Care Management Recognition Awards – Care Management Workflow
Best Practice Submission Template
Oakland Physician Network Services_James A Gibson MD_Best Practice_Care Management Workflow_2019

Contact Information

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# of Physicians in Practice: 1
Description of care team: Internal Medicine Physician and RN Care Manager imbedded in the practice two days/week since 2016
Practice Address: 5784 Highland Rd, Waterford, 48327

Executive Summary (5-8 bullet points, must include summary of results):

As part of a pilot, OPNS had previously embedded an RN care manager in two primary care physician practices. The pilot was successful in that the care manager, physician(s), and other office care team members were able to create processes to:

- identify appropriate patients for care management interventions
- create patient panels
- utilize the EMR to accurately document care management interventions
- bill PDCM services for eligible members

In addition, patients involved in the care management pilot have shown significant improvement in select quality measures including HgA1C, hypertension and decreased hospital re-admission rates.

Chronic Disease Focus: Diabetes Mellitus

90-day Clinical Outcomes Summary:
Data showed that 94% of patients enrolled in care management had a 1.8% or greater reduction in HbA1c.
Data showed that patients enrolled in care management had a readmission rate of 4.6% versus a PO rate of 9.0%.

Category of Submission: Care Management Workflow

Title of Submission: Care Manager Pilot Paves the Way for Success in Other OPNS Practices

When did the intervention start and end? (1-2 sentences):

The original pilot started in two OPNS Primary Care practice units in April 2016 and continued through July 2016. Since the completion of the pilot, OPNS has expanded the number of care managers in physician practices.

Goal of the Program/Intervention: (1-2 sentences):

The goals of the program were to develop and implement care management workflow processes focused on:

- Transitions of Care for inpatient discharges and ER treat and release patients
- Chronic care management strategies aimed at closing gaps-in-care
- Chronic disease management (Diabetes, HTN, CHF, COPD, etc)

- Leveraging Physician Direct Focus (PD Focus -data warehouse) to support care managers
- Implementing processes that support effective documentation and billing of PDCM codes

Interventions utilized:

- Managing Plan risk stratified lists to determine appropriate patients for care management interventions
- Assessing daily admission, discharge, transfer (ADT) reports published daily in PD Focus
- Reviewing gaps-in-care reports updated monthly in PD Focus
- Engaging patients either telephonically or face-to-face during scheduled appointments
- Developing process to track PDCM billing and reimbursement activity

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

The program was developed by:

- Peggy Best, RN, MSA, OPNS Lead Care Manager
- Sandy Foster, RN, BA, CCM, Director of Medical Management

Practice units were identified based on the number of attributed BCBSM PPO and MA patients and the prevalence of Diabetes Mellitus within the population. Data analysis included review of PGIP:

- Practice Unit Clinical Quality Reports
- Practice Unit Gaps-in-Care Reports
- Quarterly Datasets
- ADT Reports

Resources developed or utilized to support the program:

- OPNS RN Care Management Office Manual
- Training provided by OPNS to the Lead RN Care Manager
- PD Focus training provided by OPNS Informatics
- OPNS Care Management Activity Tracking Log and Quality Measure Report
- BCBSM PDCM Commercial and Medicare Advantage Billing Guidelines
- MiCMRC website

Description of the Program/Intervention (2-3 paragraphs): (see below)

How were patients identified for the program/intervention? (1-2 paragraphs): (see below)

OPNS employed Care Managers are initially oriented to the OPNS office and staff. Orientation includes:

- Access to physical office
- Computer and software training
- PD Focus training
  - ADT reports
  - BCBSM PDCM reports
  - Priority Health targeted hierarchal reports
  - Quality gaps-in-care reports
- Medical Management program training including quality, utilization and PCMH model of care
- Complex Care Management and Self-Management training from approved sites

Following OPNS office orientation, newly hired care managers job shadow Peggy in the two practices that she is embedded in. The focus is to educate the care managers to ensure successful implementation of processes designed to:

- Identify patients appropriate for care management services – complex needs, rising risk
- Develop patient scheduling and active patient list
- Identify resources to support care management services (i.e. diabetic action plan, diabetic patient education, CHF action plan)
- Develop patient care plans
- Utilize appropriate documentation and billing consistent with established Plan billing guidelines
- Implement transition of care aimed at reducing ER, inpatient admission and readmission
- Maintain OPNS Activity Tracking Log and Quality Measure Report
- Identify strategies that assist with integrating the care manager into the existing office care team including development of a physician partnership

The next step involves embedding the care manager in the practice unit. OPNS has developed the Care Management Office Manual to assist practices prepare for care management.

How was success measured? Please delineate whether metrics were process-based or outcome-based (2-3 paragraphs):

OPNS selected key outcome-based metrics related to the CM's focus to measure success including:

- ER Visits/1000
- PCS ER Visits/1000
- Non-Maternity IP Rate/1000
- ACS IP Rate/1000
- 30-Day All Cause Readmit Rate

Clinical Quality VBR
BCBSM PDCM VBR
BCBSM Advanced PDCM VBR
Priority Health PIP

What were the program results? Include qualitative data/graphs (2-3 paragraphs): (See Addendum B for Care Management Dashboard)

Were any new tools, processes or resources developed to aid in the implementation of the program/interventions?

OPNS has developed the Care Management Office Manual to assist practices prepare for care management. (See Addendum A for OPNS Care Management Office Manual Contents).

What are you proudest of regarding this submission? Why does this work matter?

We are proud of the success that we have seen in the OPNS Care Manager pilot as described in the Executive Summary. As a result, we are actively expanding our program to include additional OPNS RN care managers. We continue to monitor our performance using the OPNS Care Management Dashboard. Additionally, we initiated a monthly OPNS Care Manager Work Group that was originally focused on working with those practices participating in the CPC+ program. We have expanded the participation to now include all care managers employed by OPNS and private practices, as well as the transition of care specialists from St. Joseph Mercy Oakland. We are no longer working in silos, but actively reaching out and collaborating with additional disciplines to improve patient outcomes. This involves building relationships and communicating with other disciplines including home health care and skilled nursing facilities. We plan on including additional disciplines as we identify areas of opportunity to collaborate.

How will your organization use the funds if your submission wins?

OPNS will continue to subsidize the Care Management Program and expand the program to additional primary care practices. Investigate the possibility of a centralized behavioral health specialist/LMSW.

ADDENDUM A

OPNS Care Management Office Manual Table of Contents:

- RN Care Manager Job Description and education requirements
- MiCMRC resource information
- OPNS Orientation Checklist/OPNS contacts
- Office Orientation Checklist
- Program Resources:
  - Building patient panel – PRISM risk score, ADT, BCBSM PDCM, Priority Health reports
- Patient education – community resources, action plans, MQIC Guidelines
- Payer billing Guidelines
- Data Collection – OPNS Care Manager Billing and Activity Log
- Data Collection - Quality Measure Report
- Reports – practice unit financial analysis (making the value case to physicians)

ADDENDUM B

Practice Unit A								
	ER Visits/1000	PCS ER Visits/1000	Non-Maternity IP Rate/1000	ACS IP Rate/1000	30-Day All Cause Readmit Rate	Clinical Quality VBR	BCBSM PDCM VBR	Yes
2016	163	74	104	11.32	15%	0%	BCBSM Advanced PDCM VBR	Yes
2017	154	57	78	2.61	0%	15%	Priority Health PIP	Yes
% of Change	-6%	-23%	-25%	-77%	-100%			
2017 PGIP	219	103	41	4.5	9%			
2017 OPNS	201	81	60	3.55	9%			
Practice Unit A 2018	173	55	107	11.35	9%	5%		
2018 PGIP	223	99	51	4.6	9%			
2018 OPNS	206	90	54	3.9	9%			