BCBSM Care Management Recognition Award Opportunity
Care Management Workflow

Contact Information
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Physician Organization Name: Upper Peninsula Health Group
Practice Name: Upper Great Lakes Family Health Center- Houghton
Practice Address: 600 MacInnes Drive Houghton, MI 49931
How many physicians in practice: 2
Description of care team (number of care team members and their degrees/qualifications, at the time of the best practice activity): 3 physician assistants, 6 registered nurses, 3 clinic assistants, 6 patient service representatives, 1 RN care manager

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

- Implemented process to identify eligible and current care management patients (for programs including PDCM) as a part of our pre-visit planning/huddle process
- Workflow designed for reconciling, tracking, and reporting current care management patient panels
- Created workflow to guide care managers through the process for completing documentation in progress notes for billable care management phone call encounters
- Care management panels utilized to monitor billing frequency
- Care management panels utilized to measure improved clinical quality outcomes on care management patients
- Demonstrated improvement in controlling high blood pressure, diabetes A1c tested, diabetes eye exam, and depression screening and follow up for care management patients compared to total patient population
- Demonstrated increased and sustained usage of coding and billing for care management services

Category of Submission (see page 1): Care Management Workflow

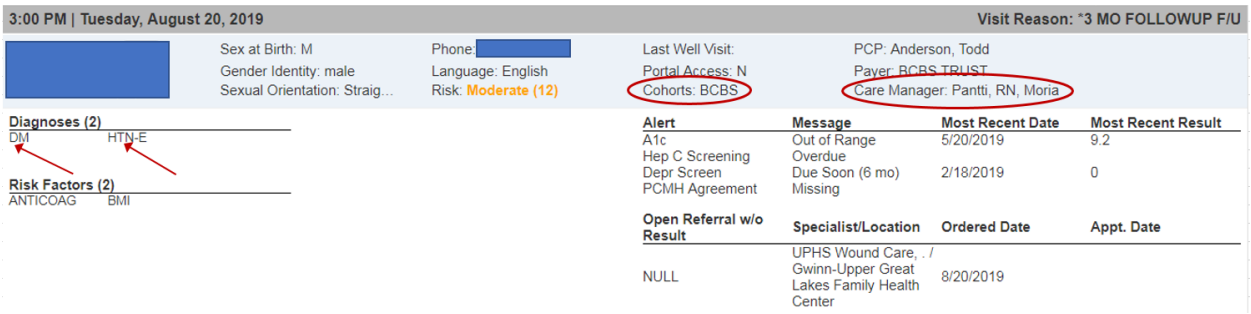
Title of Submission: Optimizing Care Management Processes to Improve Patient Health Outcomes

When did the intervention start and end? (1-2 sentences)
While care management services have been provided at the Houghton practice for a couple years, the intervention began in January 2019 and is ongoing.

Goal of the Program/Intervention: (1-2 sentences)
To improve care management workflows to better track and monitor care management activities, billing and coding practices, and to gain insight on improved clinical outcomes for our care management populations.

Who developed the program/intervention, and how? (2-4 sentences)
The quality department developed this program. We began by analyzing billing and coding requirements for each care management program and then developed a standardized EHR workflow for all care management documentation. We also established a workflow using structured data to accurately report how many patients are currently enrolled in a care management program by care manager and by PCP.

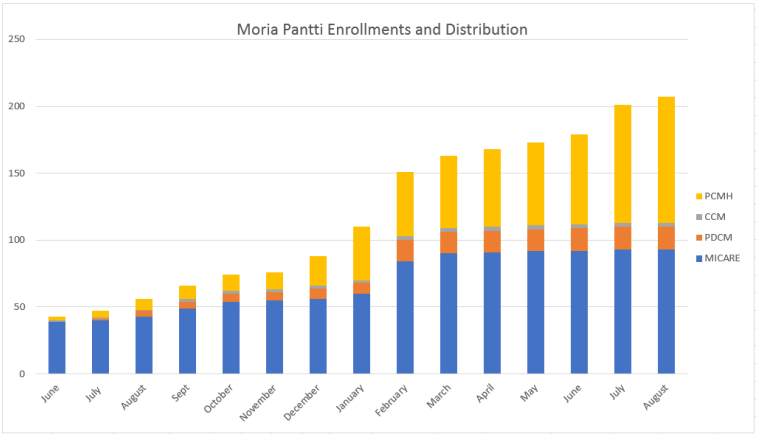
Description of the Program/Intervention (2-3 paragraphs):
Potential/current care management patients with a scheduled provider visit for that day are identified during pre-visit planning/huddle process:



PDCM Eligibility Reports are analyzed to identify eligible patients, and patients are contacted to schedule an appointment:

UGL Houghton	Anderson	Todd	M	[redacted]
UGL Houghton	Anderson	Todd	M	
UGL Houghton	TRUSOCK	BRUCE	M	
UGL Houghton	TRUSOCK	BRUCE	M	

Care management panel sizes are monitored and tracked:



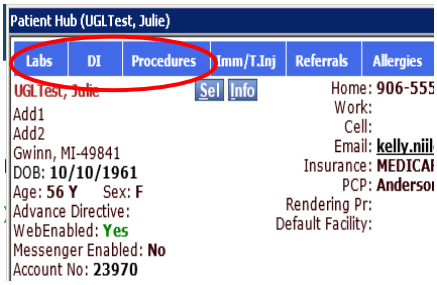
Care managers assess open gaps in care and care coordination opportunities to review with patients on monthly calls, or if meeting with the patient in the clinic:

Alerts, 1

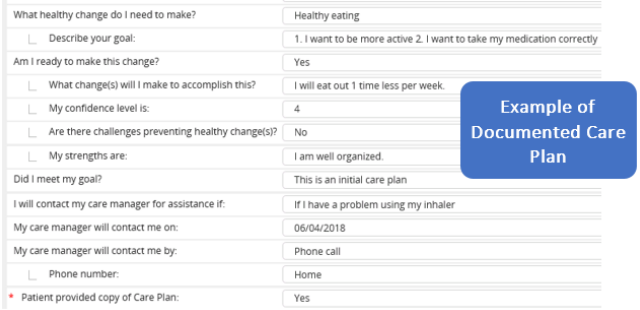
Alert	Message	Most Recent Date	Most Recent Result
Pap HPV	Overdue	4/12/16	

Open Referrals w/o Result, 2

Type	Specialist/Location	Order Date	Appt Date
Nurse Practitioner	DelValle, Janet / Sawyer-Upper Great Lakes Family Health Center	5/21/19	
Social Worker	Derks, Samone / Sawyer-Upper Great Lakes Family Health Center	5/21/19	



Care managers collaborate with the patient to develop a care plan that addresses barriers and incorporates patient preferences and lifestyle goals. The care plan is documented in the chart and shared with the primary care provider, a copy of the care plan is provided to the patient, potential barriers to meeting goals are discussed and addressed, and patient self-management skills are developed:



How were patients identified for the program/intervention? (1-2 paragraphs)
Complex, high risk patients are identified for care management during daily staff huddles. Specifically for PDCM, in addition to being identified during huddles patients are also identified using the PDCM Eligibility Reports downloaded from the PO.

How was success measured? Please delineate whether metrics were process-based or outcome-based (2-3 paragraphs)
Success was measured through the monitoring of care management claims (outcome-based, including PDCM and other programs).

Success was also measured through the measuring improvement in clinical quality measures (outcome-based).

What were the program results? Include qualitative data/graphs (2-3 paragraphs)
Demonstrated increased and sustained usage of coding and billing for care management services:

Care Management Claims in Houghton Clinic: 1/1/19-7/31/19								
CM CPT Code	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Grand Total**
98966			2		3	3	2	13
98967			4	2	7	3	19	35
98968		1	6	2	6	1	4	20
G0511	10	87	60	78	79	88	66	491
S0280		1		1	4	1	1	8
S0281	13	26	43	33	31	39	32	222
Grand Total	**23**	**115**	**115**	**116**	**130**	**135**	**124**	**789**

Care management panels were utilized to measure improved clinical quality outcomes on care management patients**.** Demonstrated improvement in controlling high blood pressure, diabetes A1c tested, diabetes eye exam, and depression screening and follow up for care management patients compared to total patient population (see Appendix 1).

Were any new tools, processes, or resources developed to aid in the implementation of the program/intervention? (1-2 paragraphs)

A written workflow was created to guide care managers through the process for completing documentation in EHR progress notes for billable care management phone call encounters.

What are you proudest of regarding this submission? Why does this work matter? (1-2 paragraphs)
We are proud to have implemented a process that makes connecting patients with care management support easy and efficient, for both patients and for staff. By utilizing a team-based care approach, the care manager can relieve the PCP of some of the workload for monitoring complex, high-risk patients who need extra time and attention. And the patient is able to receive the support that they need to improve their health. We are also proud to have demonstrated improvements in clinical quality, which is the reason behind implementing care management in the first place!

How will your organization use the funds if your submission wins? (1 paragraph)

We would plan to use the funding to support our care management program. With the increased number of patients who are being identified and connected with integrated care management services, we are faced with an increased demand for care management services, including RN care managers and community health workers.

Appendix 1: Care Management Outcomes Compared to Total Patient Population

Hypertension: Controlling High Blood Pressure

Cohort	Status	% HTN Pts with BP <140/90	Pts w/ BP <140/90	Pts w/ HTN	Excluded Pts
All Patients	70%	70%	3,904	5,590	64
Moria Care Mgmt Patients	69%	69%	72	104	0

Hypertension: Improvement in Blood Pressure

Cohort	Status	% HTN w/ BP Improvement	Pts w/ BP Improvement	Pts w/ BP	Excluded Pts
Moria Care Mgmt Patients	61%	61%	19	31	0
All Patients	38%	38%	565	1,497	15

Diabetes: A1c tested in the past 6 months

Cohort	Status	% DM Pts w/ A1c Tested (6 mo)	Pts w/ A1c Tested (6 mo)	Pts w/ Diabetes	Exclusions
Moria Care Mgmt Patients	86%	86%	50	58	0
All Patients	67%	67%	1,115	1,668	6

Diabetes: BP < 140/90

Cohort	Status	% of Diabetes Pts w/ BP < 140/90	Pts w/ BP < 140/90	Pts w/ Diabetes	Exclusions
Moria Care Mgmt Patients	81%	81%	46	57	0
All Patients	75%	75%	1,344	1,794	0

Diabetes Eye Exam

Cohort	Status	% DM Pts w/ Eye Exam	Pts w/ Eye Exam	Pts w/ Diabetes
Moria Care Mgmt Patients	83%	83%	48	58
All Patients	66%	66%	1,103	1,668

Screening for Depression and Follow-Up Plan

Cohort	Status	% Pts w/ Depression Screening & Follow-Up	Pts w/ Depression Screening & Follow-Up	Pts w/ Qual. Visit	Excluded Pts
Moria Care Mgmt Patients	77%	77%	50	65	131
All Patients	60%	60%	7,296	12,124	4,334