2019 Care Coordination Collaborative (CCC) Event

JULY 30, 2019 | 10:00 AM - 3:00 PM

AMWAY GRAND PLAZA HOTEL | GRAND RAPIDS

Welcome and Overview

KATIE COMMEY, MPH

SIM PCMH INITIATIVE LEAD

Agenda

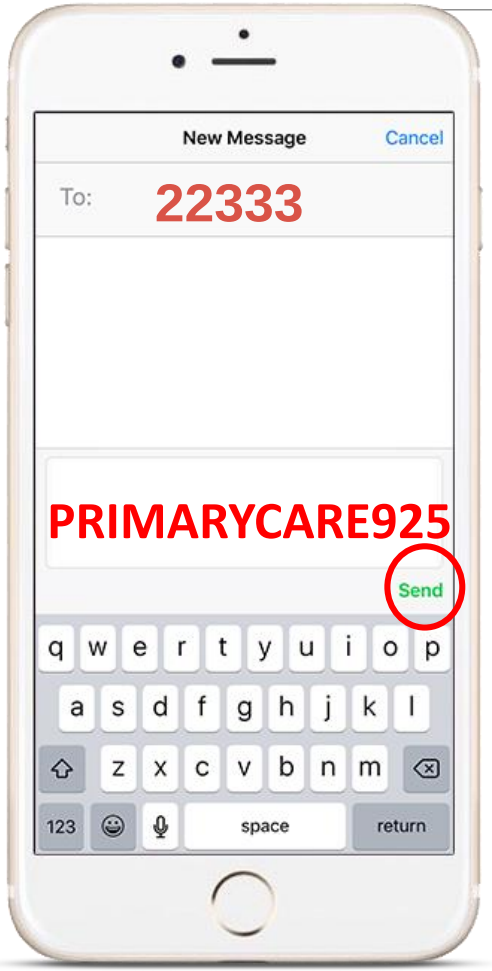
9:30 - 10:00	Registration, Continental Breakfast and Networking
10:00 - 10:10	Welcome and Overview
10:10 - 10:40	Tools for Tackling Avoidable Cost and Use and Streamlining Care • MHP Care Coordination Contacts • SIM Dashboards
10:40 - 11:40	Stories from Successful Collaborators • Transitional Care Management: A Toolkit for Success - Kerrie Barney, RN, Cherry Health • Right Time, Right Care, Right Place - Cherie Bostwick, RN, Munson Family Practice • Coordinating the Coordination of Care and Addressing Social Determinants of Health – Lori Kunkel and Chris Wise, Greater Flint Health Coalition

Agenda, cont.

11:40 - 12:10	Intensive Working Session (in small group tables)
12:10 - 1:10	Lunch (in common EHR table groups; with an MDC table)
1:10 - 2:10	Using Your Own Internal Data for Improved Coordination and Value: Case Studies and Step-by-Step Solution Finding • Michigan Medicine (Leah Corneail) • Great Lakes OSC (Marie Wendt)
2:10 - 2:50	Report-Outs and Group Sharing on Intensive Working Session and Case Study Findings
2:50 - 3:00	Wrap-Up and Closing Remarks

