaren Physician Partners
Answer Health Physician Organization
Medical Network One
GMP Network
Sparrow Care Network
Lakeland Care Inc
Oakland Southfield Physicians
The Physician Alliance, LLC
CIPA
Holland PHO
University of Michigan Health System
Oakland Physician Network Services
MSU Health Care, Inc.
Great Lakes OSC, LLC
Bronson Network LLC
Spectrum Health Medical Group
LPO, LLC
IHA
Integrated Health Partners
Primary Care Partners, Inc
Metro Health Integrated Network
St. Mary's PHO, LLC
Physician Healthcare Network PC
Northern Michigan Care Partners
Jackson Health Network, L3C
Beaumont ACO
Upper Peninsula Health Group
Trinity Health Alliance of Michigan
Ascension Medical Group ProMed
CCA Health Physician Organization
Olympia Medical LLC
MidMichigan Collaborative Care Organization
Henry Ford Medical Group
Lake Huron PHO
0
50
100
150
200
250
300
350
PO earned VBR for performance target
PO earned VBR for improvement
One or more sub-POs earned VBR for performance or improvement
PO did not earn VBR



Adult: IP Encounters (per 1000 members per year)
Program Year 2023 Lower is Better Performance = 34 / Improvement = 10%
Novello Physicians Organization
Lakeland Care Inc
Answer Health Physician Organization
Northern Michigan Care Partners
Lake Huron PHO
Upper Peninsula Health Group
Physician Healthcare Network PC
CIPA
Trinity Health Alliance of Michigan
Genesys PHO LLC
Bronson Network LLC
Metro Health Integrated Network
Spectrum Health Medical Group
McLaren Physician Partners
Professional Medical Corporation PC
United Physicians, Inc
Great Lakes OSC, LLC
MidMichigan Collaborative Care Organization
The Physician Alliance, LLC
St. Mary's PHO, LLC
Integrated Health Partners
Sparrow Care Network
Holland PHO
LPO, LLC
Primary Care Partners, Inc
Huron Valley Physicians Assoc PC
Oakland Physician Network Services
Oakland Southfield Physicians
IHA
Medical Network One
Ascension Medical Group ProMed
Jackson Health Network, L3C
GMP Network
University of Michigan Health System
Olympia Medical LLC
Beaumont ACO
Henry Ford Medical Group
CCA Health Physician Organization
MSU Health Care, Inc.
0
10
20
30
40
50
60
70
PO earned VBR for performance target
PO earned VBR for improvement
One or more sub-POs earned VBR for performance or improvement
PO did not earn VBR

Pediatrics: Weight Management
Program Year 2023 Performance = 20% / Improvement = 5%

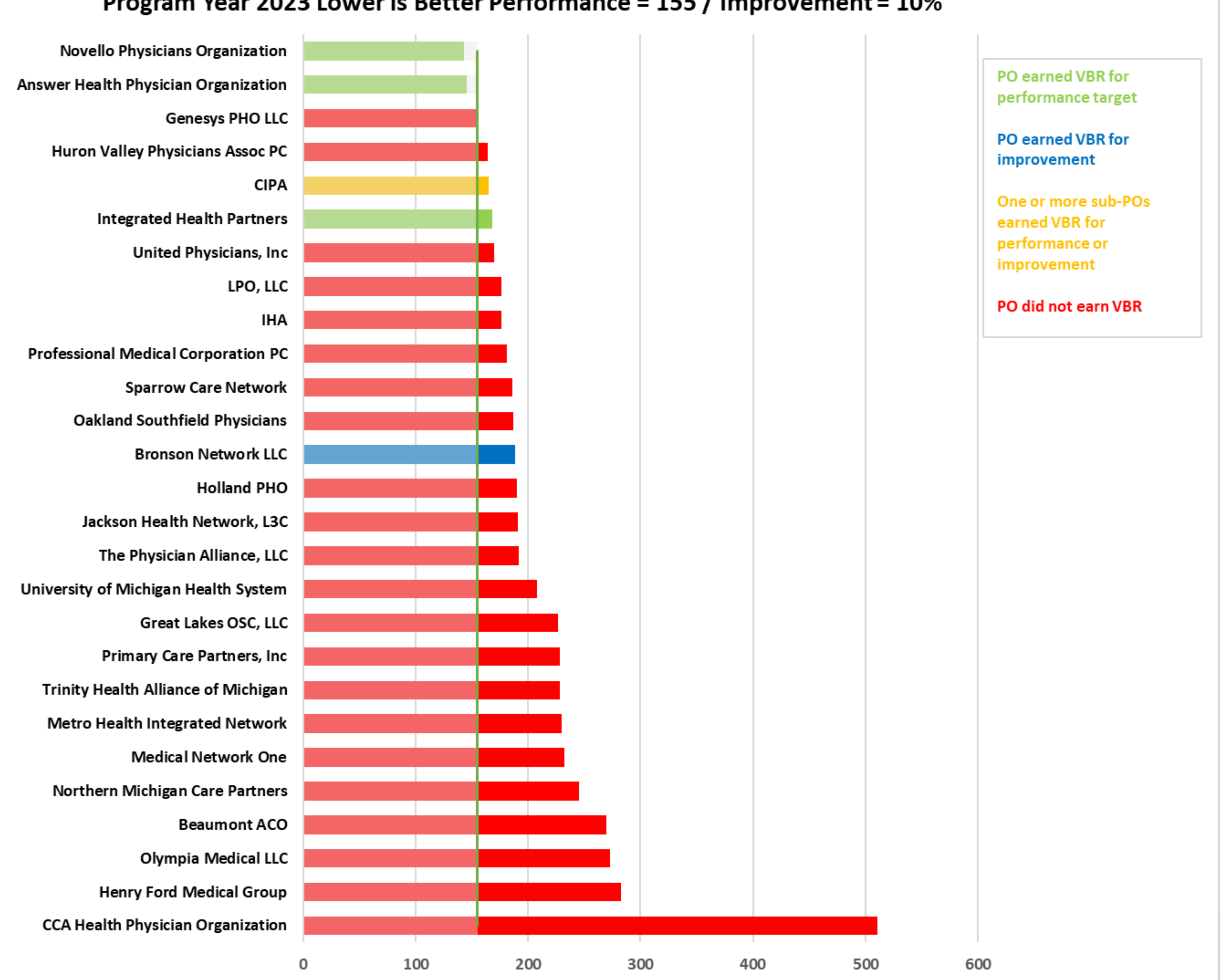


PO earned VBR for performance target

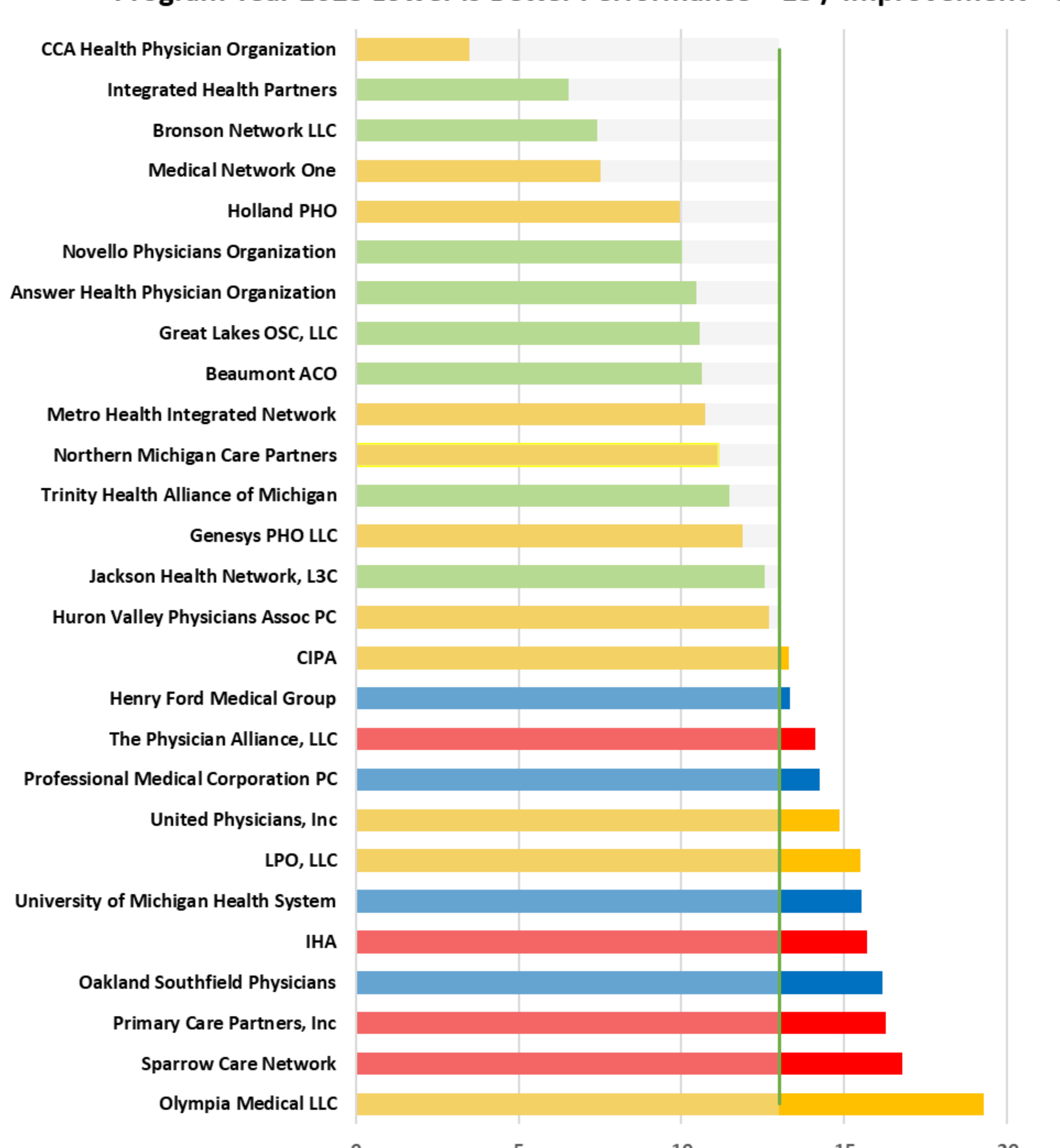
PO earned VBR for improvement

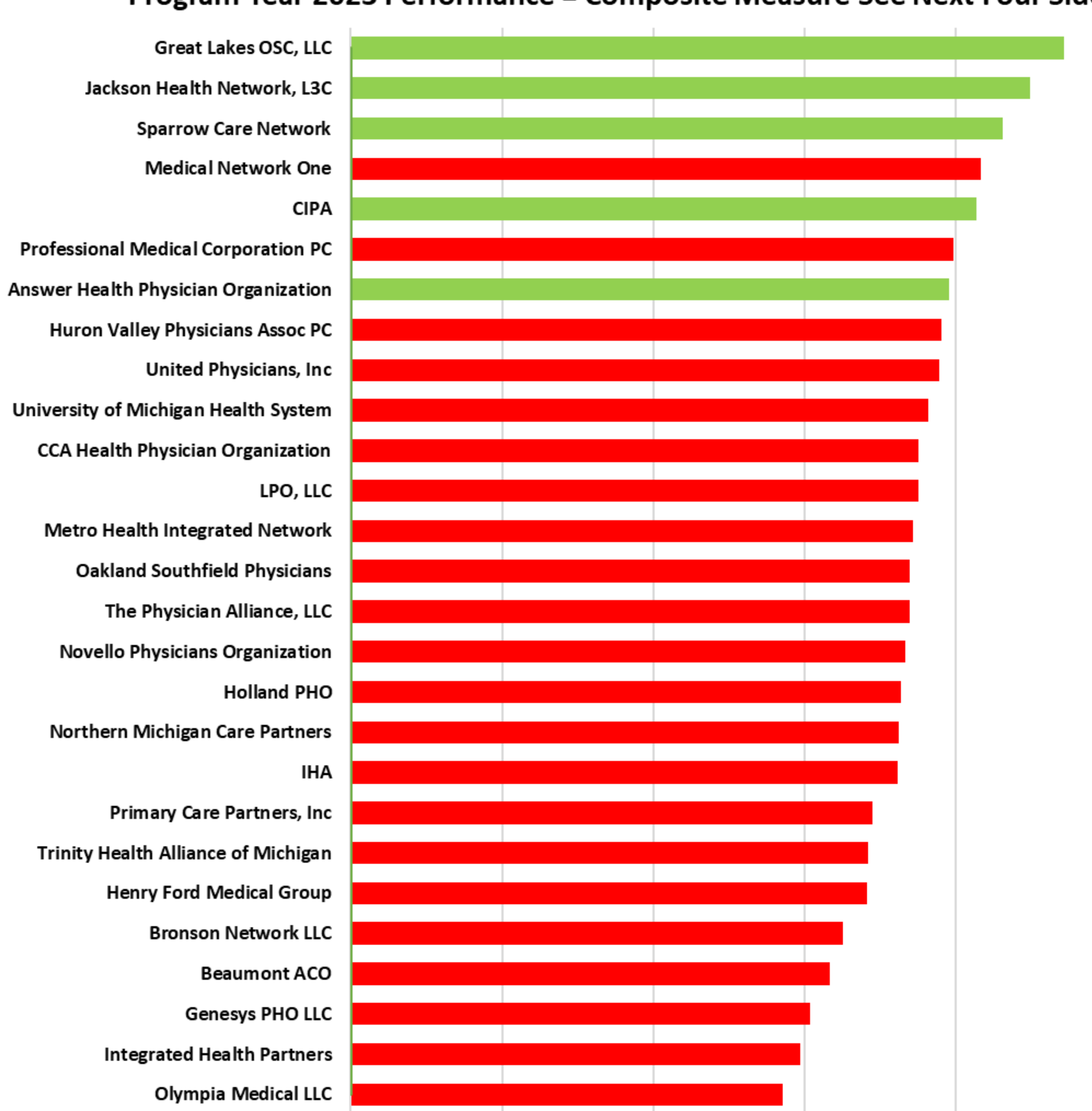
One or more sub-POs earned VBR for performance or improvement

