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Physician Organization Name: Integrated Health Partners
Practice Name: Wattles Park Family Practice II PC
Practice Address: 391 South Shore Drive, Suite 320, Battle Creek, MI 49014
Number of Physicians in Practice: 1
Description of Care Team: 1 physician, 1 nurse practitioner, 1 care manager, 3 medical assistants

Executive Summary:

- Care management has been an integral part of the practice since 2012.
- Care management uses a team-based approach for maximum effectiveness.
- The care manager meets with every new patient, explains his role, and provides a business card for future reference.
- A team approach to managing the care of patients on opioids contributed to a reduction in ED use. The care manager works closely with the physician in decreasing and eliminating patient opioid use.
- Reduction in ED utilization contributes to reduction in avoidable inpatient admissions.
- Weekend usage of the ED has decreased from 25 patients per weekend to an average of five patients or less in the past two years.

Category of Submission: Reduction in Utilization

Title of Submission: Care Management Positively Impacts ED and Inpatient Utilization

Intervention Overview:

Care management began in our practice as part of the Michigan Primary Care Transformation project in 2012. Originally, the physician organization provided care managers at the practice for a specified number of hours per week; however, we quickly realized the need for on-site care management. The opioid intervention described below began in June 2018. The behavioral health intervention began in 2016. The goal of care management is to support patients in addressing chronic conditions, including chronic pain and depression, to promote improved quality of life. In addition, the program supports our providers by expanding the use of our practice team. Program development has been an evolution driven by patient needs and practice innovation. With the help of our physician organization, care managers have been educated and continue to be a part of the Care Management Collaborative, which provides an opportunity to learn and share best practices. We are always looking at ways to improve patient care.

Intervention Description:

Care management is a team approach within our office. This team approach facilitates improved accessibility and care, thereby decreasing unnecessary utilization of emergency department (ED) services. Care management starts at the front desk, ends with the provider, and includes everyone in between. The front desk staff assist with calling the patients the day before the appointment to ensure they remember their appointment and prevent a cancellation that might result in an ED visit. The front desk staff is the first contact with the patient. They notify the care manager if they notice the patient is upset. If a patient is unable to pay the co-payment or balance due on their account, they are referred to the care manager. The care manager conducts outreach to the patient to assess social determinants of health and additional needs of the patient that might prevent him/her from coming to the office for care. This avoids an

inappropriate ED visit that might result due to the patient's concern over a bill or due to lack of transportation. Referrals are made directly by the provider and medical assistant as well. This can be done during a morning huddle or throughout the day as the need arises. Patients are also educated on use of the office and availability of the physician after-hours and on weekends. This is reiterated to the patient by the care manager and is on the patient care plans. Depression screening is completed using the PHQ-9. The care manager trained in integrating behavioral health into primary care and an LMSW who comes on-site weekly assist in depression management which, without intervention, would lead to an ED visit.

The care manager meets with every new patient; the role of the care manager is explained at that time. While meeting with the patient an assessment is made to determine if care management is needed. If the patient has no needs, a business card is given with the direct line of the care manager for a resource. The lead medical assistant contacts patients who have recently been discharged from the emergency department. The care manager contacts those discharged from an inpatient stay. The care manager and the lead medical assistant discuss emergency department patients that are high utilizers. The care manager contacts these patients to assess needs. These combined efforts have helped decrease our utilization of the ED and inpatient hospitalizations. Our care manager sits in the same work area as both providers and medical assistants, which aids in the daily huddles and communication about patients needing services throughout the day.

Because we want to make an impact on the opioid epidemic in our community, we began using a team approach with a specific plan using the care manager as a key member of the team. The physician, practice manager (who is a registered nurse), and care manager attended several conferences to obtain resources in developing an effective plan. The care manager meets with all patients currently on prescription opioids. Working closely with the physician, our practice has been very successful with decreasing and eliminating some patients' use of opioids. The care manager meets with the patient every three months to reassess and re-educate the patient on alternative pain management techniques, as well as to determine how successful they are with using the techniques taught. The care plan is revised as needed at that time. This has helped with building a relationship with the patient to ensure success managing their pain. It provides the patient with a contact person for questions or needed reassurance and re-education. We also review the toxicology screen to ensure the patients are taking the medications as prescribed. If the patient is on an antidepressant, we assess adherence to the medication to facilitate the management of fibromyalgia and complex regional pain syndrome. Success with this part of the care management program avoids a common reason for patients using the ED.

