Contact Information
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Physician Organization Name: Lakeland Care Network
Practice Name: N/A
Practice Address: 2500 Meadowbrook Benton Harbor, MI 49022
How many physicians in practice: N/A
Description of care team (number of care team members and their degrees/qualifications, at the time of the best practice activity): Lakeland Care Network (LCN) Care Managers; RN, MSW, Pharm D. Aetna Better Health (ABH) Care Managers: RN, MSW, Pharm D, and Utilization Review. Integrated Healthcare Specialist with Southwest Michigan Behavioral Health (SWMBH)

Executive Summary (5-8 bullet points, must include summary of results)
* Reduction of 21.3% year over year for Admissions/1000
* Reduction of 15.4 % year over year of ED/1000/month
* Improved A1C testing rates for assigned members
* Greater collaboration among Care Managers for all involved organizations
* Improved Care Manager efficiency for all involved organizations

Category of Submission (see page 1): Reduction in Utilization

Title of Submission: Dual – Eligible Transition of Care Program; Collaborative Approach

When did the intervention start and end? (1-2 sentences) January 2016 - current

Goal of the Program/Intervention: (1-2 sentences)
Goals of the program include a reduction of utilization by at least 5 percent as well as an increase in collaboration among care managers across various health organizations (LCN, ABH, SWMBH, and community services)

Who developed the program/intervention, and how? (2-4 sentences)
It was a dual effort between LCN and ABH to develop a plan for better managing this population. Initially the focus was on Transition of Care from the inpatient side to either home or long-term care. With time it was expanded to also watch and manage those frequently utilizing the emergency department; 2+ ED visits in 6 months or less.

Description of the Program/Intervention (2-3 paragraphs):
ToC Program (weekly call):
Weekly the High-Risk CM from LCN, using a list created in EPIC, looks for any patient who had either an observation or inpatient stay over the last seven days. A collaborate call list is then created; this list includes any new patients located that week as well as patients from previous weeks; a ToC patient is discussed a minimum of 4 weeks in a row. This list is sent onto ABH and SWMBH for them to review and research. The following week, a 30 minutes Collaborative Conference Call is then held. People invited to this call include from LCN: High Risk Care Manager, Care Manager(s) from PCP offices and at times Home Care. Invited from Aetna are: RN Care Manager, MSW Case Managers, Pharm D and Utilization Review. From SWMBH their Integrated Healthcare Specialist is invited.

ED Program (Bi-weekly call):
Weekly the High-Risk CM from LCN, using a list created in EPIC, looks for any patient who had an ED visit in the last week. The patient's chart is then reviewed to see if this visit causes the patient to have 2+ ED in the last 6 months. If yes, they are added to the ED collaborate call list. This list is discussed bi-weekly; a patient remains on the list for a minimum of 12 weeks, which means they are discussed 6 times.

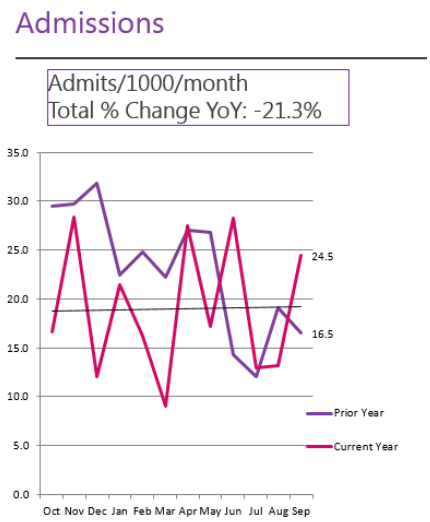
For both the ToC and ED Program Care Managers are discussing what barriers may be present (transportation, authorization issues, housing issues, etc.), gaps in care, and consulting/collaborating with outside organizations that

may be interacting with patient (Home Care, PACE, AAA, etc). That information is then brought to the weekly or bi-weekly call to be discussed. The call's time is used to discuss any barriers, how they may be resolved, and who is best suited to work on that barrier/issue. Since the Aetna CMs are often going into the homes for the ToC patients it is also used to update the PCP CM on the status/progress of the patient.