PO did not earn VBR

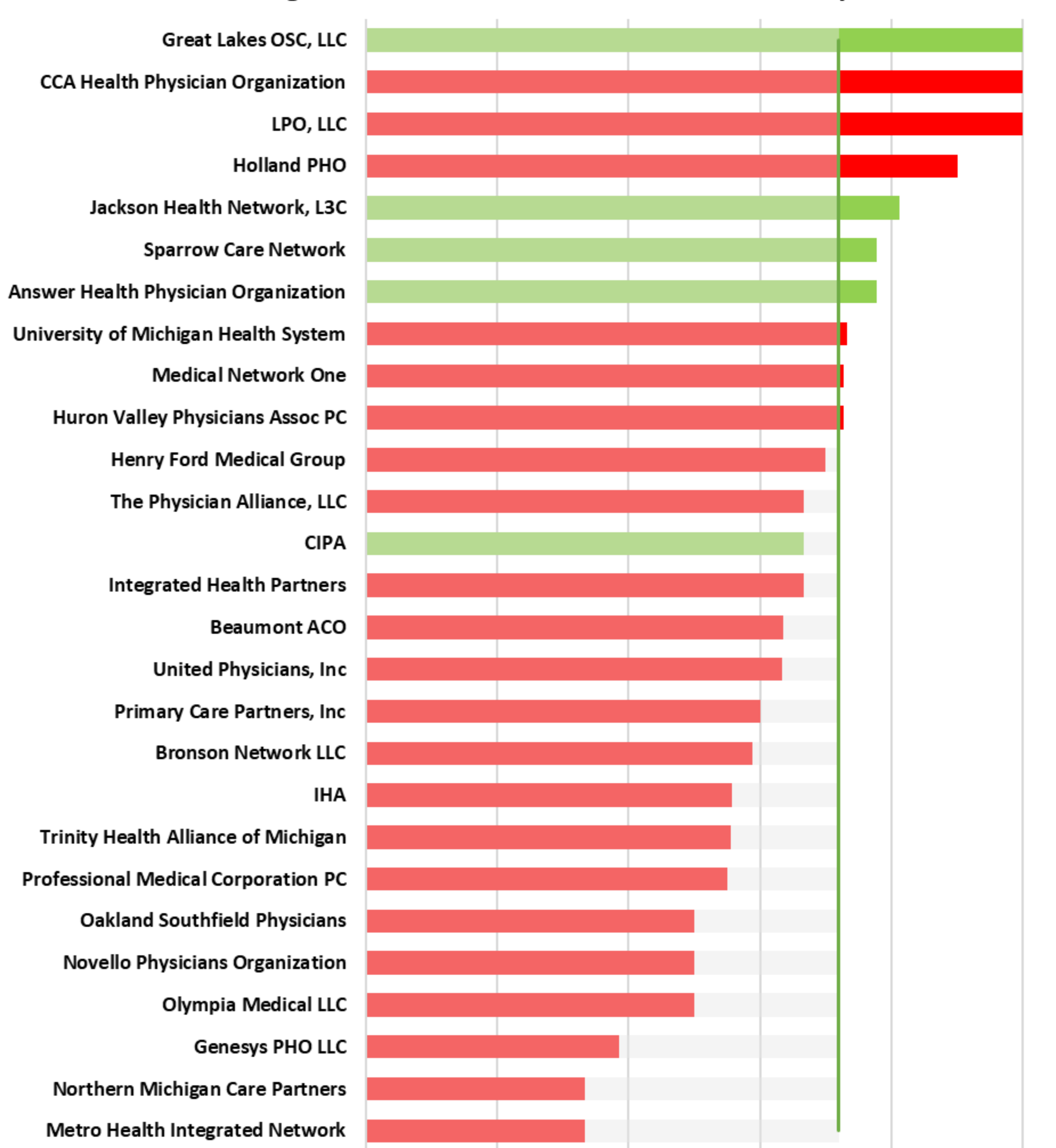


Pediatrics: ED Encounters (per 1000 members per year)
Program Year 2023 Lower is Better Performance = 155 / Improvement = 10%
Novello Physicians Organization
Answer Health Physician Organization
Genesys PHO LLC
Huron Valley Physicians Assoc PC
CIPA
Integrated Health Partners
United Physicians, Inc
LPO, LLC
IHA
Professional Medical Corporation PC
Sparrow Care Network
Oakland Southfield Physicians
Bronson Network LLC
Holland PHO
Jackson Health Network, L3C
The Physician Alliance, LLC
University of Michigan Health System
Great Lakes OSC, LLC
Primary Care Partners, Inc
Trinity Health Alliance of Michigan
Metro Health Integrated Network
Medical Network One
Northern Michigan Care Partners
Beaumont ACO
Olympia Medical LLC
Henry Ford Medical Group
CCA Health Physician Organization
0
100
200
300
400
500
600
PO earned VBR for performance target
PO earned VBR for improvement
One or more sub-POs earned VBR for performance or improvement
PO did not earn VBR


Pediatrics: IP Encounters (per 1000 members per year)
Program Year 2023 Lower is Better Performance = 13 / Improvement = 9%
CCA Health Physician Organization
Integrated Health Partners
Bronson Network LLC
Medical Network One
Holland PHO
Novello Physicians Organization
Answer Health Physician Organization
Great Lakes OSC, LLC
Beaumont ACO
Metro Health Integrated Network
Northern Michigan Care Partners
Trinity Health Alliance of Michigan
Genesys PHO LLC
Jackson Health Network, L3C
Huron Valley Physicians Assoc PC
CIPA
Henry Ford Medical Group
The Physician Alliance, LLC
Professional Medical Corporation PC
United Physicians, Inc
LPO, LLC
University of Michigan Health System
IHA
Oakland Southfield Physicians
Primary Care Partners, Inc
Sparrow Care Network
Olympia Medical LLC
0
5
10
15
20
25
PO earned VBR for performance target
PO earned VBR for improvement
One or more sub-POs earned VBR for performance or improvement
PO did not earn VBR


Pediatrics: PEDCOMP1
Program Year 2023 Performance = Composite Measure See Next Four Sides
Great Lakes OSC, LLC
Jackson Health Network, L3C
Sparrow Care Network
Medical Network One
CIPA
Professional Medical Corporation PC
Answer Health Physician Organization
Huron Valley Physicians Assoc PC
United Physicians, Inc
University of Michigan Health System
CCA Health Physician Organization
LPO, LLC
Metro Health Integrated Network
Oakland Southfield Physicians
The Physician Alliance, LLC
Novello Physicians Organization
Holland PHO
Northern Michigan Care Partners
IHA
Primary Care Partners, Inc
Trinity Health Alliance of Michigan
Henry Ford Medical Group
Bronson Network LLC
Beaumont ACO
Genesys PHO LLC
Integrated Health Partners
Olympia Medical LLC
0%
20%
40%
60%
80%
100%
PO earned VBR for performance target
PO earned VBR for improvement
One or more sub-POs earned VBR for performance or improvement
PO did not earn VBR

Pediatrics: Follow-Up After ED Visit for Mental Illness
Program Year 2023 Performance = 72% / Improvement = NA