Identification of Patients:

There are several methods for identifying patients for intervention. With the general care management program focused on reducing ED visits, all new patients meet with the care manager and are educated on the care manager's role and on patient centered medical home. Physician and practice staff referrals are made based on need; risk stratification identifies highest risk populations; depression screening identifies patients needing behavioral health intervention; and huddles are used to identify patients for care management in real time. Special populations targeted for intervention include diabetic patients and patients taking prescription opioids.

Measuring Success:

Success was measured in two primary ways using outcomes data. First, to be able to focus on weekly results, a count of patients who had been in the ED over a given weekend were counted manually. These numbers are tracked to allow a real-time view of whether interventions undertaken to address ED use are successful. Second, our physician organization provides data on ED visits/1000 and inpatient

admissions/1000, which allows a more longitudinal view of utilization. Additional patient-level reports that show practice visits, ED visits, inpatient admissions, and care management interventions assist with targeting patients for outreach as well as allow us to see whether there were potential interventions missed that could be implemented in the future.

Results:

Weekend usage of the ED has decreased from 25 patients per weekend to an average of five patients or less in the past two years. As indicated on Appendix 1, ED utilization has decreased in adult and pediatric populations for both all ED use and primary care sensitive ED use. Appendix 2 shows a decrease in ambulatory care sensitive conditions, as well as decreasing utilization for all conditions.

Tools and Processes:

We use two assessment tools to evaluate pain and how it impacts the patient's daily life. These tools are the PEG 3 and SOAPP-R. The care manager educates patients regarding alternative pain management techniques. This is done through a teach back method that ensures the patient understands nonpharmacological alternatives and how to implement them into their daily lives. A care plan is developed, in collaboration with the patient, for pain management. A business card is provided with a direct phone number to reach the care manager.

Why This Work Matters:

The real reason why the work matters is better patient care. One example is related to a patient who was taking chronic pain medication and using heroin and accidently overdosed. After his discharge from the hospital, the patient and care manager met at his follow up appointment. Based on a discussion with the provider, care manager, and patient, agreement was reached of the need for substance abuse intervention. The patient was referred to a suboxone clinic. With the permission of the patient, the care managers at our office and the suboxone clinic coordinated care. The patient has continued to be successful and avoid substance relapse. The patient has had no other ED or inpatient visits.

Having a care manager at this office is also very important to all the staff. We found through staff meetings and care management meetings we can make changes based on outcome data to continue to assess and reevaluate the needs of the patients. This is not a static process. Our providers are as committed to the care management process as the rest of the staff. Having the leadership believe in the importance of care management and the processes that have been developed, and will continue to be improved, sets a positive example to all the staff. Patients come to us to obtain the help they need at vulnerable times. Patients are the reason this work matters and why it is important to our practice.

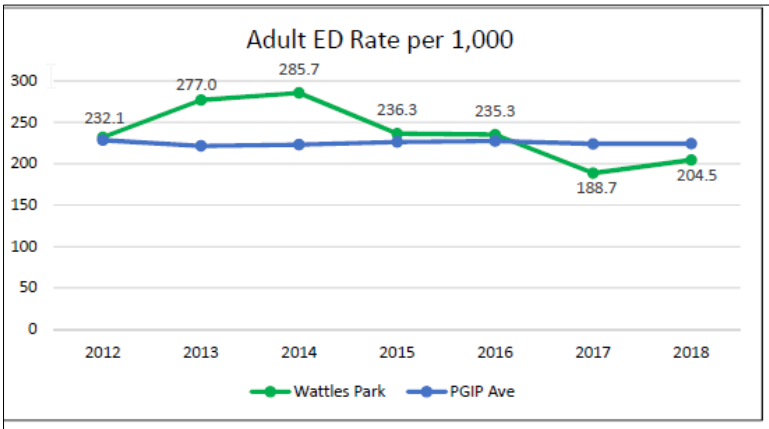
How Funds will be Used:

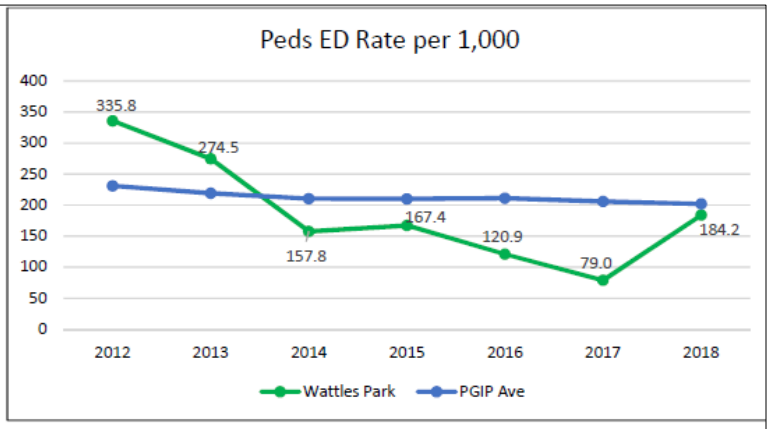
The funds will be used in three primary ways: staff education, patient education, and staff recognition. Staff will benefit from additional education on chronic conditions and the most updated ways in which to engage the patient in his/her care. Based on input from our patients through conversation and surveys, we found they enjoy coming to the office to learn about various chronic conditions. We have had great success with our diabetic education classes. We are hoping to engage a guest speaker with experience in caregiver burnout to speak on this topic. Additional topics that have been discussed include preventive health services and behavioral health. Some funds will be used for rewarding our staff for their continued dedication to the patients we serve. Staff have put in many hours working together through the processes and continually improving how we serve the patients. Hiring additional resources for care management is being considered based on the ability to sustain staff after funding is utilized.

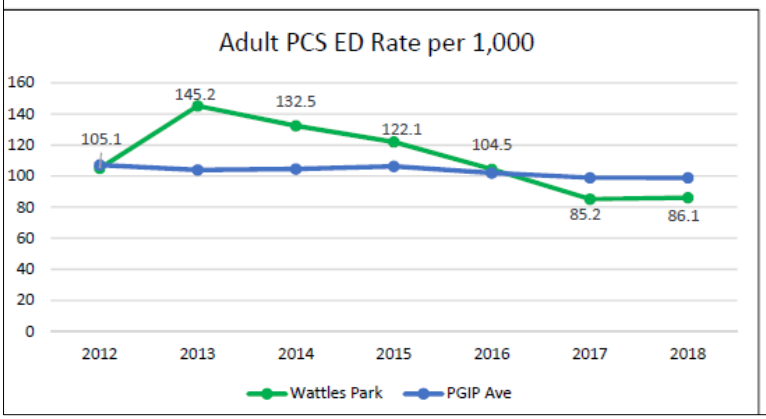
Appendix 1

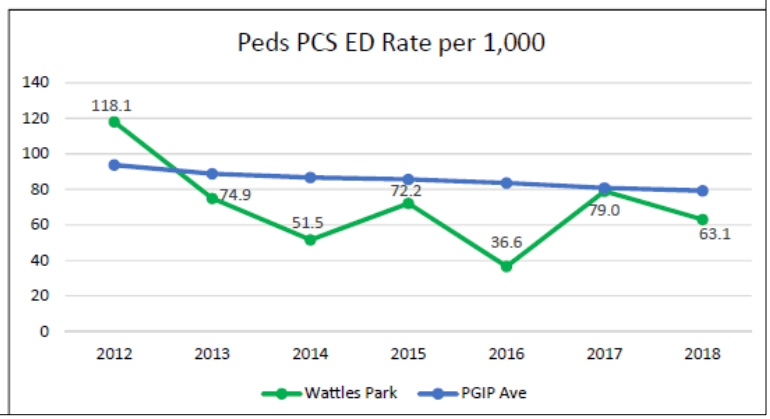
Emergency Department Utilization Improvement

Wattles Park Family Practice









Appendix 2

Inpatient Utilization Improvement

Wattles Park Family Practice