Poll Everywhere

Step 1

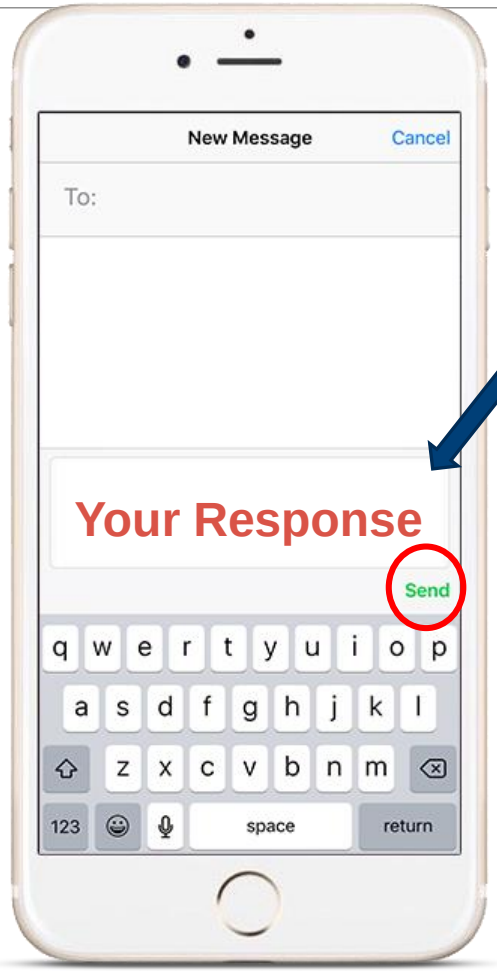


Then you will receive a text message that says…

You've joined PRIMARYCARE925's Session (PRIMARYCARE925)

Note: If you do not receive this message, you are not in Poll Everywhere.

Step 2



Here is where you enter your poll response…

A
B
C
D

Send

Tools for Tackling Avoidable Cost and Use and Streamlining Care

10:10AM - 10:40 AM

Care Coordination Contacts

- Medicaid Health Plan (MHP) Care Coordination Contacts

MDC Dashboard and Reports

SUSAN STEPHAN, BUSINESS SYSTEMS ANALYST, STAFF SPECIALIST

SIM Dashboard Access and Availability

- Dashboards are accessible by Authorized Users appointed by your organization

- Dashboards will be available for your use until 12/31/19 (the end of the SIM demonstration period)

Care Management Reports

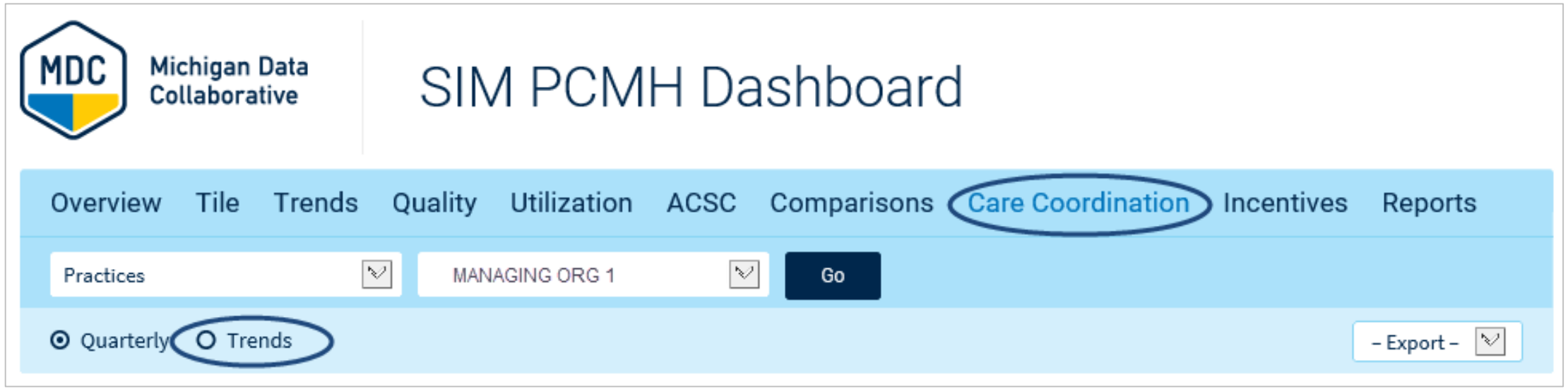
- Each month MDC generates Care Management and Coordination reports in Excel:
  - ✓ Percent of Patients with Care Management
  - ✓ Care Management Claims Detail corresponding to the Percent of Patients
  - ✓ Follow-up After Acute Inpatient Admission
- Visualizations are available on the Dashboard (demo to follow)
- Reports are available for download or are sent via sFTP