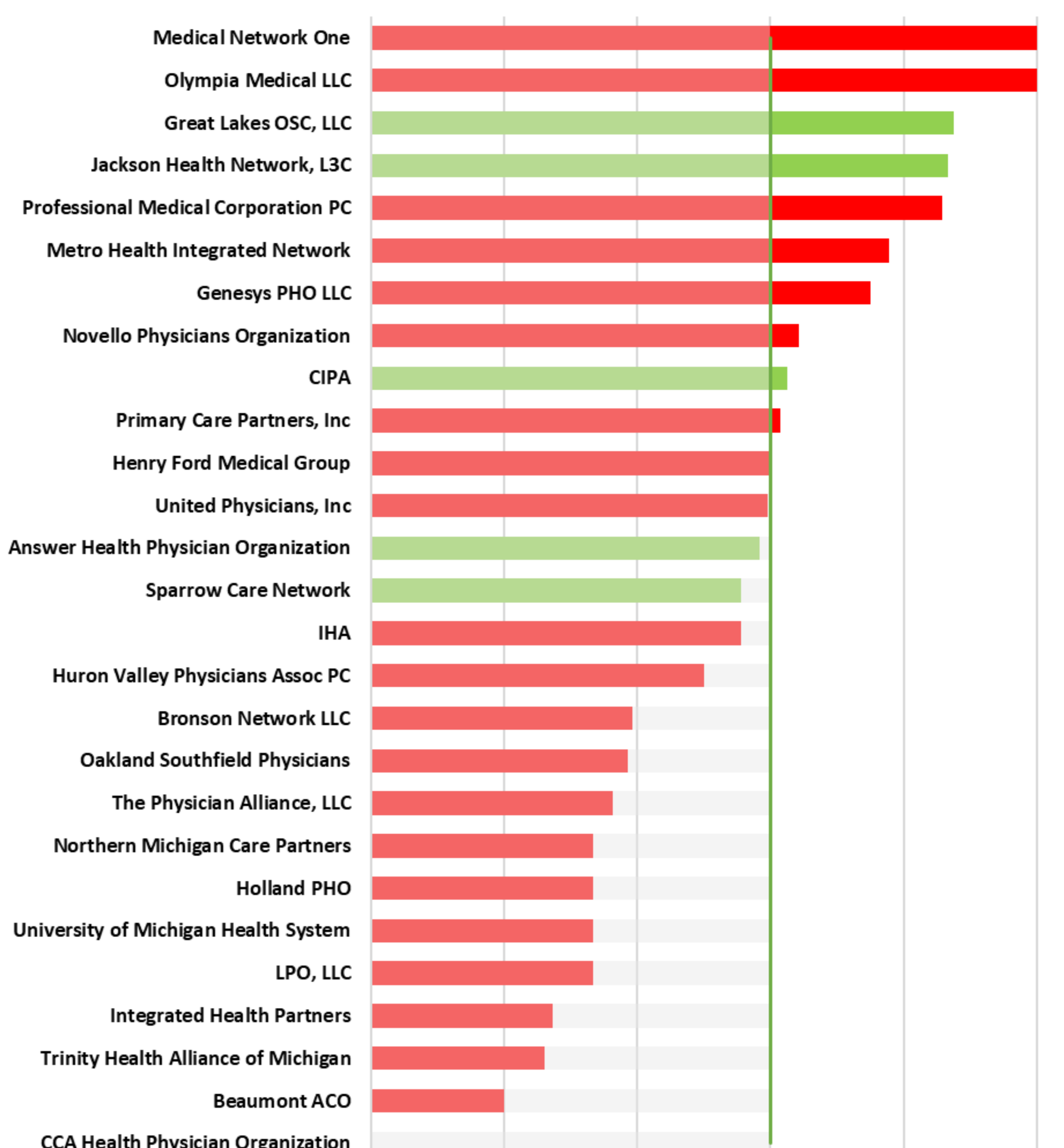


PO earned VBR for performance target

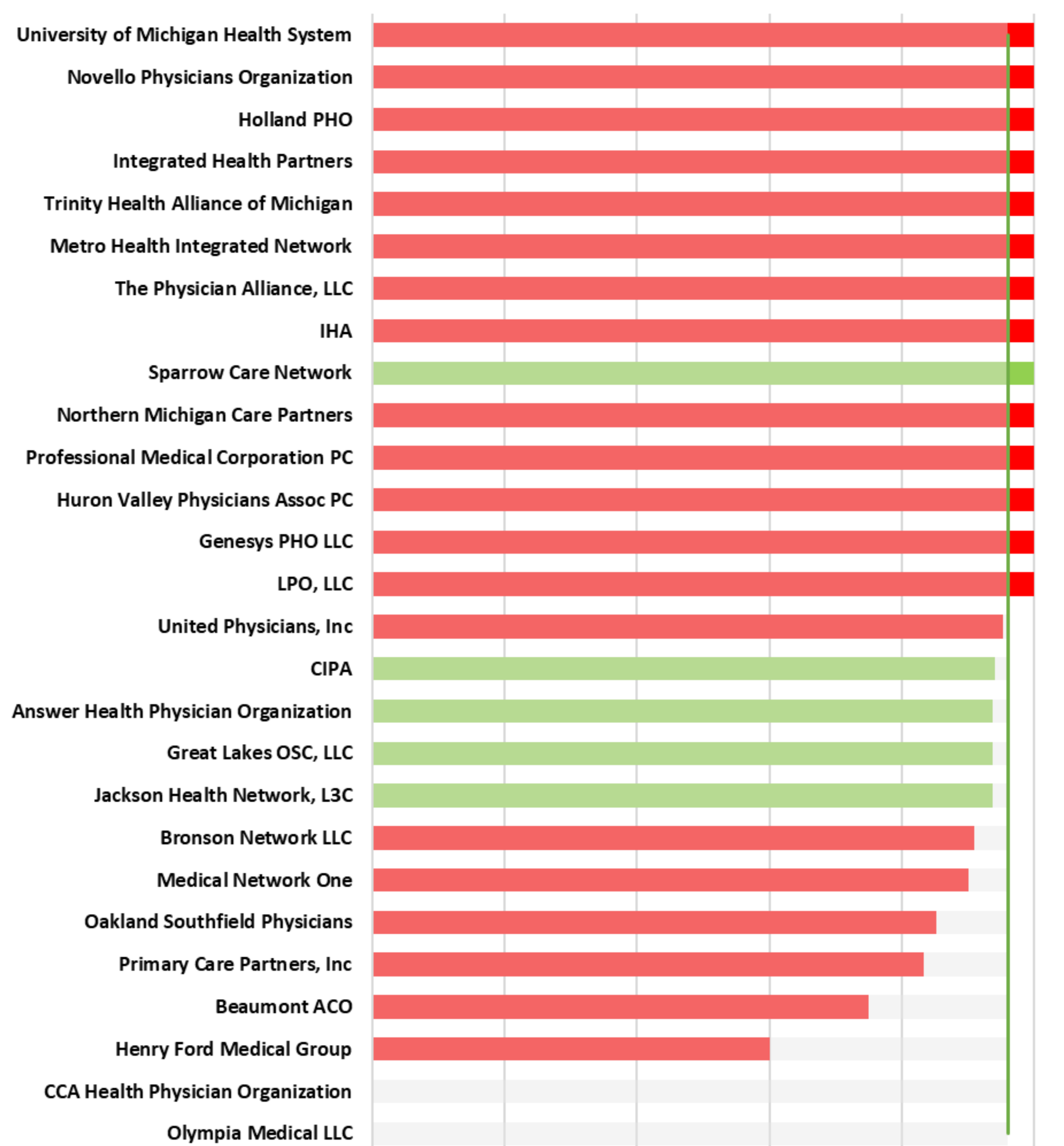
PO earned VBR for improvement

One or more sub-POs earned VBR for performance or improvement

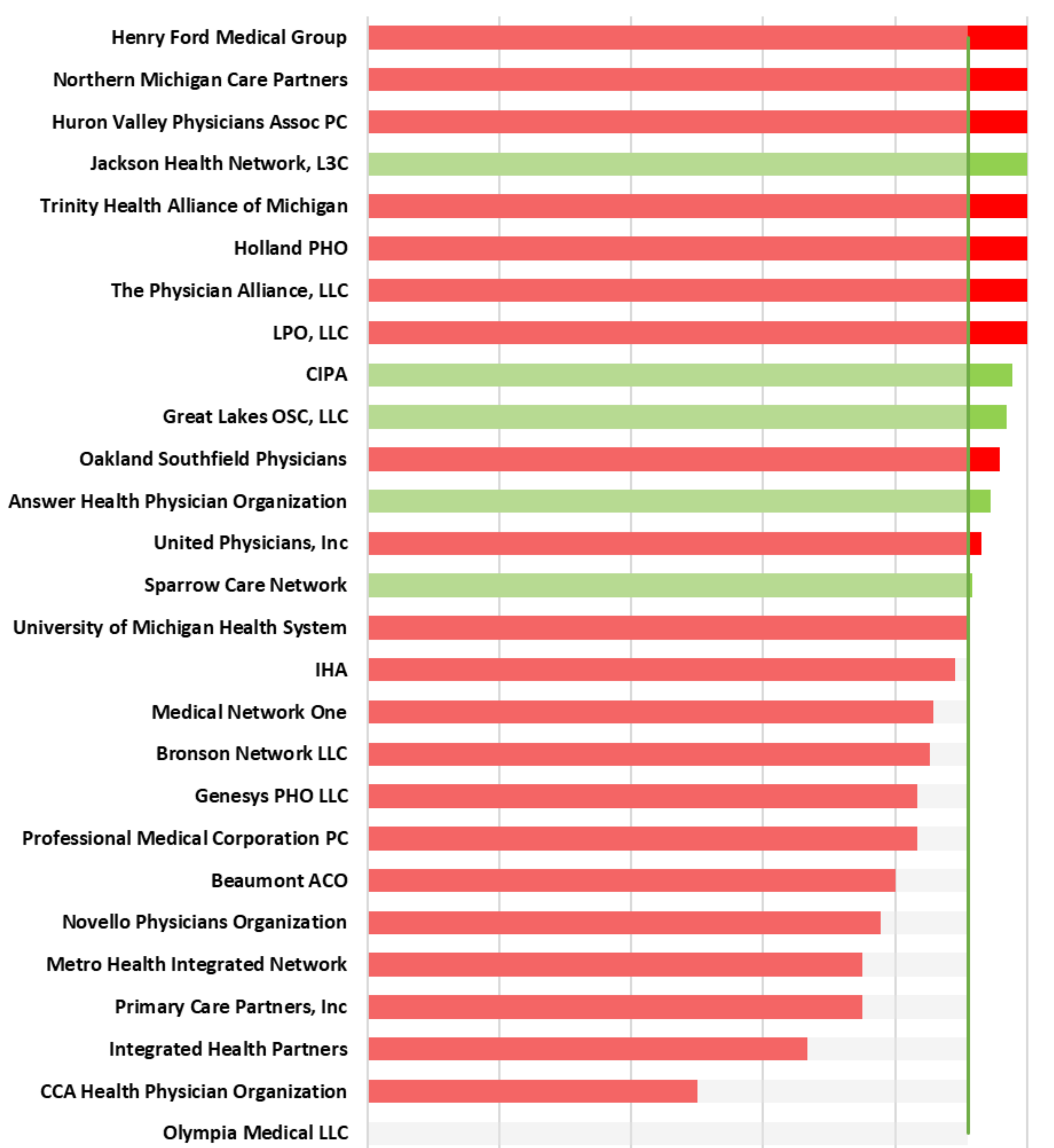
PO did not earn VBR



Pediatrics: Follow-Up Care for ADHD Medication - C and M Phase
Program Year 2023 Performance = 60% / Improvement = NA
Medical Network One
Olympia Medical LLC
Great Lakes OSC, LLC
Jackson Health Network, L3C
Professional Medical Corporation PC
Metro Health Integrated Network
Genesys PHO LLC
Novello Physicians Organization
CIPA
Primary Care Partners, Inc
Henry Ford Medical Group
United Physicians, Inc
Answer Health Physician Organization
Sparrow Care Network
IHA
Huron Valley Physicians Assoc PC
Bronson Network LLC
Oakland Southfield Physicians
The Physician Alliance, LLC
Northern Michigan Care Partners
Holland PHO
University of Michigan Health System
LPO, LLC
Integrated Health Partners
Trinity Health Alliance of Michigan
Beaumont ACO
CCA Health Physician Organization
0%
20%
40%
60%
80%
100%
120%
PO earned VBR for performance target
PO earned VBR for improvement
One or more sub-POs earned VBR for performance or improvement
PO did not earn VBR



Pediatrics: Asthma Med Ratio - 5 to 11 Ratio > 50%
Program Year 2023 Performance = 96% / Improvement = NA
University of Michigan Health System
Novello Physicians Organization
Holland PHO
Integrated Health Partners
Trinity Health Alliance of Michigan
Metro Health Integrated Network
The Physician Alliance, LLC
IHA
Sparrow Care Network
Northern Michigan Care Partners
Professional Medical Corporation PC
Huron Valley Physicians Assoc PC
Genesys PHO LLC
LPO, LLC
United Physicians, Inc
CIPA
Answer Health Physician Organization
Great Lakes OSC, LLC
Jackson Health Network, L3C
Bronson Network LLC
Medical Network One
Oakland Southfield Physicians
Primary Care Partners, Inc
Beaumont ACO
Henry Ford Medical Group
CCA Health Physician Organization
Olympia Medical LLC
0%
20%
40%
60%
80%
100%
120%
PO earned VBR for performance target
PO earned VBR for improvement
One or more sub-POs earned VBR for performance or improvement
PO did not earn VBR



Pediatrics: Asthma Med Ratio - 12 to 17 Ratio > 50%
Program Year 2023 Performance = 91% / Improvement = NA
Henry Ford Medical Group
Northern Michigan Care Partners
Huron Valley Physicians Assoc PC
Jackson Health Network, L3C
Trinity Health Alliance of Michigan
Holland PHO
The Physician Alliance, LLC
LPO, LLC
CIPA
Great Lakes OSC, LLC
Oakland Southfield Physicians
Answer Health Physician Organization
United Physicians, Inc
Sparrow Care Network
University of Michigan Health System
IHA
Medical Network One
Bronson Network LLC
Genesys PHO LLC
Professional Medical Corporation PC
Beaumont ACO
Novello Physicians Organization
Metro Health Integrated Network
Primary Care Partners, Inc
Integrated Health Partners
CCA Health Physician Organization
Olympia Medical LLC
0%
20%
40%
60%
80%
100%
120%
PO earned VBR for performance target
PO earned VBR for improvement
One or more sub-POs earned VBR for performance or improvement
PO did not earn VBR

Practice Unit Engagement in PDCM

PCMH Practices with PDCM Attributed Members by Percent Engagement

	2018	2019	2020	2021	2022
Less then 1%	895	921	799	691	671
4% or more	159	260	469	536	567
1 to 3.9%	321	469	366	381	350

100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%

■ 1 to 3.9% ■ 4% or more ■ Less then 1%

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Practices with < 1% Engagement Observations (N = 671)

- 191 (28%) practices attested to having CTMs
  - 91 (14%) not billing at all.
  - 100 (15%) billing but it is less than 1%
- 510 (76%) have only one or two PCPs
  - 364 (54%) 1 PCP
  - 146 (22%) 2 PCP
- 63 (9%) have less than 100 attributed members
- 292 (44%) belong to five POs
- 34 (5%) made it to 0.75% Engagement

Physician Organizations who Achieved at Least 4% with Two CM Encounters

- Bronson Network LLC
- Great Lakes OSC, LLC
- Holland PHO
- Huron Valley Physicians Assoc PC
- IHA
- Integrated Health Partners
- Jackson Health Network, L3C
- LPO, LLC
- Medical Network One
- Oakland Physician Network Services
- Professional Medical Corporation PC
- Reliance PO of Michigan, Inc.
- The Physician Alliance, LLC
- United Physicians, Inc
- University of Michigan Health System

Care
Management
in Michigan
MICMT
Michigan Institute for Care Management & Transformation

Attestation: Practices Reporting Dedicated CTMs

	2019	2020	2021	2022	2023
PCP or Mixed	649	897	950	974	907
Specilaty	4	12	48	57	64
PUs Billing PDCM (PCP/Mixed)	1115	1483	1405	1394	1394
1% PUs	734	883	959	961	961

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2023 Attestation: CTMs (Care Team Members) by Role

(N = 1,753 CTMs)

	Grand Total	Nurse	Social Worker	Medical Assistant	Nurse Practitioner	Pharmacist	Dietitian	Other	Behavioral Health Care Manager	Licensed Practical Nurse	Non Clinical Community Health Worker	Non Clinical Care Navigator
Total	1,760	990	175	155	87	83	82	76	34	31	28	19
Centralized	239	121	30	14	3	11	12	3	5	5	22	13
Mixed Practice	286	182	27	5	20	13	12	14	6	5	1	1
Specialty Practice	142	49	9	16	6	13	42	5	0	1	0	1
Primary Care Practice	1,149	672	112	120	58	54	24	54	26	20	5	4

Attestation: CTMs by Year

2000
1800
1600
1400
1200
1000
800
600
400
200
0

1753
1532
1447
239

Care Managers
Dedicated Care Managers
Dedicated Care Managers Working 4+ Hours per Week
Centralized Care Managers

2019 2020 2021 2022 2023

MICMT

Proportion of PDCM Two Encounters on 1% Practices with Dedicated CTMs

	2019	2020	2021	2022
Percent with No CTM attested	21%	15%	12%	13%
Percent of Practices w/ Dedicated CTMs Working < 4 Hours per Week	4%	11%	7%	7%
Percent of Practices w/ Dedicated CTMs Working 4+ Hours per Week	75%	74%	81%	80%

Y-axis: 0%, 10%, 20%, 30%, 40%, 50%, 60%, 70%, 80%, 90%, 100%

MICMT

Change in Nbr of Practices Attesting for CTMs (2022 -2023)

