Physician HealthCare Network

Contact Information

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Practice Name: Physician Healthcare Network
Practice Address: Main Office, 3050 Commerce Drive Fort Gratiot MI 48059
How many physicians in practice: PHCN has 26 Family Practice Providers and Pediatric10 providers
Care Team: Care Coordinator, BS and Two Care Managers, RN

Executive Summary

- PHCN has made numerous improvements to its Care Management program over the last year that has enabled the department to grow and reach a larger number of patients
- Improved workflows, appointment availability at all primary care locations, medication management and care coordination with the PCP
- Written workflows for major illnesses and planned visits
- Nutritional education following ADA standards, self-management goal education, and access to community resources
- Transitional Care Management process, reduction in ED visits as well as hospital re-admissions

Category: Care Management Workflow

Care Management Workflow Processes at PHCN

PHCN first began its Care Management program in 2016 with one Care Manager. In May of 2018, PHCN revamped its Care Management program with the addition of a second Care Manager as well as improved workflows. There is no projected end date for the program. We are continuing to improve processes as needed.

The goal is Care Management at PHCN is to be a set of activities designed to assist patients and their support systems in managing medical conditions and related psychosocial problems more effectively, with the aim of improving patient's health status and reducing the need for medical services. The goals of care management are to improve patients "functional health status, enhance coordination of care, eliminate duplication of services, and reduce the need for expensive medical services."

Our current Care Management program and workflows were developed by Nancy Mason, Quality Coordinator and Shannon Oehmke, Care Manager.

Provider or Mid-level determines when a patient would benefit from care management services, based on office visit outcome, lab results, frequent ER use, need for community resources, end of life care, and Transitional Care Management. Provider orders care manager referral or contacts the care management department directly through Athena text, e-mail or phone call. Referral process is then followed. Care manager will then add patient's name to her referral list and contact patient and schedule them accordingly. The care managers are also reaching out to patients from lists that show patient risk rating. High risk patients are likely to have Chronic Illness with multiple co-morbidities, multiple hospitalizations and are in the greatest need for care management services.

Care Managers are working ADT documents to ensure Care Coordination happens for patients leaving the hospital or Skilled Nursing Facility. This time is high risk for the patients and the care manager does a thorough review of the patient's clinical condition, including is the patient is taking their medications correctly, has their progress has

continued, have questions been answered and to ensure the chance for re-admission has lessened. An appointment to see their PCP within 7 or 14 days is also scheduled.

Care Manager/Care Coordinator receives lists from insurance payers and patient lists from our population health EMR of patients that could benefit from care management services. Care Manager/Care Coordinator calls the patient to explain the benefits of care management services and schedules the patient for an initial consultation with the care manager if the patient agrees to the services. Care Manager sends documentation of visit/phone call to the provider for review in the form of a patient case, telephone encounter or face to face encounter.

In the event that patient is seeing a specialist, specialist is notified that patient has a care manager. This is so that the patients care can be coordinated between providers. The Care Manager will focus on coordinating the patient's care with the specialist to avoid duplication of services and to ensure the Specialist has all of the information so the patient can receive the best possible care.

We measure success of this program based on outcomes as well as processes. We know that our program has been successful due to changes in the process of how and where we see patients. Prior to May of 2018, our Care Manager was only seeing patients in four of our family practice offices – PHCN North, PHCN Marysville, PHCN South, and PHCN Macomb. Currently, we have a Care Manager scheduled to see patients at all nine of our primary care clinics. Care Managers are also able to see patients at two of our specialty offices, Gastroenterology and Surgical. A second measure of success has been the increase in the volume of patients being seen at face to face visits. We originally started with our Care Manager seeing on average 25 patients a month. One of our Care Managers currently sees an average of 25 patients a week.

