**Contact Information**

**Submitter Name:** Francine Burley

**Submitter Title:** Clinical Program Manager

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**Submitter Phone Number:** 586-498-3588

**Physician Organization Name:** The Physician Alliance

**Practice Names and Addresses:** Six pilot practices (See practice demographics- Appendix 1)

**Physician Organization Address:** The Physician Alliance, 20952 E. Twelve Mile Road, Ste 130, St Clair Shores, MI, 48081

**How many physicians in practices:** Please see the attached - Appendix 1.

**Description of TPA care team:**

Francine Burley MSN RN CPHQ- Clinical Program Manager, Sharon Ross MSN NP RN – Executive Vice President, Karen Swanson MD – Chief Medical Officer, Carolyn Rada MSN RN - Vice President of Operations, Ashley Shreve - Director of Practice Transformation, Jennie Lekich MSA - Director of Clinical Informatics, and Practice Care Teams.

**Executive Summary:**

- In 2017 Medicare costs attributed to the management of diabetics was estimated to be $100 billion with a prediction those costs would rise to $142 billion by 2030.
- The CDC reported in 2017 that the average cost of care for a diabetic is approximately $13,700.00 annually and are estimated to be over $100,000.00 over a lifetime.
- Opportunity was identified to tag high-risk and very high-risk diabetic patients using Wellcentive Registry for care management engagement.
- Assertive interventions in the high-risk diabetic population can result in significant savings over time and improve the quality of life for our patients.
- Touch rate was 8% in 2017 and has increased to 18% in the first quarter 2019.

**Category of Submission:**

**Care Management Workflow**

**Title of Submission:**

TPA Care Management Workflow: High Risk Diabetic Pilot

**When did the intervention start and end?**

The project began in 2018 with the establishment of the baseline population and distribution of the first quarterly report of high-risk diabetics in each of the pilot practices in August 2018. The pilot remains in progress and is scheduled for completion in September 2019.

**Goal of the Program/Intervention:**

The goal for the initiative is to achieve an 8% increase in the amount of care management touches to the diabetics stratified as high-risk and very high-risk in the pilot practices by September 2019.

**Who developed the program/intervention, and how?**

Sharon Ross and Fran Burley were leads in developing the program and interventions. Using Wellcentive, TPA has identified 64, 919 diabetics in our OSC population. Analyzing our reports, we were able to identify practices with high-density populations of patients with diabetes. High-density practices with care managers were selected to participate.

**Description of the Program/Intervention:**

A quarterly report is sent to the pilot practices that identifies patients that would benefit from care management interventions based on their level of risk which is calculated in Wellcentive (Johns-Hopkins risk stratification calculation.) See copy of report title headings – Appendix 1.

The report is used as an aid to the care managers to identify patients (high-risk diabetics) who would benefit from care management interventions. Care Management workflow includes address gaps in care, improve care coordination, address social determinants of health needs, establish self-management goals to improve patient outcomes and reduce healthcare costs, and address appropriate use of ED.

Each quarter, a webinar is held with the care managers from the six pilot practices, the director of Clinical Informatics and the Clinical Program manager to discuss efficacy of the reports, support the use of technology among the care managers, and discuss needs and best practices. In addition, the practices receive individual quarterly performance trend reports.

**How were patients identified for the program/intervention?**

Patients targeted for intervention for the High-Risk Diabetic Care Management Touch were included based upon the following criteria: ≥ 18 years with a diagnosis of diabetes type I or II by either and ICD 10 code of E10-E11, or insulin use, or a diabetes diagnosis on the Wellcentive care tab with an active office visit within the last two years in the total risk adjusted population in the targeted practices. Care management engagement with diabetics with a 4 or 5 risk score is tracked using the twelve PDCM codes billed (G9001, G9002, G9007, G9008 S0257, 98966, 98967, 98968,99487, 99489 or PDCM-related codes 98945, 98946 or 1111F).

**How was success measured? Metrics were process-based or outcome-based?**

An outcomes-based metric is being used to measure success. Internal reports are generated, also from Wellcentive, to track progress towards goal by incorporating inclusion metrics (above) and coupling with claims data fed into Wellcentive to be able identify increases in billing by tracking the use of the twelve PDCM and three PDCM-related codes.

**What were the program results? Include qualitative data/graphs:**

Pilot interventions have thus far: (Please see the attached graphs – Appendix 2)

- Increased the care management touches from 8% at the 2017 year to date baseline to 18% by March 2019.
- Surpassed the improvement target by the end of first quarter 2019.The targeted improvement in care management touches was an 8% improvement (or 16% total rate). Pilot practices realized 10% improvement in the care management touches.

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

In order to achieve success several new processes, tools, collaborations and resources were developed.

1. Development of a multidisciplinary team not only across our organization but across our affiliate partners- Ascension Healthcare (including diabetic educators, clinical transformation,) Partners in Care (including Pharmacy, Nutrition support, Care Management). - that initially met weekly for approximately 3 months and currently meets bi-monthly.

2. New reports were created, and existing reports modified using the Wellcentive registry to assist in the identification of the targeted population, and new processes were developed to support the care managers in this work- quarterly webinars to reinforce and develop technology skills.

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

Certainly, we are proud that it appears our interventions are reaching targeted goals. Of course, we are happy these interventions can potentially reduce healthcare costs by affecting change in the population management of diabetics to deter the development of conditions related to the sequalae of diabetes. But above that we are proud to be able to help individuals with diabetics lead higher quality lives and reduce the financial burden of managing their chronic condition and proud to be a part of the team building efforts across our organization, across the care continuum and across the diabetic patient population.

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

Should our submission win the recognition reward in this category, we will use the dollars to expand these processes to additional PCP practices with care managers by supporting additional care manager training, further development of reports, and data analytic support.

## Appendix 1

| Practice Name | # of Physicians | Address | Phone | Care Manager |
|---|---|---|---|---|
| Bay Area Family Physicians | 6 | 34301 23 Mile Road Ste. New Baltimore, MI 48047 | 586-725-1770 | Cheryl Barbara MA, Linda Kraydich RN, Kelly Monden RN |
| Berkley Primary Care | 1 | 26711 Woodward Ste. 103 Huntington Woods, MI 48070 | 248-543-6000 | Katie O'Neill, NP |
| Deighton Family Practice | 9 | 22250 Providence Dr. Ste. 500 Southfield, MI 48075 | 248-849-3441 | Donna Woike RN, Carla James, LMSW |
| Lakefront Internists | 1 | 20952 Twelve Mile, Ste. 100, SCS MI 48081 | 586-498-3550 | Christine LaValley RN |
| Providence Family & Athletic Medicine | 4 | 26750 Providence Parkway, Ste. 210 Novi, MI 48374 | 248-465-4782 | Michele Myles RN |
| St. John Family Medical Center | 7 | 24911 Little Mack, Ste. C. St. Clair Shores, MI 48080 | 586-447-9060 | Karen Black RN |
| **TOTAL** | **28** | | | |

**Data Points Included on the High-Risk Diabetics with Care Management Touches**

| First Name | Last Name | Date Of Birth | Gender | Language | Phone Number | Address Line 1 | City | State | Zip Code | Primary Physician | BCBSM | BCBSM | Priority | Priority | All Other | All Other | Risk Score |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|

# Appendix 2

## High-Risk Diabetics with Care Management Touch