PO (Nbr of PUs in 2023)	Change
Huron Valley Physicians Assoc PC (32)	9
Lake Huron PHO (15)	7
University of Michigan Health System (51)	5
United Physicians, Inc (29)	5
Beaumont ACO (81)	5
St. Mary's PHO, LLC (12)	2
Upper Peninsula Health Group (34)	1
Olympia Medical LLC (21)	1
Novello Physicians Organization (22)	1
Northern Michigan Care Partners (30)	1
Holland PHO (13)	1
Primary Care Partners, Inc (21)	0
McLaren Physician Partners (17)	0
Great Lakes OSC, LLC (16)	0
Genesys PHO LLC (50)	0
Answer Health Physician Organization (39)	0
Trinity Health Alliance of Michigan (51)	-1
Spectrum Health Medical Group (32)	-1
Oakland Physician Network Services (12)	-1
MSU Health Care, Inc. (2)	-1
Metro Health Integrated Network (16)	-1
LPO, LLC (8)	-1
Jackson Health Network, L3C (31)	-1
Integrated Health Partners (21)	-1
Henry Ford Medical Group (27)	-1
CCA Health Physician Organization (4)	-2
Professional Medical Corporation PC (10)	-3
Lakeland Care Inc (12)	-3
Ascension Medical Group ProMed (12)	-3
Physician Healthcare Network PC (0)	-4
Medical Network One (28)	-5
Sparrow Care Network (35)	-6
IHA (19)	-6
Bronson Network LLC (29)	-6
GMP Network (0)	-8
MidMichigan Collaborative Care Organization (15)	-9
CIPA (51)	-9
Oakland Southfield Physicians (35)	-12
The Physician Alliance, LLC (38)	-13

-15 -10 -5 0 5 10 15

MICMT

Number of Practices Providing Care Management

2023 Attestation by County and Role

- Behavioral Health Care Manager
- Dietitian
- Licensed Practical Nurse
- Medical Assistant
- Non Clinical Care Navigator
- Non Clinical Community Health Worl
- Nurse
- Nurse Practitioner
- Other
- Pharmacist
- Social Worker

MICMT

Care Management Billing

Claims Activity: Claim Counts

PGIP PCP and Mixed Practices

Claims Activity: Member Counts

PGIP PCP and Mixed Practices

140,000
120,000
100,000
80,000
60,000
40,000
20,000
0

130,148
57,470
47,220

Number of Members with 1 or More CM Claims
Number of Members with 2 or More CM Claims
Number of Members with 2 or More PDCM Claims

2018 2019 2020 2021 2022

MICMT

Claims Activity: Claim Counts

PGIP Specialty Practices

25,000
20,000
15,000
10,000
5,000
0

20,318
968
1,024
3
22,313

PDCM
TCM
MED REC
HICM
ALL

2019 2020 2021 2022

MICMT

Claims Activity: Percent of Claims by Specialty (Top 25)

Specialty	Percent of Claims
Other	11.5%
Cardiovascular Disease	8.8%
Endocrinology, Diabetes / Metabolism	8.7%
Oncology	8.0%
Internal Medicine	5.9%
Nephrology	5.0%
Pediatric Pulmonolgy	4.9%
Pulmonary Disease	4.8%
Gastroenterology	4.3%
Pediatric Gastroenterology	4.1%
Clinical Genetics (MD)	3.4%
General Surgery	3.2%
Pediatric Endocrinology	3.0%
Orthopedic Surgery	2.7%
Hematology	2.6%
Obstetrics / Gynecology	2.6%
Allergy/Immunology	2.2%
Neurology with Special Quals in Child Neurology	2.0%
Pediatric Hematology/Oncology	1.8%
Neurology	1.8%
Pediatric Cardiology	1.8%
Urology	1.8%
Otolaryngology	1.8%
Endocrinology	1.3%
Dermatology	1.0%
Pediatric Surgery	1.0%

Axis: 0.0% 2.0% 4.0% 6.0% 8.0% 10.0% 12.0% 14.0%

MICMT

2024 MICMT Scorecard

- Training reimbursement paid in January 2025 check. Will include those trainings that occur between October 11, 2023, and October 10, 2024.
- Scorecard payment paid in January 2026 check.

2024 Scorecard				
Measure #	Weight	Measure Description	Points	Data Source
1	48	**Outcomes**		
		Points for the below outcome measures are earned based on the PO performance with the PDCM Outcomes VBR. *(See Appendix A for more information)*		Outcomes measures align with BCBSM outcomes reporting for POs/sub-POs.
		Peds: IP Utilization	**6**	
		Peds: ED Utilization	**6**	
		Peds: Weight Metric	**6**	
		Peds: Composite Metric	**6**	
		Adult: A1c performance	**6**	
		Adult: BP Performance	**6**	
		Adult: ED Utilization	**6**	
		Adult: IP Utilization	**6**	

2024 MICMT Scorecard (cont.)

Michigan Institute for Care Management & Transformation

2024 Scorecard				
Measure #	Weight	Measure Description	Points	Data Source
2	34	**Care Management Operations (Note: This will not impact PDCM Outcomes or Population Outreach VBR)**		
		Percent of PCMH Designated practices that achieve the PDCM Participation threshold (2 encounters on 1% of the PDCM attributed population). **Note that this uses a different list:** The % of PDCM Participating practices will be assessed using the 2024 1% PDCM List (2 encounters on 1% of patients) from 2023 Claims. These practices are identified in the reports provided with the Value-Based Reimbursement and PDCM Participation reports that BCBSM will distribute in Fall, 2024.	**% of PCMH practices** / **# of points**: 90% – 7 75% – 5 50% – 3 25% – 1	BCBSM 2024 PDCM reports (2023 claims) titled "....2023_PDCM_PU_Rpt...".
		Percentage of PDCM Participating (2 encounters on 1% of the PDCM population) practices that achieve the Population Management VBR (2 encounters on 4% of the PDCM attributed population). **Note that this uses a different list:** The % of PDCM Participating practices will be assessed using the 2024 1% PDCM List (2 encounters on 1% of patients) from 2023 Claims. These practices are identified in the reports provided with the Value-Based Reimbursement and PDCM Participation reports that BCBSM will distribute in Fall, 2024.	**% of PDCM practices** / **# of points**: 90% – 7 75% – 5 50% – 3 25% – 1	BCBSM 2024 PDCM reports (2023 claims) titled "....2023_PDCM_PU_Rpt...".
		Patient Satisfaction Survey: PCMH Capability 4.4 in place. "PCMH/PCMH-N patient satisfaction/office efficiency measures are systematically administered."	**% of PDCM practices** / **# of points**: 90% – 4 75% – 3 50% – 2 25% – 1	First snapshot of 2024, looking at CY 2023.
		Patient Satisfaction Evaluation & Improvement: PCMH Capability 4.23 in place. "Practice has engaged in root cause analysis of any areas where there are significant opportunities for improvement in patient experience of care using tested methods such as Journey Mapping or LEAN techniques."	**% of PDCM practices** / **# of points**: 90% – 6 75% – 4 50% – 3 25% – 2	First snapshot of 2024, looking at CY 2023.
		Medication Reconciliation Rate Improvement Incentive: 10% Overall rate increase	**10**	BCBSM 2025 Performance Reporting for POs

2024 MICMT Scorecard (cont.)

2024 Scorecard				
Measure #	Weight	Measure Description	Points	Data Source
3	18	**Engagement:**		
		Practice & Care Team Member Attestation/Verification	**5**	MICMT Reporting
		At least 3 scheduled phone conferences (30 minutes) with MICMT	**5**	
		Participation in the entire Annual Team-Based Care Conference by at least 1 PO representative	**4**	
		Participation in the entire Annual MICMT meeting by at least 1 PO Representative with a leadership role in Care Management activity at the PO level	**4**	

"Harnessing the Relationship between the Community and Barbers to Create Healthcare Connections"

The Barbershop Connections mission is to harness the special relationship community members have with barbers to educate about blood pressure concerns and connect people to local healthcare resources.

- **Blue Cross Blue Shield of Michigan**
- **Michigan Department of Health and Human Services**
- **Michigan Institute for Care Management and Transformation**
- **Packard Health**
- **Trinity Health IHA**
- **University of Michigan Health**

The Barbershop Connections is a collaboration in Washtenaw County between local barbershops, community groups, and the following local organizations involved within healthcare:

To learn more, check out the contact information below!

- **Mr. Fuller Cut**
  - 307 Ecorse Road, Ypsilanti 48198
  - Barbershop Connections Partner:
    - **Alex Fuller -** (734) 484-2860
- **Premium Cutz**
  - 308 Perrin Street, Ypsilanti 48197
  - Barbershop Connections Partners:
    - **Dana Maggard -** (734) 484-2240

Scan me with your phone to link to the Barbershop Connections Website!

POEM Update

- Partnership between MICMT and MOQC
- Launched October 2020 and successful in providing care across the State of Michigan
  - 10 Clinical Oncology Pharmacists
  - 11 Physician Organizations
  - 27 Oncology Sites
  - Over 80 Physicians
- 4692 Patients*
- 14,688 Encounters
- 12,308 Interventions

POEM Successes

Quality Outcomes

- Improved dose intensity = Increased overall survival
- Improved antiemetic guideline concordance = Decreased total cost of care
- Increased patient education and adherence assessment = Improved adherence to regimens
- 2 POEM posters being presented at upcoming American Society of Clinical Oncology Quality Symposium

Statewide Cancer Drug Repository

- https://yesrx.org/
- Launched based on work of POEM sites
- Allow unused drugs to be donated and shared with patients in need
  - Prevent waste of valuable medications
  - Received first donation of drug from patient in September
- Other oncology practices encouraged to join

Planned Website Enhancements

- Dashboard Functionality
  - Better organized to accommodate various website roles (i.e., learner, PO leader, trainer)
  - Improved efficiency and flow to indicate incomplete/completed evaluations and tests
  - Increased reporting capabilities from a snapshot view for PO leaders and trainers
- PO Level Reports
  - Improved filters to access by training, date
  - Cleaned up columns to remove excess or unnecessary data fields

- Submit your Advanced Patient Engagement training for the scorecard points
- MICMT job-board is available for your postings
  - Any team-based care job opening
  - Contact Linny or Ashley if you are unsure how to submit
- Consultative services continue to be available
  - Patient engagement coaching/simulations, Ask the pharmacist/TOC, pharmacogenetics
  - Free service for PGIP POs and practices

Coming in 2024

- 2-hour training reimbursable at $125 for next training cycle
  - 2 sessions of an MICMT webinar series
  - External trainings
- Chronic Kidney Disease webinar series planned for launch Q1 2024

Collaborative Care Model Implementation: Current State

Kathleen Kobernik
BCBSM

EXPANDING THE USE OF COLLABORATIVE CARE UPDATE

- BLUE CROSS BLUE SHIELD OF MICHIGAN – PHYSICIAN GROUP INCENTIVE PROGRAM
- OCTOBER 2023

Blue Cross Blue Shield of Michigan and Blue Care Network are a nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association.

Why behavioral health care is so important

NEARLY 50 M OR 19.86% OF AMERICAN ADULTS EXPERIENCED A MENTAL ILLNESS IN 2019.

4.58% OF ADULTS REPORT HAVING SERIOUS THOUGHTS OF SUICIDE. THIS HAS INCREASED EVERY YEAR SINCE 2011-2012.

15.08% OF YOUTH EXPERIENCED A MAJOR DEPRESSIVE EPISODE IN THE PAST YEAR.

24.7% OF ADULTS WITH A MENTAL ILLNESS REPORT AN UNMET NEED FOR TREATMENT. THIS NUMBER HAS NOT DECLINED SINCE 2011.

OVER 60% OF YOUTH WITH MAJOR DEPRESSION DO NOT RECEIVE ANY MENTAL HEALTH TREATMENT.

EVEN IN STATES WITH THE GREATEST ACCESS, **NEARLY 1 IN 3** ARE GOING WITHOUT TREATMENT.

MORE THAN HALF OF ADULTS WITH A MENTAL ILLNESS DO NOT RECEIVE TREATMENT, TOTALING OVER 27 MILLION U.S. ADULTS.

10.6% OR OVER 2.5 MILLION YOUTH IN THE U.S. HAVE SEVERE MAJOR DEPRESSION. THIS RATE WAS HIGHEST AMONG YOUTH WHO IDENTIFY AS MORE THAN ONE RACE, AT

EVEN AMONG YOUTH WITH SEVERE DEPRESSION WHO RECEIVE SOME TREATMENT, **ONLY 27%** RECEIVE CONSISTENT CARE. IN STATES WITH THE LEAST ACCESS, ONLY

Behavioral Health access issues are effectively addressed through unique partnerships with Collaborative Care

- While the psychiatrist shortage is nationwide, the situation in Michigan is even more acute. The state had 1,180 active psychiatrists in 2018, or 11.84 practitioners per 100,000 residents, which is below the national average
- We know this can be more frustrating in rural regions as two-thirds of Michigan psychiatrists are based in the Ann Arbor-Detroit region
- Collaborative Care allows patients to receive expert medication recommendations and adjustments from a psychiatric consultant they may otherwise not have access to. There is a shortage of psychiatrists, long wait times and insurance barriers

- 20% of PCP visits are related to mental health.[1]
- 80% of antidepressants are prescribed by PCPs.
- PCPs see first signs of behavioral health issues.

