Care Management Recognition Awards
Best Practice Submission Template

Contact Information:
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Physician Organization Name: HVPA
Practice Name: All
Practice Address: 2002 Hogback Rd, suite 3, Ann Arbor, Mi 48105
How many physicians in practice: between 1 provider to 6 providers in an office.
Describe of care team (number of care team members and their degrees/qualifications, at the time of the best practice activity): MSW Behavioral Health Care Managers, RN Care Managers, MA Care Coordinators

Executive Summary (5-8 bullet points, must include summary of results)
HVPA is a Physician Organization of independent physicians who has created a care management program which provides different options for each office to be able to engage in care management and/or care coordination services.

- Embedded Care Manager leased from HVPA
  - HVPA Care Manager will work in the office a minimum of 8hrs per month.
- Centralized Care Manager leased from HVPA
  - HVPA Care Manager will work at a centralized location for an office a minimum of 8hrs per month.
  - Team conference meetings are a requirement a least once every other week with the provider from the office.
- Office hires or trains their own care manager or care coordinator
  - HVPA will cover the cost of the required training
  - HVPA to host monthly CM/CC workgroups to make sure all office trained staff are on target and compliant with CM/CC program.

Category of Submission (see page 1):
Care Management Workflow

Title of Submission:
Options for the Independent Physician to participate in care management services.

When did the intervention start and end? (1-2 sentences)
Our intervention started in March 2019 and has been an evolving program that we are developing in 2019. We are expected to have all offices engaged in some level of care management services by September 2, 2019, however this will be an ongoing intervention that will need to be followed and tracked to measure the success of the program.

Goal of the Program/Intervention: (1-2 sentences)
The goal of this program is to have all HVPA offices engaged in care management services that works best for their individual practice and their patient population, which primary focus is to decrease ED/IP utilization, reduce cost-of-care, close quality gap measures and connect patients to community resources as applicable.

Who developed the program/intervention, and how? (2-4 sentences)

HVPA leadership, Quality team and Care Managers developed this program during collaborative workgroups. Having collaborative conversations with the whole team has helped us to make sure all needs of the care management workflows are met. Having input from the whole team has allowed us to develop what we believe will be a more sustainable program in the long-term.

Description of the Program/Intervention (2-3 paragraphs)
There are three options that the office can choose from in order to be engaged in care management or care coordinator services with the goal of reducing ED/IP utilization. HVPA has hired two full-time care managers that the office can lease at an hourly rate to work in their office for a minimum of 8 hours per month. The HVPA care managers can also work centralized from HVPA for the office if the office feels that a centralized outreach for high ED/IP utilizers would work best. The last option they have is to hire or train their own staff to work as a care manager or care coordinator.

Our goal with the requirement is for each practice to provide care management or care coordinator services to support the reduction of ED and IP utilization. By having a designated person for each office targeting a specific population will offer the additional outreach and support that the patients may require. We will be relying on real-time ADT data feeds as well as monthly reports to identify ED frequent utilizers, those with ED PCP treatable diagnosis as well as patients IP patient discharges (TCM)

How were patients identified for the program/intervention? (1-2 paragraphs)
Patients are identified for the care management/care coordination program and intervention based on their diagnosis conditions, risk scores and ED/IP utilization. Patients being identified for these services will also depend on which CM/CC program the practice is participating with.

Embedded and Office trained Care Manager patient population of focus:

1. Episodic Care Management:
    a. ED/IP event or high utilization
    b. Social Needs barriers
    c. Life event
2. Longitudinal Care Management:
    a. Uncontrolled chronic conditions or multiple chronic conditions
    b. Frequent IP utilization and readmissions
    c. Limitations to perform daily activities of life due to physical, mental and/or psychosocial changes

Centralized Care Management or office trained Clinical Coordinator patient population of focus:

1. Episodic Care Management/Care Coordination
    a. ED or IP event follow-up
    b. Uncontrolled chronic condition – additional support to meet goals and any care coordination for other appointments or resources.
    c. Social Needs barriers – provider referral

How was success measured? Please delineate whether metrics were process-based or outcome-based (2-3 paragraphs)
We are currently tracking ED utilizations for all offices and would anticipate that the offices who are engaging in CM services and doing this work would have a lower utilization.

What were the program results? Include qualitative data/graphs (2-3 paragraphs)
Offering the different types of care management is a new program that HVPA is implementing into each primary care physician practice. However, we did have a few practices who started their care management engagement prior to this program modification. We have seen with these practices that their ED utilization has improved and is trending to be lower compared to the year prior. We would expect this to be the trend amongst all of HVPA PCP offices that are engaging in care management services.

Were any new tools, processes, or resources developed to aid in the implementation of the program/intervention? (1-2 paragraphs)
HVPA developed a monthly report that identifies each practice ED utilization along with a patient list, which identifies patients who access or are frequent utilizers of the ED as well as if they are utilizing the ED for PCP treatable reasons. This report is then distributed to all PCP practices each month and reviewed with their Practice Coach to discuss what ED education and intervention steps are taking place to include the workflow of their care manager or care coordinator.

What are you proudest of regarding this submission? Why does this work matter? (1-2 paragraphs)
We are proud of this program model because we can offer alternatives for independent physician practices to implement a level of care management services that are more financially amendable, meets their practice and patient needs an ultimately can be more sustainable for the long-term.

This work matters in order to offer care coordination and self-management support to our patients who have complex conditions. This work also matters to our network for us to be able to identify high-risk populations that need additional support and for us to work on decreasing ED utilization and overall cost or care.

How will your organization use the funds if your submission wins? (1 paragraph)
If our submission wins, we would use the rewarded funds to reinvest into our care management program by the following items.

1. Hire another HVPA care manager or care coordinator to support our physicians.
    a. We would consider hiring a RN to be focused on medical care management task that could be leased to the office to work as their care manager.
    b. We would consider hiring a skilled MA to focus on care coordination of ED utilization and/or to focus on community health relationships in order to complete care coordination for patients who are identified as having social needs.
2. Support training and education for our office hired care managers and care coordinators
    a. With unpredictable turn-over rates we would need to support our practices for them to be able to sustain a trained CM or CC and we would do this by covering the cost for the required training they need to stay compliant.
3. Support the efforts of utilizing a telehealth vendor
    a. HVPA would cover the initial integration cost and subsidize up to a year of the telehealth monthly maintenance cost for a practice would want to participate in telehealth. Implementing telehealth into the office workflow would offer alternative visits for their patients in order to improve the efforts of care management and decreasing utilization.