Care Management Recognition Rewards: Best Practice Submission

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## Executive Summary

Patient engagement has been a challenge for many care management programs around the state. Physicians who discuss care management with patients and provide a warm hand-off to the care manager are more successful with patient engagement and adherence to a self-management program than those who do not. After the conclusion of the Michigan Primary Care Transformation (MiPCT) program, Clinton County Medical Center (CCMC) saw an opportunity to restructure its office staff, including care managers, into physician-led teams to offer care management to all patients who could benefit from it. Through the changes in workflow over an 18-month period, CCMC was able to substantially increase engagement in both Provider Delivered Care Management (PDCM) claims and overall longitudinal care management.

**Category:** Care Management Workflow
**Title:** *Restructuring Practice Workflow to Enhance Care Management Engagement*
**Start date**: June 2017
**End Date:** December 2018
**Goal:** To increase patient engagement in CCMC's Care Management program by ensuring care management is discussed with all patients during their appointments.

## Development

The process change was initiated by Dr. Messenger, the office manager, the nurse practitioner who oversees the care managers, and all care managers. Together they determined the best approach, after learning some lessons from MiPCT participation, for patient engagement through team-based patient care. Dr. Messenger wanted to ensure that all of the patients were afforded the opportunity to work with an RN care manager to improve outcomes.

## Program Description

Each physician-led team member in the practice is banded up with an RN care manager and a medical assistant (MA) in one physical location to serve that physician's attributed patients. These team locations are called pods. The role of the MA is to room the patient and assist with medication reconciliation. The role of the care manager initially is to scribe for the physician. This put the care manager in the room with the physician team member during the patient visit. This allowed the care

manager to discuss patient needs or concerns with the physician and the patient for a well-rounded warm handoff. The physician is then able to share the importance of care management to the patient with the care manager in the room. The care manager stays in the room to discuss plan of care and next steps.

Early in the program, the scribing RN care manager handed off to another RN care manager for the patient's return face-to-face appointment or phone call follow-up. Patient feedback suggested that the original RN care manager be the one to follow up with the patient for continuity of care. This change was made within a few months of starting the team-based workflow.

In addition to care managers being assigned to pods, other additional care managers are available to see scheduled patients, ensure care management follow-up phone calls are being completed, as well as transitional care management (TCM) for hospital admissions. They are also available to provide "relief" care management with patients being seen in the pods when the care manager has more than one patient needing attention at the same time. This may occur, for example, when a complicated patient needs more time devoted to the appointment and the next patient has arrived.

## Patient Identification

Two methods are utilized for patient identification for when day-to-day operations prevent care managers from being in the room of every individual patient. First, the patients are risk-stratified in the electronic medical record (EMR) to depict low, medium, and high risk. This risk flagging was manually completed by the lead care manager of the practice using the American Academy of Family Physician's "Risk Stratified Care Management and Care Coordination" medical model of risking patients 1 through 6 (6 being the highest risk). The quality coordinator of the practice then reviewed each physician team's daily patient schedule 1 to 7 days in advance and placed medium to high risk patients on the care managers schedules of their respective pods. Other patients who were added to the care manager's schedule included State Innovation Model (SIM) and CPC+ Medicare patients. The pod care manager arrives to work with a full schedule of patients to see for the day.

The second method for identifying patients was having the care manager in the room identifying patients while scribing for the physician. This occurs when the care manager is available and not seeing patients identified by the method above. For example, if the patient was not flagged by the quality coordinator prior to the appointment, the RN Care Manager and physician were able to refer based on other needs, including social determinants of health (SDoH).

## Measurement of success

During the MiPCT program various care management workflows were utilized to address a mostly all payer model for care management. Knowing that outcomes are greatly improved with care management support, the team set out to offer care management to the full attribution where possible. Measurement of the newly developed care team workflow was based on three measures:

1. Increase number of BCBSM PDCM claims by 100%
2. Increase number of BCBSM PDCM claims with 2 or more touch points by 100%
3. Increase number of BCBSM PDCM longitudinal claims by 100%

## Outcomes

According to claims activity reports provided by BCBSM,

1. Total PDCM claims were 790 for 2017 and 2804 for 2018. An increase of 255%. (See Appendix A)
2. In 2017, CCMC had 140 unique patients with 2 or more PDCM claims. In 2018, this number increased to 481. An increase of 244% (See Appendix A)

3. In 2017, CCMC had 141 PDCM claims, compared to 734 in 2018. An increase of 420%. (See Appendix B)
    a. CCMC was able to demonstrate an increase in longitudinal care management for their BCBSM population. Longitudinal visits ranged from 2-10 visits per patient throughout the year. Two and three visits per patient revealed the greatest growth. However, 4-10$^{+}$ visits per patients also demonstrated meaningful increases in longitudinal engagement as well. In some cases, patients were seen as many as 27 times in one year. (See Appendix B)

## Processes & Resources Utilized:

Frequent team meetings occurred in the planning stages of the process. The decision to move to pod-based structure, in addition to re-assigning roles for processes like medication reconciliation and scribing, all contributed to a new workflow which ultimately fostered a successful care management program. Once the process was incorporated, meetings occurred on a monthly basis to provide feedback. Revisions were based on challenges and identified opportunities for efficiencies.