[1] **Source:** 2010 National Ambulatory Medical Care Survey. Available at http://www.cdc.gov/nchs/ahcd.htm

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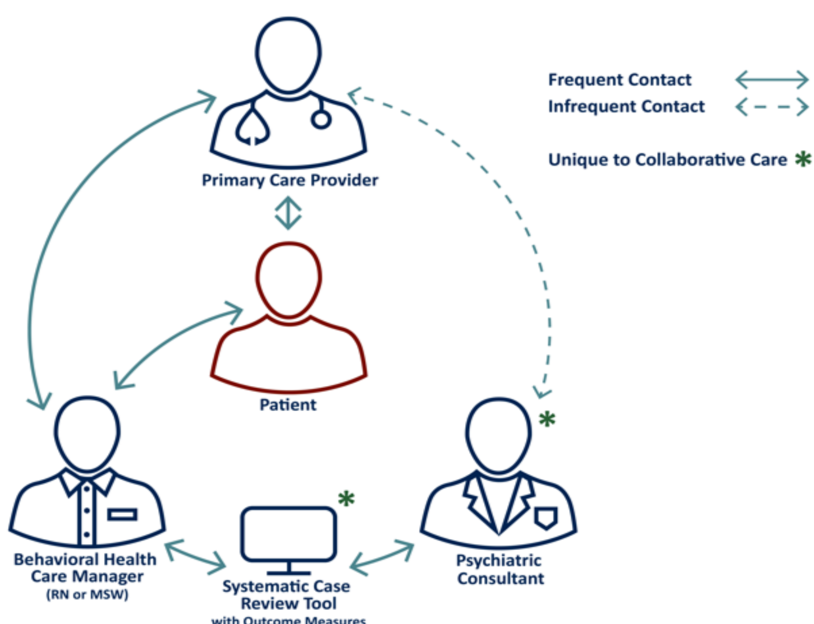
Expanding the collaborative care model



- In traditional care, the primary care team consists of the PCP and the patient with referrals to behavioral health specialists.
- CoCare adds:
  - A behavioral health care manager
  - A psychiatric consultant
- The psychiatrist and BHCM meet weekly to review the caseload of patients with mental health or substance use issues identified in the PCP office.
- The BHCM brings the psychiatrist's recommendations to the PCP, who decides whether or not to change the patient's treatment.
- Cycle repeats until patient is in remission.

Sources: (1) 2010 National Ambulatory Medical Care Survey (2) University of Washington IMPACT (Improving Mood: Providing Collaborative Treatment) Study

Initiative history

Initiative description history

- 2020 – Blue Cross Blue Shield of Michigan and Blue Care Network began to actively promote the Psychiatric Consultant Collaborative Care Model, which is also known as CoCM which integrates behavioral health care into general medical care.

- 2021 – 2022 Increasing the number of CoCM practices were corporate goals These goals were exceeded each year. Learning module “Delivering CoCM to Adolescents” was developed and implemented

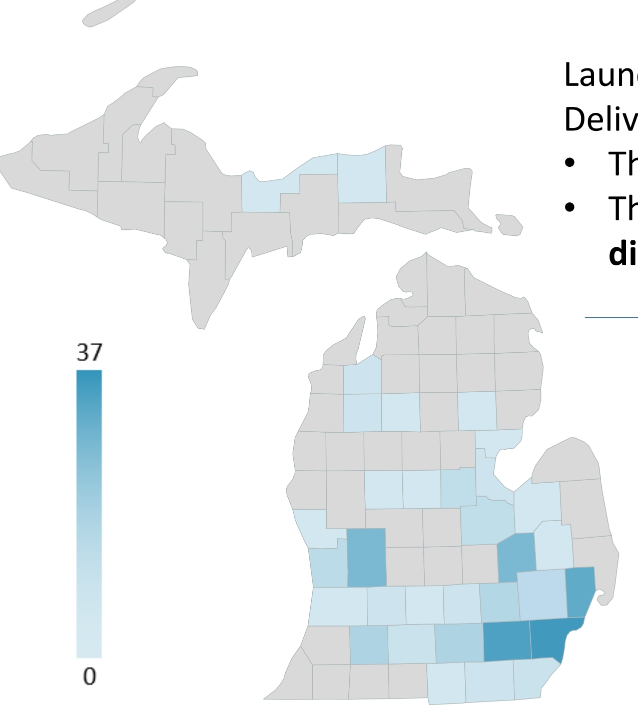
- 2022 – The CoCM Designation Program was launched. Learning module for Delivering CoCM to the Perinatal Population was developed and implemented.

- 2023 – Required that more CoCM capabilities be met to achieve CoCM Designation. Delivering CoCM to those with substance use issues learning module was developed and implemented.

- Up next – More focus on meeting fidelity to the original CoCM model. Develop learning module for oncology patients.

Collaborative Care Model Utilization

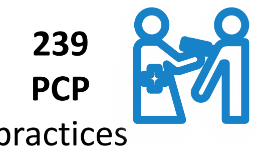
Our solid foundation has allowed Blue Cross to expand utilization of the Collaborative Care Model (CoCM).



Sept. 2023-Aug 2024 Designation cycle

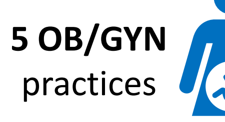
Launched ***new learning modules*** for Delivering CoCM to:

- The **perinatal** population
- Those with **substance use disorders**



239 PCP practices

CoCM **Designated**



5 OB/GYN practices

CoCM **Designated**

practitioners trained in CoCM

~1,270 PCP and OB/GYN practitioners receiving CoCM value-based reimbursement

Blue Cross:

Population-specific modules attendees:

- Trained 36 practitioners from 23 offices on perinatal CoCM
- Trained 8 practitioners from 6 offices on SUD CoCM
- Trained 113 practitioners from 90 offices on adolescent CoCM

Blue Cross Blue Shield of Michigan and Blue Care Network are a nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association.

Expanding the collaborative care model

Bronson

- We had a 19 year old patient that had some underlying depression due to covid and not having a regular senior year of high school. after meeting and starting on anti depressant, his score improved 5 points and he indicated that he never knew he could be this happy!!

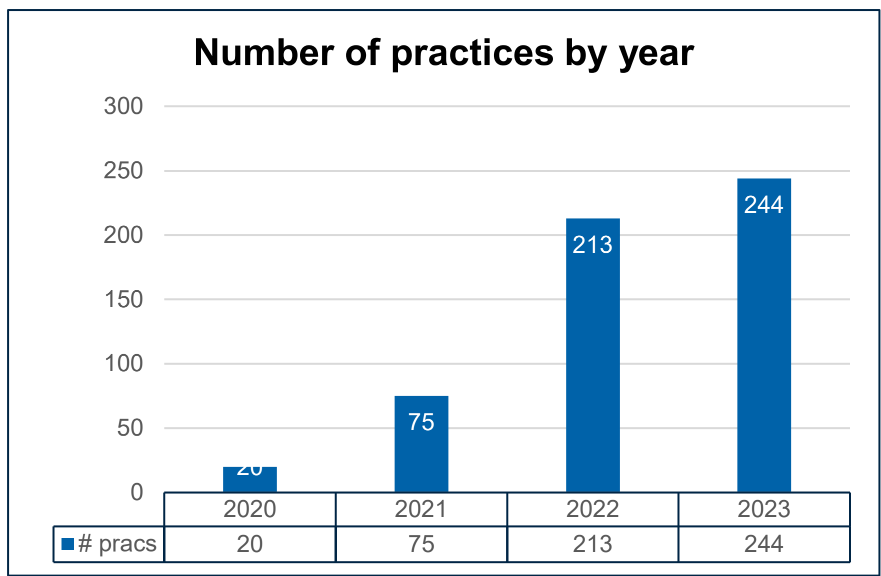
United Physicians

- Our biggest success for 2023 has been the enthusiasm with which our OBGYN practices have embraced the care model. UP

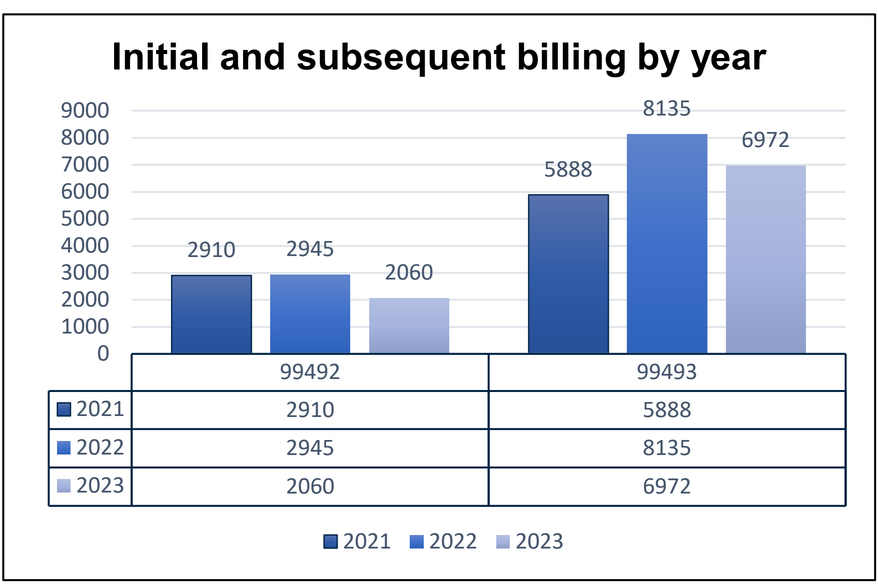
Oakland Southfield Physicians

- Patient who was in a very abusive relationship was very depressed and anxious to leave her husband. Our BHCM worked with her on resources for support, patient started therapy, and left her husband. With the recommendation of our psychiatrist consultant, the patient started a good medication regimen and is now in a healthy relationship doing much better. – Oakland Southfield Physicians

CoCM growth



	2020	2021	2022	2023
# pracs	20	75	213	244



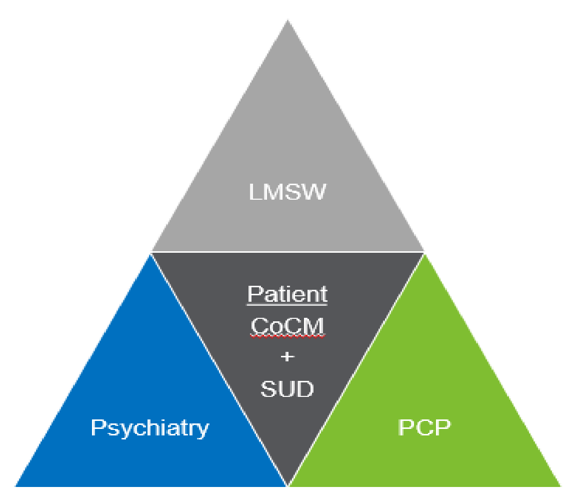
	99492	99493
2021	2910	5888
2022	2945	8135
2023	2060	6972

COLLABORATIVE CARE
DATA UPDATE AND REFLECTION

August 2023

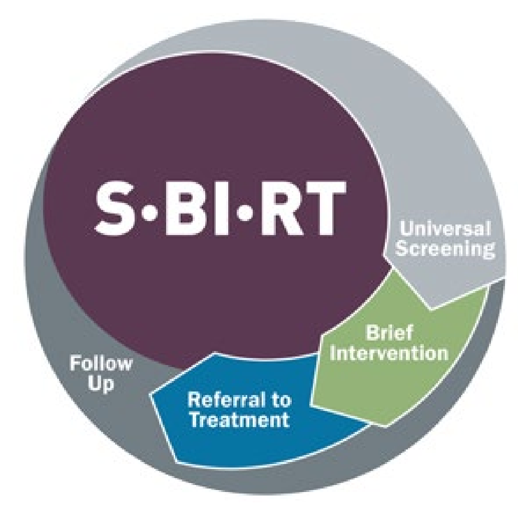
COCARE FOOTPRINT FOR TH WEST MI

- Current State: 13 primary care offices with triad relationship

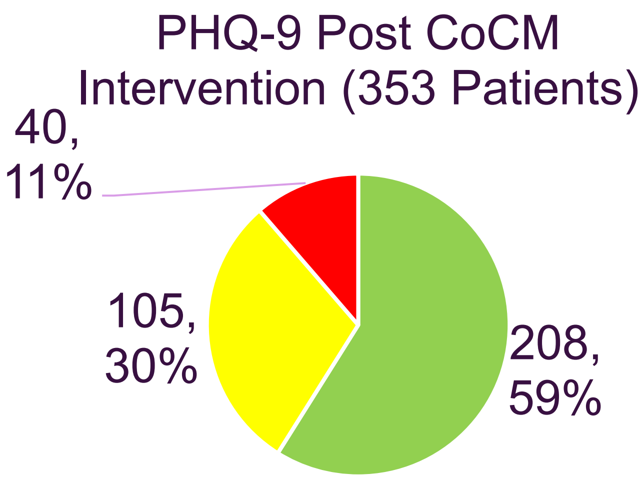


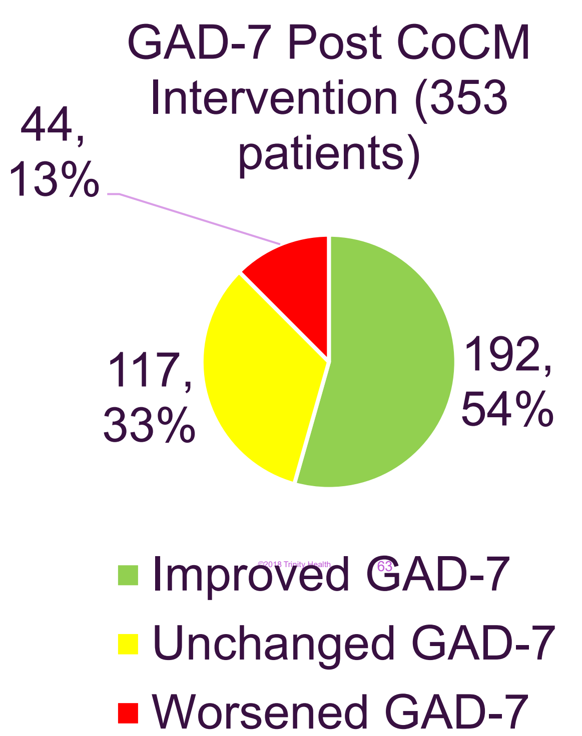
- Pilot: Inclusion of screening for substance use disorder (SUD) and SBIRT intervention