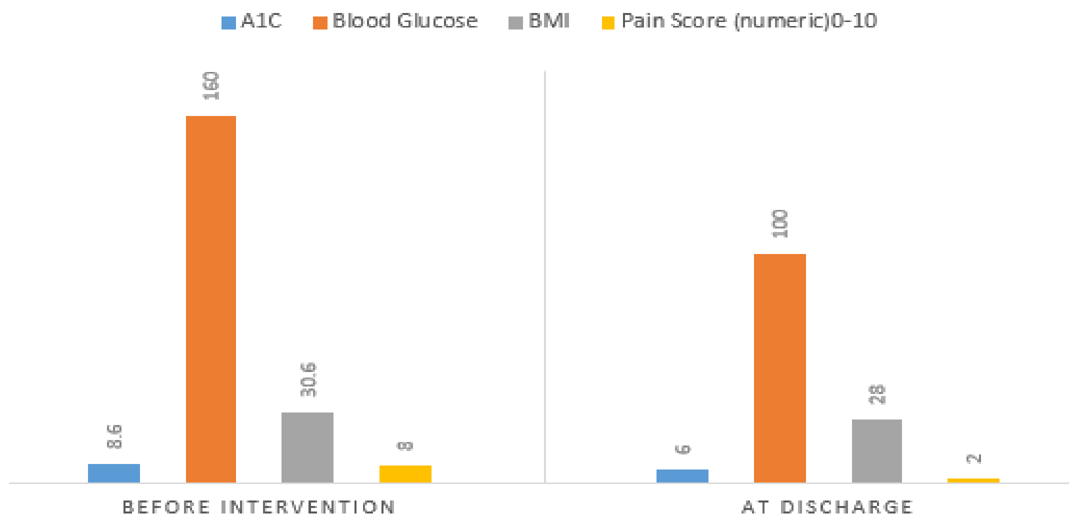
The other way we measure success is based on the outcomes for our patients. For example, a patient was referred to Care Management on 8/9/18 for Uncontrolled Diabetes Mellitus 2 with elevated A1C of 8.6%, and BMI >30%. The patient was referred to Care Management by the Primary Care Physician for education regarding his Uncontrolled Diabetes Mellitus 2, & Essential Hypertension. The patient had seen the PCP for a physical exam and blood work was done that resulted with an elevated fasting glucose and A1C of 8.6%. The PCP explained that he was referring patient to Care Management for intervention and to educate him on how to improve his health.

The Chronic Care Manager met with the patient as a face-to-face visit. She educated patient about etiology of Diabetes, Hypertension and arthritis. She developed the above mentioned interventions and set goals with the patient. Follow up intervals were set initially at biweekly and eventually increased to monthly as the patient met set goals. Patient was educated regarding PLATE and DASH method of eating, instructed to keep a detailed food log, and to check his blood glucose one to three times a day. He adjusted well to eating a structured meal plan to ensure he got the needed nutrients to improve his health. He started checking his fasting blood glucose daily. Initially his blood glucose readings were 150-160mg/dL and improved to 120-140 mg/dL within the first follow up. This was achieved by his lifestyle changes.

The patient initially saw the Care Manager biweekly and then increased intervals to monthly as the patient was meeting set goals. He started riding his bike for 30 minutes a day and gradually increased to riding 5 miles a day. His wife was starting to eat healthier with him and that encouraged the patient to keep improving his lifestyle habits.

The Care Manager reviewed the patient's food and glucose logs and adjusted his diet as needed to achieve optimal blood glucose readings and to help patient decrease his BMI. She also provided emotional support and encouragement. He was discharged from Care Management on 2-21-19 with an A1C of 6%, BMI of 28%, stable blood pressure of 122/84 and decrease arthritis pain due to weight loss and ability to exercise more.

The success was measured by patients improved blood glucose readings, decrease in A1C, decrease in BMI, increase in activity as tolerated (see graph). Patient was educated with the use of developed Diabetes Action Plan, Food/Glucose Log, and Diabetes Education Folder (which included the Cornerstones4Care program.



Many new tools and process have been developed since May of 2018. Some of the highlights include:

- Chronic illness workflows (see Appendix A)
- New Care Management templates in Athena to document encounters
- Transitional Care Management process put in place to follow up on patients discharged from the hospital
- Social Determinates of Health survey being implemented at our primary care practices
- Many new contacts found for resources for our patients. Including housing, household items, shelters, food resources, and medication assistance.

We are proud as Care Managers and thankful that we are able to make a difference in patient's lives.

Education is our passion and being able to share this with our patients and see them succeed is the ultimate reward. In this patient's case, he was so excited to see his improvements. He stated he "looked forward" to seeing the Care Manager to share his improvements and receive the encouragement to continue to improve his health. He was excited to see his wife getting healthier with him. We not only are here to help our patients, but to improve their overall life, which includes their families!

PHCN and CHC Plans if awarded the $125,000

Our Care Team will continue to develop, grow and expand our services to reach more of our patient population. Our first Care Manager was hired in June 2018 with the Care Coordinator in July. The second Care Manager was added in August 2018 and a year later, August 2019 we have now added our third Care Manager.

We will move our Care Coordinator from part time to full time. We will add an additional Care Coordinator to focus efforts on supporting the SDOH surveys and expanding resources. We will increase the amount of time spent on Outreach to our patient population and analysis of reports from Athena to identify patients in need of Care Management.

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Appendix A