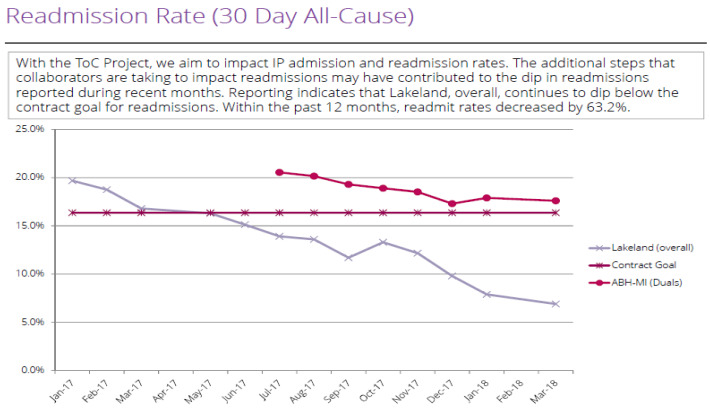
How were patients identified for the program/intervention? (1-2 paragraphs)
Aetna Medicare/Medicaid adult patients in Southwest Michigan who were assigned to Primary Care Physicians within the Lakeland Care Network. In this target region, poverty affects 57 percent of this population and 40 percent have less than a high school diploma. A majority have five or more comorbid conditions and at least half have behavioral health diagnosis. Dual-eligible beneficiaries have limited transportation and financial resources and experience housing and food instability.

How was success measured? Please delineate whether metrics were process-based or outcome-based (2-3 paragraphs)
HA1C testing rates – process. By supplying supplemental data; LCN practices were able to reach 100 % of the target for A1C testing for 2018!
30 day all - cause readmits – outcome. Early in the program saw a dramatic reduction of 63.2 percent; as the program continued it was holding at a reduction of 51.5 percent for year over year!
ED/1000 – outcome. Year over year we were seeing a reduction of 15.4 percent!
IP admits – outcome. Year over year we were seeing a reduction of 21.3 percent!

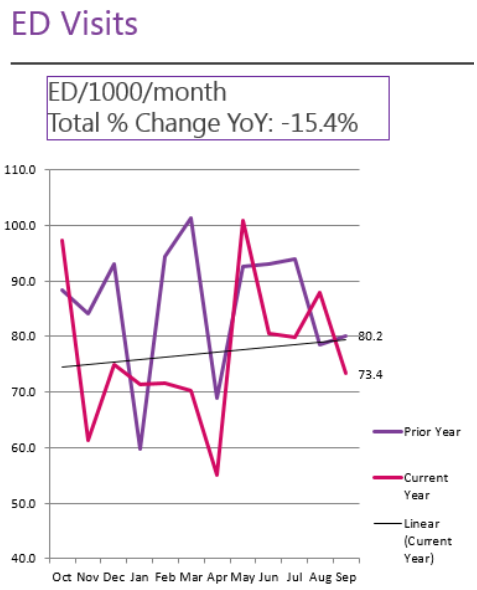
What were the program results? Include qualitative data/graphs (2-3 paragraphs)
Reduction of Admits/1000



Reduction of Readmissions



Reduction of ED/1000/month



Digging deeper into the data we learned that this population would continue to require close monitoring; we were able to see that for those patients who were involved in the program there was a 23.5 % reduction in a 30 day readmission 3 months post being part of the program; 15% post 6 months and showed no further impact 9 months out. Looking at the impact on ED utilization we saw similar results with a reduction of 31.2 % 3 months post being part of the program, 31.3 % post 6 months, 25.6 % post 9 months and no difference post 12 months. All of this to solidify our theory that closer monitoring of this higher risk population has positive impact on their health and medical costs.

Were any new tools, processes, or resources developed to aid in the implementation of the program/intervention? (1-2 paragraphs)
Planning and scheduling weekly Care Collaborative calls were implemented among LCN HR CM and PCP CM, Aetna CM and SWBH. Contact information was also shared among this group to provide access to the various CM at any time. Aetna also provided access to their Care Unify Patient Portal for the LCN High Risk Care Manager.

What are you proudest of regarding this submission? Why does this work matter? (1-2 paragraphs)
Improved patient care for a high-risk population. Those who are dually eligible experience financial struggles and other barriers that have a direct impact on their health. By working closing with the ABH team and SWBH we have often been better suited to address these issues in a timelier manner thereby removing them as barriers to the care they need. One patient we were able to assist in getting moved to a more stable environment, tests and treatment for persistent ongoing GI issues, and more consistent medication administration which resulted in a reduction of the patient ED use from over 40 in one calendar year to 3 the following year!

How will your organization use the funds if your submission wins? (1 paragraph)
Social Determinants of Health needs became very apparent as we started and have continue to work with this population. Sometime acquiring that information can be a challenge. Our current workflow includes having the questionnaire available in MyChart for those who have access, mailing them prior to appointments, and/or giving them the questionnaire during the check in process. The questionnaire is lengthy and taking it from the paper form and then adding it into EPIC is time consuming; we'd like to provide Ipads with wifi and EPIC access for our PCP offices for patients to use to complete the check in process; especially the SDoH questionnaire to improve workflow and increase the number of completed questionnaires.