## Why This Work Matters:

This work is important because CCMC is a great example of how a practice or organization can learn from prior experiences and adapt their workflow(s) to achieve success and provide optimal patient care. Once part of the MiPCT program, CCMC was able to identify workflow deficits affecting patient engagement. Revamping their entire workflow has allowed them to be instrumental to meeting with most patients within the practice within a relatively short time frame. Care managers working closely with physicians and medical assistants has demonstrated to patients the importance of joining their care management program. When patients self-manage, outcomes are expected to improve. Costs attributed to patient's care are also lowered.

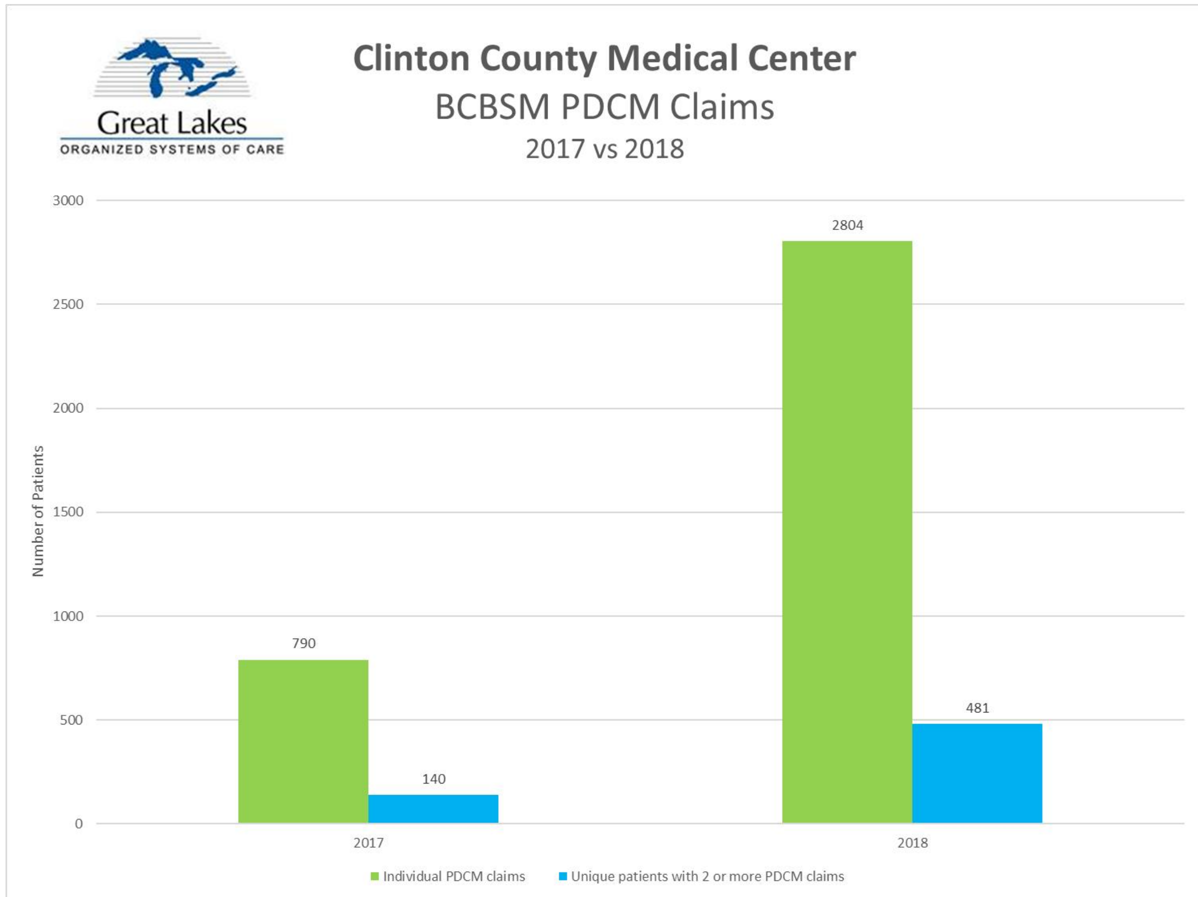
## Utilization of Funds:

Funds received through this award will be utilized in two ways. First will be to expand the CHL role to all GLOSC practices, including specialists. Roles such as the CHL will continue to be a critically important to quality outcomes and key to the health care team. They offer the real possibility of bettering patient lives by connecting them one-on-one to vital resources while reducing costs and improving health outcomes. Funding will aid in adding additional staff to conduct patient reach-out and assistance in the real of community health. This would utilize approximately 50% of the funding opportunity.

Secondly, it has long been a goal of Great Lakes OSC to employ a pharmacist to aid in programs such as the one described above for our high-risk populations with respect to use of chronic pain medications. The remaining funding (approximately $62,500) would be applied towards funding this position with a long-term commitment in mind.

## Appendix A

*CCMC BCBSM PDCM Claims (2017 vs 2018)*



## Appendix B

*Longitudinal Care Management Trends (2017 vs 2018, BCBSM)*