- Future State: ongoing effort to expand SUD screening and recruit more psychiatric support and LMSW's for expansion within the PO



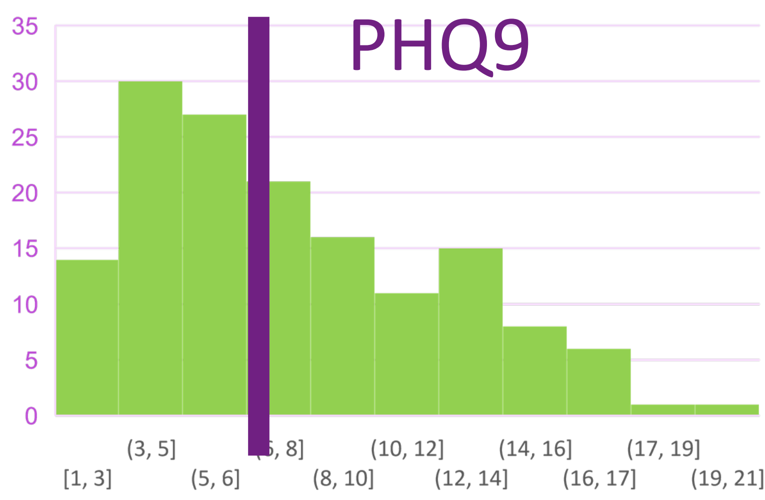
COCARE RESULTS – PHQ-9 & GAD-7

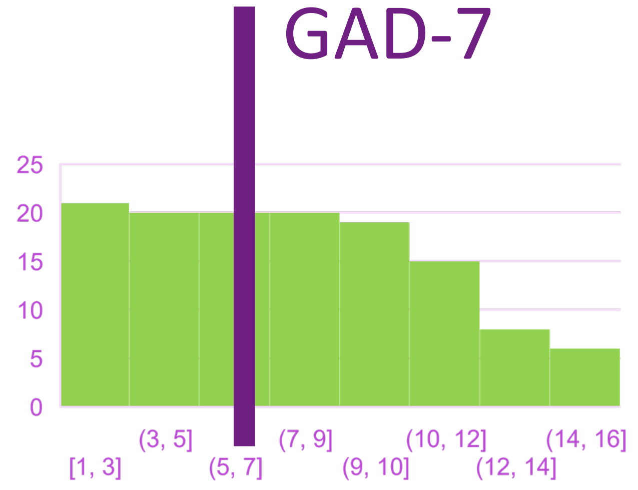




Denominator: all enrollees in CoCare from Jan – Jun 2023

COCARE IMPROVEMENTS





- Baseline: 13.2
- End: 6.4
- Mean Decrease: 6.8

- Baseline: 12.3
- End: 6.2
- Mean Decrease: 6.1

Denominator: baseline of ≥10 per each measure

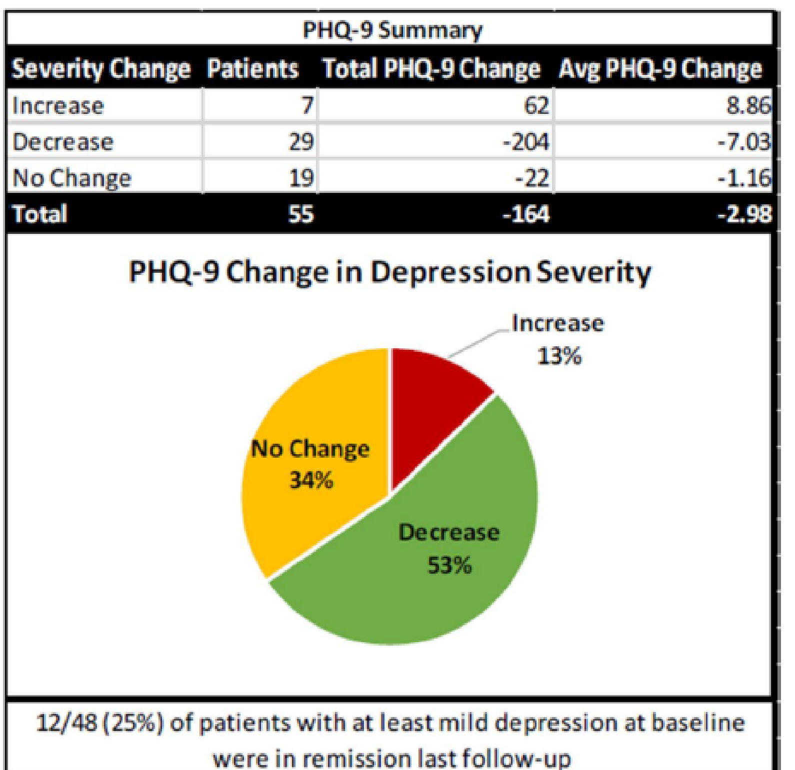
COCARE PHQ-9 OR GAD-7 UNCHANGED

- Readiness of the patient for change/engagement
- Need for outpatient psychiatry referral for medications not prescribed by a PCP
- Need for more specific therapy (EMDR, brainspotting, ECT) that is not provided via CoCM relationship

COCARE PHQ-9 OR GAD-7 INCREASES

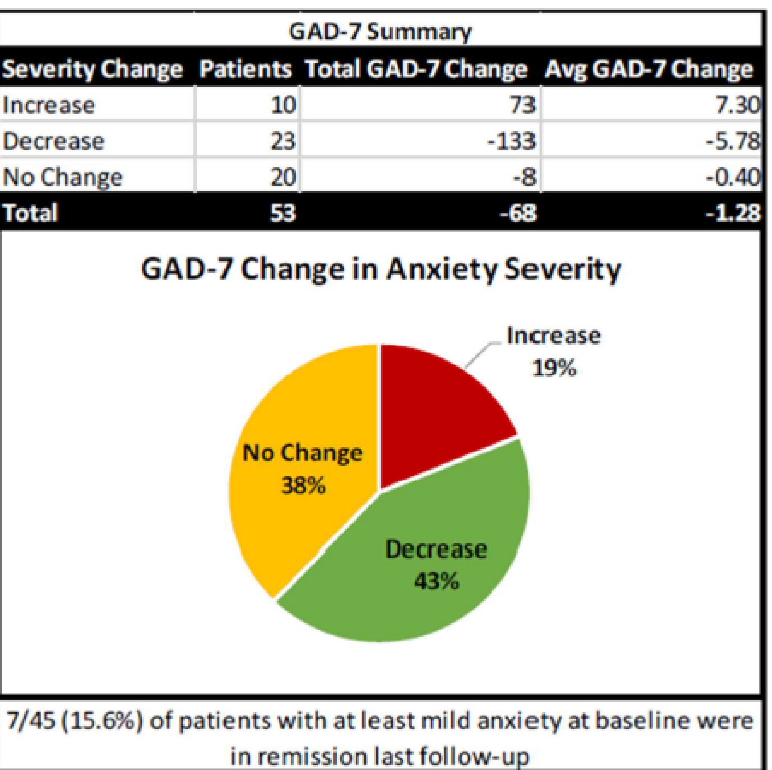
- Known fluctuations in screening results for individual patients
- Worsening scores during unpacking of psychological trauma
- Hesitancy by enrollees to start medications
- Uncovering of what are generally non-PCP-related diagnoses (e.g. bipolar disorder, schizophrenia, etc.)
- Strategies
  - More frequent touches for patients enrolled in CoCare
  - In house therapy by psychology / LMSW when medications not desired
  - Referral to psychiatry

HVPA CoCM Program – Data Summary



PHQ-9 Summary			
Severity Change	Patients	Total PHQ-9 Change	Avg PHQ-9 Change
Increase	7	62	8.86
Decrease	29	-204	-7.03
No Change	19	-22	-1.16
Total	55	-164	-2.98

12/48 (25%) of patients with at least mild depression at baseline were in remission last follow-up



GAD-7 Summary			
Severity Change	Patients	Total GAD-7 Change	Avg GAD-7 Change
Increase	10	73	7.30
Decrease	23	-133	-5.78
No Change	20	-8	-0.40
Total	53	-68	-1.28

7/45 (15.6%) of patients with at least mild anxiety at baseline were in remission last follow-up

www.hvpa.com

2002 Hogback Rd. #3 | Ann Arbor, Michigan 48105 | 734-973-0137 | 734-975-1248 fax

Story 1

I’ve worked with several teens who have been successful in the CoCM program who are now discharged.

With the correct medication recommendations from Dr. Block and support from the BHCM (me), they have been successful and have been discharged from the program.

Most of them needed just a little support and the right medications to get them through the tough transition to high school and they are now doing great.

They are discharged with the knowledge that they can come back to the program anytime if their situation changes.

Story 2

Patient G.C a 73-year-old female, enrolled in CoCM in April 20223 with a PHQ 9 of 10 and GAD 7 of 14. She was diagnosed with moderate major recurrent depression several years ago and recently began feeling more anxiety due to her husband's health issues. Fluoxetine was increased from 20 mg to 40 mg, per Psychiatrist Consultant's recommendation. Patient reported improvement in depression shortly after the dose increase, but still reported some anxiety. We worked on mindfulness techniques, such as deep breathing and progressive muscle relaxation, as the patient did not want to add another medication to target anxiety specifically.

Behavioral health care manager continued to follow patient for symptom monitoring and support.

Sleep hygiene, behavioral activation, and mindfulness techniques were implemented by BHCM during in person and virtual visits, wherein BHCM would check in regarding meds and any side effects, while providing patient education around coping skills.

Patient stayed in program for a total of 5 months, while checking in monthly with BHCM. When she felt ready to discharge, her PHQ 9 had decreased from a 10 to a 2, and GAD 7 went from a 14 to a 2. The patient completed a relapse prevention plan, and reported that her sleep, exercise, hobbies, and mood significantly improved since enrolling in Collaborative Care.

As a team, we were satisfied with the results and feel that our collaborative efforts helped the patient improve considerably.

United Physicians Behavioral Health Collaborative Care Management Program

Sara Baig, MPH, Senior Manager, Behavioral Health and Clinical Quality Programs

United Physicians, Inc.
Independent PO-practice collaboration

Centrally supported, PO led program

PO Staffing

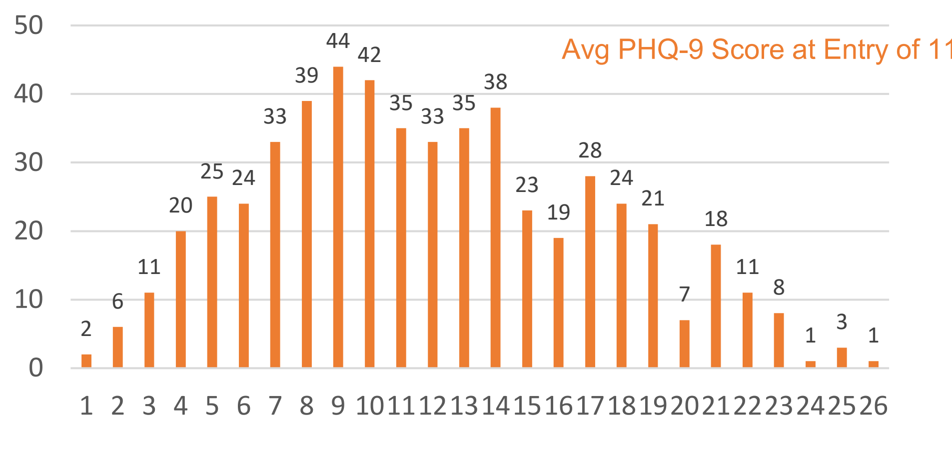
- Program Manager
- 4-6 BHCMs
- 2 Psychiatric Consultants (0.4FTE)
- Billing and Scheduling support

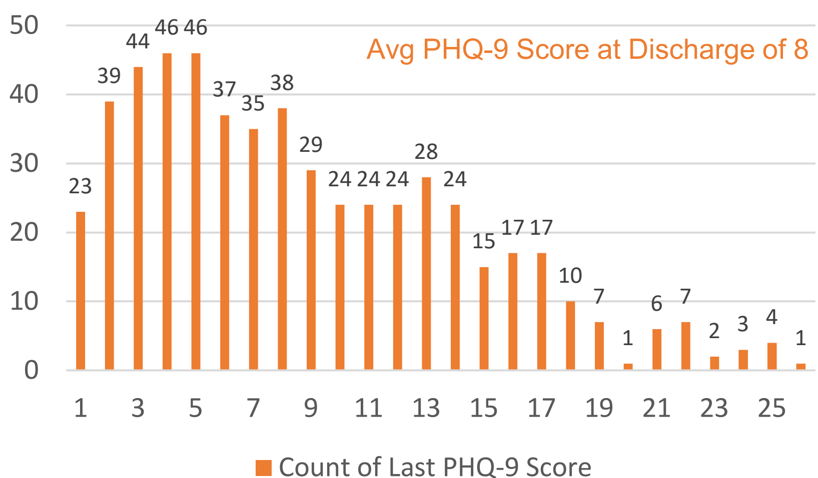
- PO delivers services at no charge to practice
- PO reports outcomes for practices
- PO bills for CoCM services
- All services are delivered via telemedicine