Care Management Reports – Rolling Quarters

Reporting Cycle 1	Report Delivery	Reporting Cycle 2	Report Delivery	Reporting Cycle 4	Report Delivery
CY 4Q18 (Oct – Dec 18)	Early April	**CY1Q19 (Jan – Mar 19)**	Early July	**CY2Q19 (Apr – Jun 19)**	Early October
Nov 18 – Jan 19	Late April	Feb – April 19	Late July	May – Jul 19	Late October
Dec 18 – Feb 19	Late May	Mar – May 19	Late August	Jun – Aug 19	Early December

- Each report is produced monthly and contains 3 months worth of data
- Three quarters (in bold green) are used for Care Management Improvement Reserve (CMIR)
- Helps to better assess how your organization is performing ahead of the calendar quarter reports that are used for CMIR
- REMINDER: The rate is recalculated by SIM PCMH (sum the numerator and average the denominator for the quarters in green)

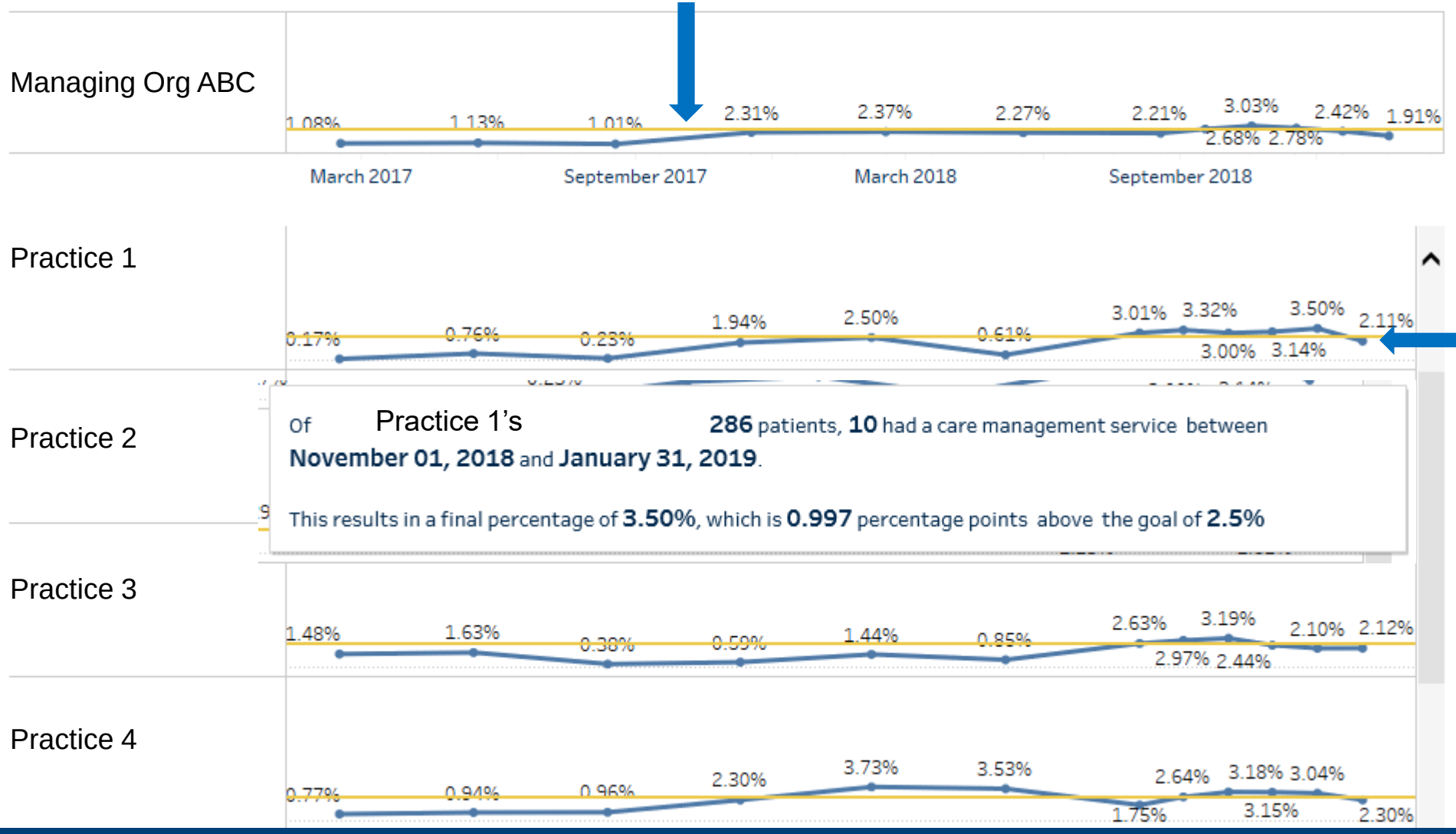
Care Coordination Pages - Trends



Quarterly Care Management, Percent of Patients

Inpatient Follow-Up
Percent of Patients

Yellow bar shows benchmark



Of Practice 1's **286** patients, **10** had a care management service between **November 01, 2018** and **January 31, 2019**.

This results in a final percentage of **3.50%**, which is **0.997** percentage points above the goal of **2.5%**

Overall managing organization performance across time

This practice's most recent results are lower than previous months.

Hover your cursor over a trend point to open a tool tip with more details.

Care Coordination Pages – Quarterly Reports

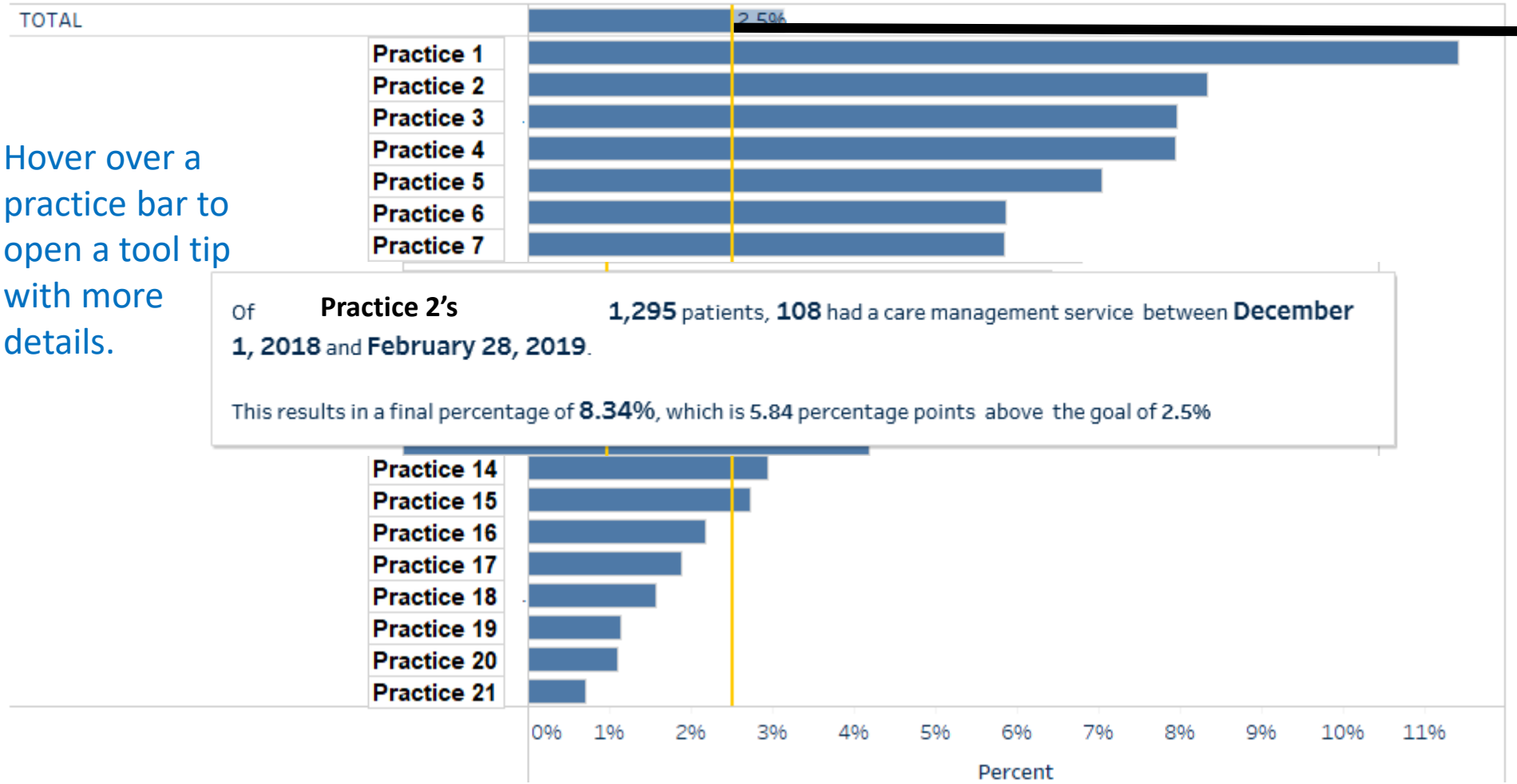
- Quarterly Reports show all the Practices in the Managing Organization