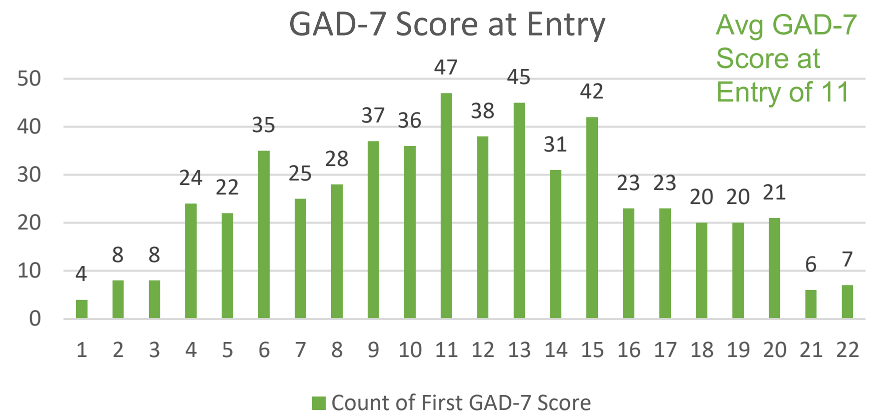
30 Practices

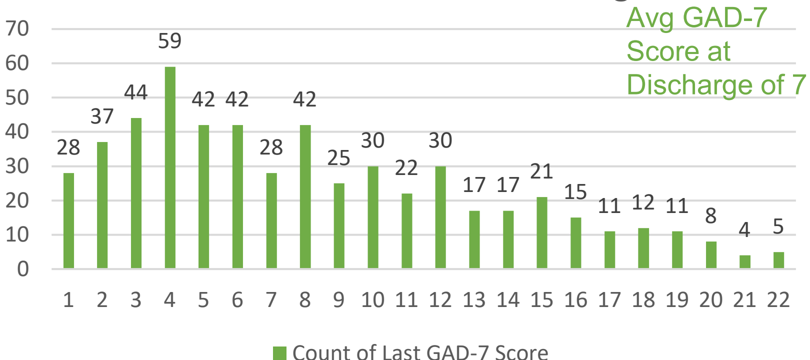
- 146 physicians
- 13 Pediatric with 52 physicians
- 9 Lifecycle with 33 physicians
- 7 Adult with 40 physicians
- 2 OB/Gyn with 21 physicians

- Practices screens all eligible patients with PHQ9 and GAD7
- Practices meet biweekly with BHCM
- Practices expected to demonstrate "meaningful participation" with average panel of 3-5 patients/provider to be considered eligible for VBR nomination

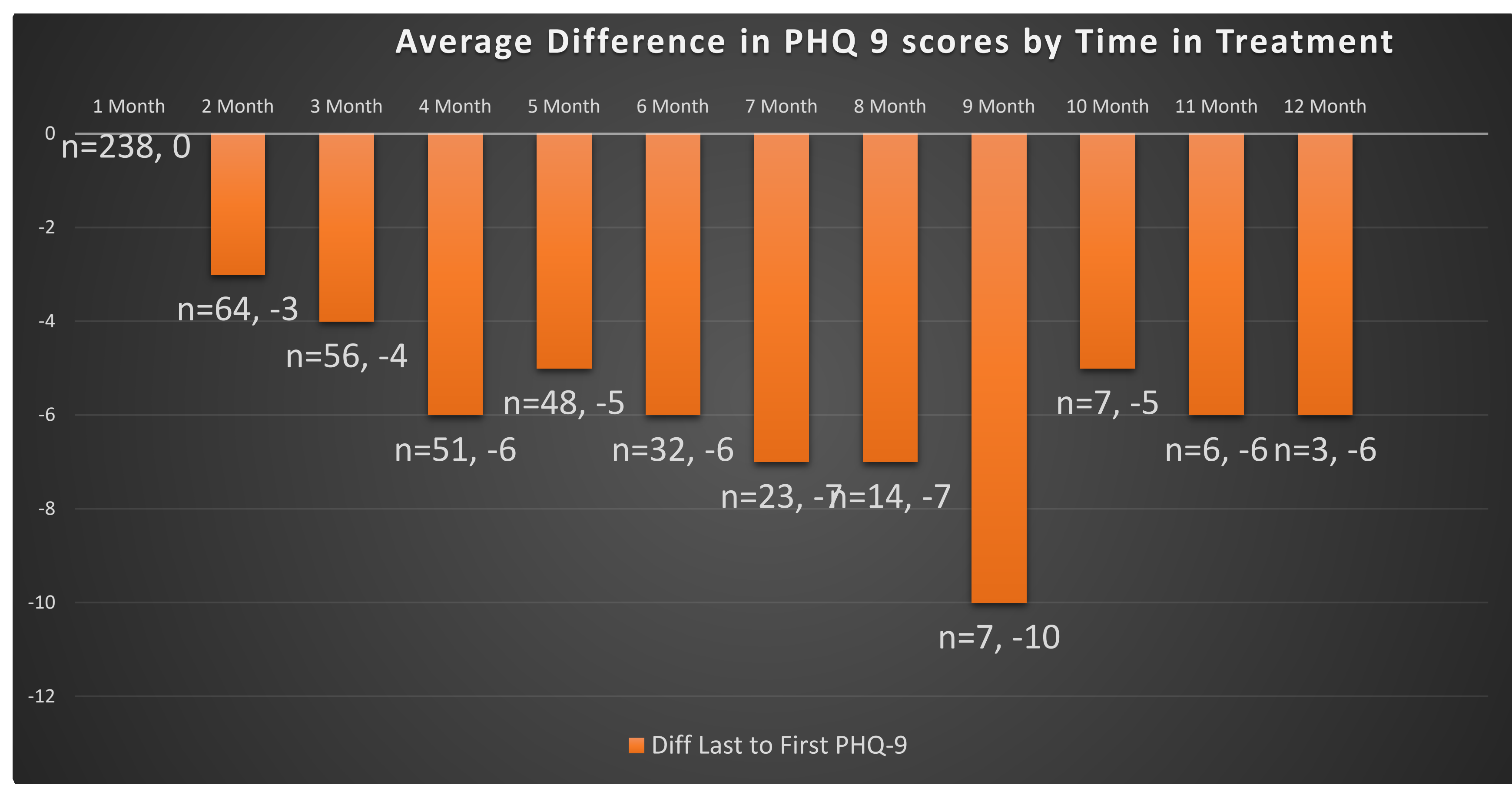




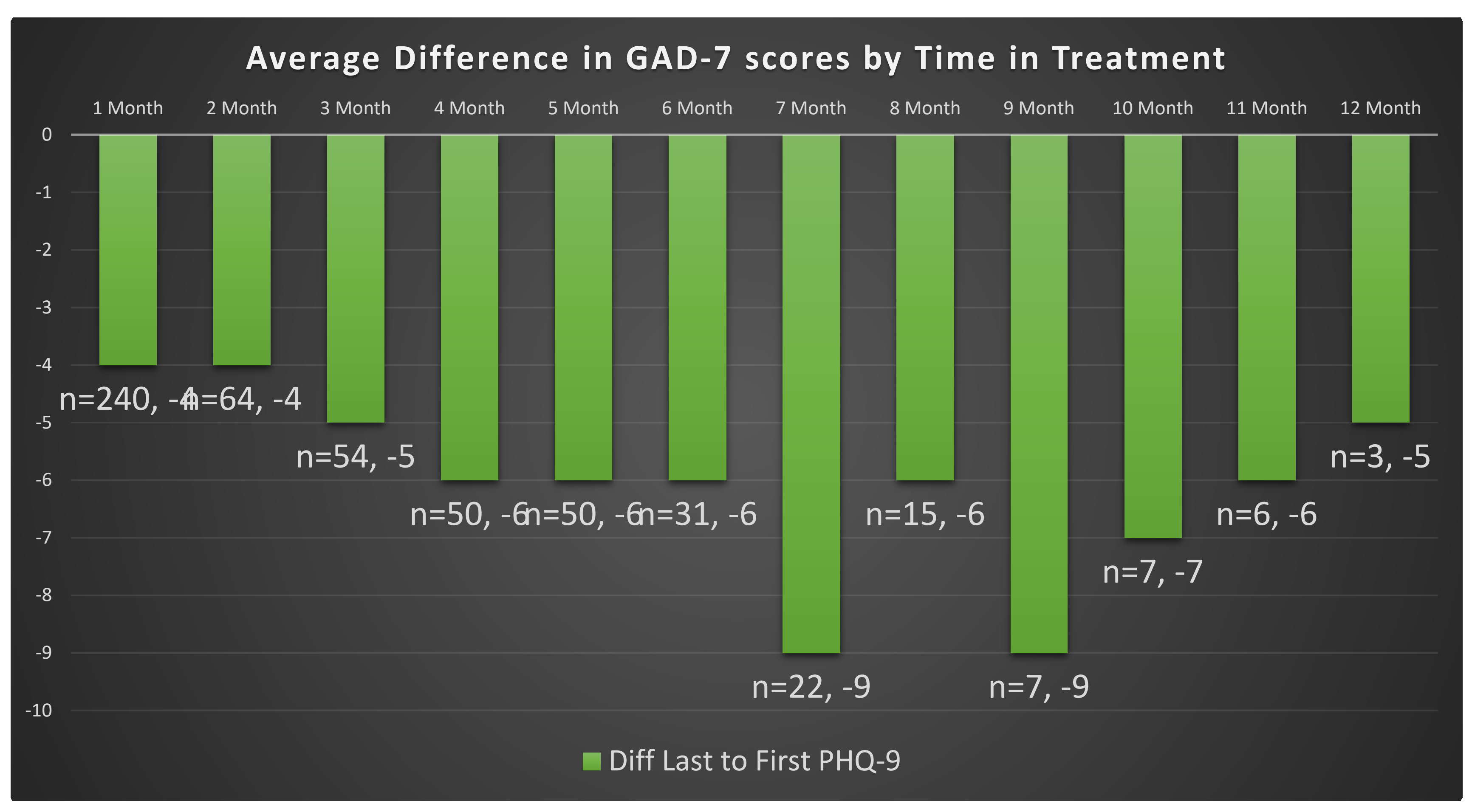




560 patients enrolled and discharged from program – average treatment duration = 20 weeks



Average Difference in PHQ 9 scores by Time in Treatment
1 Month
2 Month
3 Month
4 Month
5 Month
6 Month
7 Month
8 Month
9 Month
10 Month
11 Month
12 Month
0
-2
-4
-6
-8
-10
-12
n=238, 0
n=64, -3
n=56, -4
n=51, -6
n=48, -5
n=32, -6
n=23, -7
n=14, -7
n=7, -10
n=7, -5
n=6, -6
n=3, -6
Diff Last to First PHQ-9


Average Difference in GAD-7 scores by Time in Treatment
1 Month
2 Month
3 Month
4 Month
5 Month
6 Month
7 Month
8 Month
9 Month
10 Month
11 Month
12 Month
0
-1
-2
-3
-4
-5
-6
-7
-8
-9
-10
n=240, -4
n=64, -4
n=54, -5
n=50, -6
n=50, -6
n=31, -6
n=22, -9
n=15, -6
n=7, -9
n=7, -7
n=6, -6
n=3, -5
Diff Last to First PHQ-9

LUNCH

Please join us back here at 1

Transitions of Care Approaches

Sandra Kaltz, McLaren Physician Partners
Annette Price, Silver Pine Medical Group, United Physician, Inc
Susan Nason, Bronson Network LLC
Carissa Cowen, Munson Healthcare Clinically Integrated Network, Northern Michigan Care Partners

Sandra Kaltz, BSN, RN
Care Coordination Manager

- 6 dedicated TOC member
- Supportive team includes RN
- Centralized, process about 1800 per month
- Mihin to identify ADT activity and flows into our population health tool
- Attempt to schedule follow up appointments
- Patient unwilling at time of call directed to office/ office notified and contacts them
- Barriers include:
  - Different workflows for employed vs non-employed
  - Lower engagement rate for patient we call (36% engagement rate on initial phone call)

McLaren Physician Partners (MPP)

Transition of Care Program

Speaker: Sandra Kaltz RN, BSN

Team Structure-Overview

McLaren Physician Partners (MPP) Care Coordination

- Manager: Sandy Kaltz RN, BSN
- Care Coordination Department Team Composition: RN, LPN, MSW, Navigator
- Dedicated TOC Team: 6 Patient Navigators
- Patient Navigators- Non-licensed individuals & Occupational Therapist

Program Structure Overview

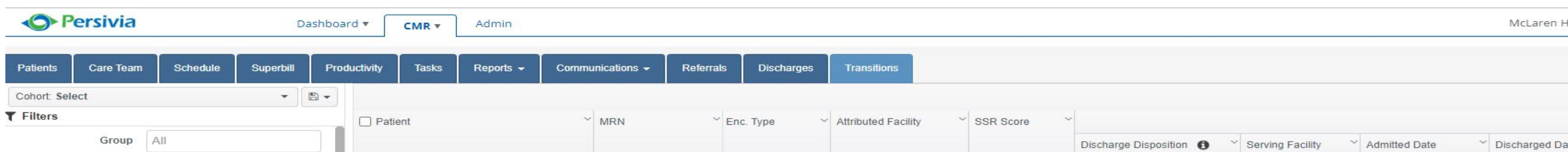
Transition of Care Program

- Target Population: Attributed (patients in at-risk contracts)
- Total Physician Membership: 2700
- PCP Membership: 30% (810)
- Source: ADT-MiHiN
- Volume: 1800 Inpatient discharges processed per month