Quarterly Care Management, Percent of Patients

Inpatient Follow-Up
Percent of Patients

Managing Organization 1

Report Period: December 1, 2018 - February 28, 2019



Of **Practice 2's** **1,295** patients, **108** had a care management service between **December 1, 2018** and **February 28, 2019**.

This results in a final percentage of **8.34%**, which is **5.84** percentage points above the goal of **2.5%**

Hover over a practice bar to open a tool tip with more details.

Yellow bar shows the benchmark

Quickly see how different practices are performing

High performers could provide insight to others about what is working for them

Care Coordination Reports

Sample Claims Detail Report – Part 1

	Managing Organization ID	Practice Name	Practice ID	Attributed PCP Name	Attributed PCP NPI	Patient First Name	Patient Last Name	Patient Date of Birth	Patient Gender
Managing Org 1	MNORG1ID	PRACTICE 1	PRACID1	JOHN WHITE	1013917442	DEVIN	JONES	09/16/04	M
Managing Org 1	MNORG1ID	PRACTICE 1	PRACID1	JOHN WHITE	1013917442	SKYLER	DUNN	08/19/46	M
Managing Org 1	MNORG1ID	PRACTICE 1	PRACID1	JOHN WHITE	1013917442	FAITH	JOHNSON	09/09/04	F
Managing Org 1	MNORG1ID	PRACTICE 1	PRACID1	JOHN WHITE	1013917442	CONNOR	JOHNSON	04/25/44	M
Managing Org 1	MNORG1ID	PRACTICE 1	PRACID1	JOHN WHITE	1013917442	AVALIA	LUCAS	05/31/47	F
Managing Org 1	MNORG1ID	PRACTICE 2	PRACID2	DAVID JONES	1902874126	LORI	BAKER	05/30/86	F
Managing Org 1	MNORG1ID	PRACTICE 2	PRACID2	DAVID JONES	1902874126	NICOLE	CEASER	08/09/91	F
Managing Org 1	MNORG1ID	PRACTICE 2	PRACID2	DAVID JONES	1902874126	CARTER	BELI	06/22/48	M
Managing Org 1	MNORG1ID	PRACTICE 3	PRACID3	BRUCE WAYNE	1003996547	KEITH	PLATTER	08/25/61	M