Notification

Transition of Care Program

- Attributed patient files are sent to Michigan Health Information Network (MiHIN) every month
- Admission Discharge Transfer (ADT) Notifications are sent from MiHIN to our Population Health Management Software- (Persivia)
- Cerner Hospital Discharge List –MPP Physician Member Patients
- Internal referral process
- Department phone number on hospital discharge instructions



Notification Process

Transition of Care Program

- Population Health Management Software- Persivia
  - Sort the daily feed of previous day discharges
  - Inpatient, Observation, Psych, SNF
  - Review & assign to Patient Navigator’s schedule
  - Average 25 outreach per day/ per person (including 2-week follow-up)

Outreach Frequency & Assessment

Transition of Care Program

Outreach (Appt. Reason)	Outreach Timeframe	Assessments to Complete
TCM Initial Outreach	within 2 business days of D/C	**TCM Assessment + SDOH**
TCM 2nd Attempt	next business day following initial outreach attempt	
TCM Follow-Up *(if not referred upon initial outreach – see referral guidelines)*	after follow-up appt w/ provider *OR* 1-2 weeks post initial outreach	**TCM/ED Follow-Up + SDOH** *(if not prev. completed)*

Scheduling

Goal within 14 days with a focus on 7 days

Employed

- Directly schedule in Cerner while on phone
- Communicate in Cerner to front office for assistance in scheduling

Non-Employed

- Assistance offered/patient encouraged to schedule
- Communicate via phone/email/fax to office for assistance in scheduling

Communication to Provider

Subject:

TOC ACTION REQUIRED

Body:

The specified patient below was contacted for initial TOC outreach and needs an appointment. Please contact the patient to schedule a transition of care appointment within 14 days from discharge.

Provider:
Patient Name:

Patient DOB:

Inpatient Discharge Date:

Billable Codes for Transition of Care

- **CPT code 99495** - Requires direct contact within 2 business days of discharge (TOC Outreach) and medical decision of ***moderate complexity*** during a visit within ***14 calendar days*** of discharge
- **CPT Code 99496**- Requires direct contact within 2 business days of discharge (TOC Outreach) and medical decision of ***high complexity*** during a visit within ***7 calendar days*** of discharge
- **If seeing patients outside of the 14 day window, between day 15 – 30 post discharge, please bill the appropriate E/M code and include CPT II Code 1111F to document that a medication reconciliation was performed.**

Additional Transitional Support Services

- Lists sent to practice each week with eligible patients
- Refer into another program if patient agreeable and would benefit
  - Chronic Care Management (CCM)
  - Complex Care Management Services (CCMS)
  - Remote Patient Monitoring (RPM)

Remote Patient Monitoring

Post-Discharge Program

- Self Reporting for high-risk inpatient discharge
- Enrolled in about 3 days after discharge
- Receives one-five messages x four weeks
- Communication sent as reminder to schedule a follow-up appointment

Regarding your recent visit, if you need assistance scheduling follow-up care, have any questions regarding your recent illness or have questions about your discharge instructions or medication plan, please call (833) 508-0670

Data For	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
General Medical - High-Risk Discharge (Post Discharge)												
Total Enrolled							124	144				
Total Alerts							85	112				
Issue Breakdown												
Fever/Chills							9	4				
Nausea/Vomiting/Diarrhea							8	11				
Stomach/Abdominal Discomfort							15	8				
New/Painful Rash or Skin Redness							9	6				
New/Worse Cough							8	5				
Difficulty Breathing							7	6				
Leg Swelling							11	12				
Changes or Discomfort with Urination							11	9				
Concern about missing dialysis appts, symptoms, or access sites							2	4				
Positive ROS Symptoms								1				
HTN												

TOC and Readmissions

IP & SNF Discharge Claims

PCP Region: All

Reporting Month: Oct 2022

Inclusion: IP & SNF discharges

Employment Status (All)

Average of 30-Day All Readmission Rate	Column Labels				
Row Labels	**1-7 Days**	**8-14 Days**	**15-30 Days**	**No TOC**	**Grand Total**
Region 1 - Oakland	15.0%	9.2%	15.0%	35.3%	16.7%
Region 2 - Macomb	15.4%	9.6%	12.9%	27.0%	16.0%
Region 3 - Flint	13.5%	10.1%	8.1%	24.7%	14.1%
Region 4 - Greater Lansing	11.6%	6.8%	7.9%	28.2%	13.2%
Region 5 - Bay	14.5%	12.7%	13.0%	31.3%	16.8%
Region 6 - Central	14.2%	10.9%	9.1%	32.0%	16.4%
Region 7 - Port Huron	11.8%	10.5%	13.6%	38.2%	16.3%
Region 8 - Northern	16.4%	5.4%	9.9%	31.6%	15.9%
Region 9 - Lapeer	14.3%	15.7%	16.1%	27.7%	17.6%
Region 10 - Wayne	40.0%	25.0%	0.0%	40.0%	34.4%
Region 13 - St Lukes	10.4%	7.8%	2.4%	40.9%	12.5%
Unknown				0.0%	0.0%
Grand Total	**14.00%**	**9.50%**	**10.57%**	**30.22%**	**15.47%**

Readmission Rate

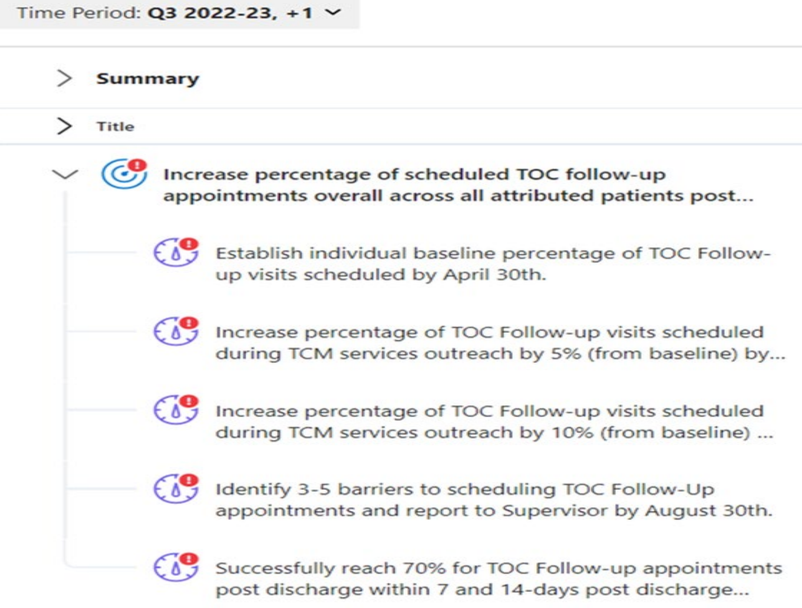
PCP Region: (All)

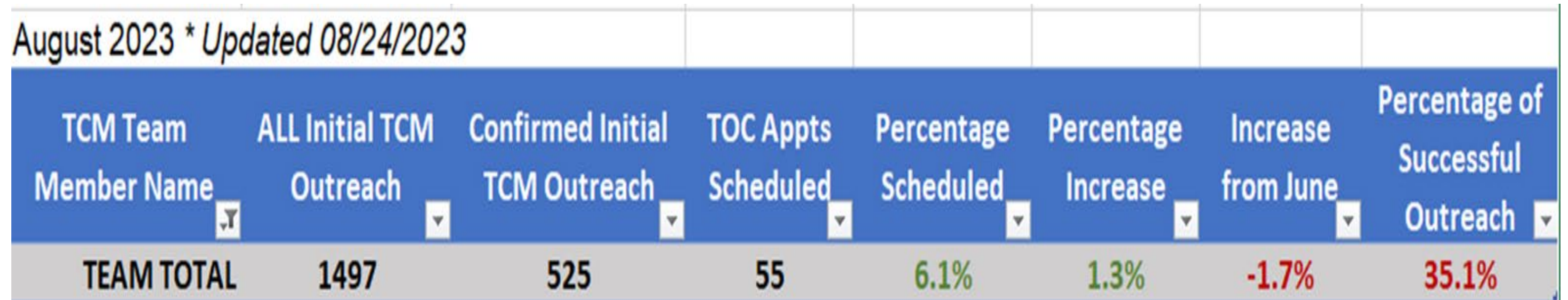
Employment Status: (All)

Average of 30-Day All Readmission Rate Row Labels	Column Labels 1-7 Days	8-14 Days	15-30 Days	No TOC	Grand Total
Vascular	15.8%	25.0%	0.0%	28.6%	19.0%
Cardiovascular	15.8%	10.6%	17.5%	40.2%	18.4%
Endocrinology	10.6%	14.6%	13.0%	43.2%	18.1%
Other General Medicine	11.4%	12.5%	18.2%	38.9%	18.0%
Pulmonary Disease	17.0%	9.1%	9.8%	33.9%	17.9%
Nephrology	19.1%	15.2%	13.2%	22.4%	17.9%
Gastroenterology	15.5%	9.3%	13.6%	37.8%	17.5%
Infectious Disease	18.1%	10.2%	4.8%	33.8%	16.7%
Dermatology	16.7%	10.0%	12.5%	26.7%	16.5%
Oncology/Hematology	21.2%	0.0%	10.0%	25.0%	15.5%
Spine	14.3%	20.0%	0.0%	25.0%	14.7%
Neurology	9.6%	7.4%	8.6%	29.8%	12.4%
Trauma Medical	15.0%	0.0%	0.0%	25.0%	11.1%
(blank)	7.6%	5.4%	6.2%	19.0%	9.7%
ENT	0.0%	16.7%	0.0%	50.0%	8.8%
Orthopedics	6.3%	0.0%	0.0%	18.2%	7.9%
Urology	0.0%	33.3%	0.0%	0.0%	7.7%
Psychiatry or Substance Abuse	0.0%	0.0%	0.0%	0.0%	0.0%
Gynecology	0.0%	0.0%			0.0%
Grand Total	14.00%	9.50%	10.57%	30.22%	15.47%

Team Outcomes

- Department Goals
- Individual Goals – Weekly Tracking
- Process Improvement
- Real-Time Scheduling Barriers





August 2023 * *Updated 08/24/2023*

TCM Team Member Name	ALL Initial TCM Outreach	Confirmed Initial TCM Outreach	TOC Appts Scheduled	Percentage Scheduled	Percentage Increase	Increase from June	Percentage of Successful Outreach
TEAM TOTAL	1497	525	55	6.1%	1.3%	-1.7%	35.1%

Challenges and Barriers

7-Day Follow-up

- Employed vs. non employed workflows
- In some cases-no physician availability
- Many provider bill E&M visit and not TCM code
- Patients with transportation or social issues are support by Care Coordination team (or Social work)
- 35% successful outreach rate (lack of engagement)

Annette Price
Quality Manager
Silver Pine Medical Group
United Physician, Inc

Silver Pine Medical Group- TOC Team

Care Management Team:

- Patient Care Coordinators
  - CMA or RMA certified in Care Management
- Care Managers
  - RN
  - NP / PA
  - LMSW
- Physicians
- Data Analyst
- Quality Manager

Silver Pine Medical Group- TOC Process

SILVER PINE
MEDICAL GROUP

Process Overview:

- PCC pulls discharge reports
- PCC downloads discharge summaries
- PCC attempts to schedule patient within 2 business days
    - Successful: document & close
    - Unsuccessful: document & send to Care Managers

- Care Manager contacts patient
    - Discharge summary review
    - Medication Reconciliation
    - Addresses Barriers, Educates, & Provides Resources
    - Ensures appointment is scheduled
    - Documents discussion & close

- Clinician completes Hospital Follow-Up appointment
- PCC follow-up with patient 30 days post discharge
- Care Manager will follow-up pending PCC engagement note

Susan Nason, BSN, RN, CMC
Ambulatory Care Navigator
Bronson Centralized Disease Management

- Our team uses a mix of licensed and unlicensed personnel
- Medical Assistants call low and medium risk patients
- Registered Nurses call high risk patients
- We have RNs, pharmacists, and Social Workers imbedded in primary care offices in addition to a centrally located team with RNs, MAs, ASAs, and social workers
- We are planning to start utilizing MAs for medication reconciliation soon (with billing)

Carissa Cowen, CMA
Care Team Coordinator
Clinically Integrated Network

- Team includes Carissa and another trained Certified Medical Assistant to do hospital follow up calls for Munson Healthcare's outpatient primary care offices. We currently have 11 clinics we are doing calls for with more to be added.
- Carissa has been doing TOC calls since 2018 for the resident clinic, Munson Family Practice.
- We get our lists of discharged patients from McKesson STAR Reports, McLaren NM direct EMR access, MiHIN ADT Inbox, Right Fax notifications.
- We call all TOC patients and go over their discharge summary, along with also scheduling their TOC with their PCP.

Transitions of Care Discussion

Thank You for Joining!

Please complete the evaluation
e-mailed to you after the meeting.