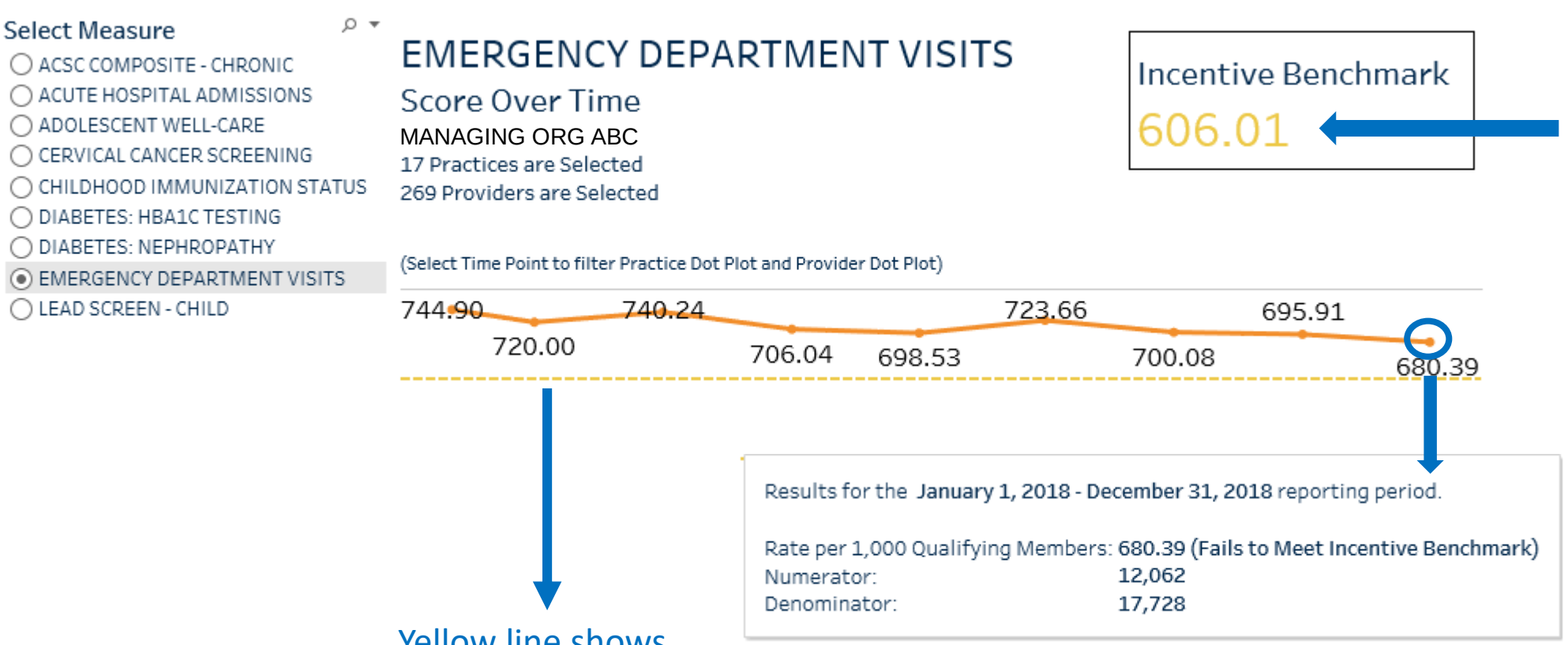
All data is sample data (does not contain real patient information)

Sample Claims Detail Report – Part 2

Service Date	Procedure Code	Servicing Provider NPI	Servicing Provider First Name	Servicing Provider Last Name	Billing Provider NPI	Billing Provider Name	Claim Status Code	Provider Practice Flag
12/04/2018	98966	1811217755	ALLISON	JONES	1811217755	JONES	Paid	Yes
01/24/2019	98966	1013917442	SUSAN	WHITE	1013917442	WHITE	Paid	Yes
02/23/2019	98967	1467716522	ERIC	GARCIA	1467716522	GARCIA	Paid	Yes
02/11/2019	98966	1811217755	ALLISON	HALONEN	1811217755	HALONEN	Paid	Yes
01/22/2019	98966	1811217755	ALLISON	HALONEN	1811217755	HALONEN	Paid	Yes
02/12/2019	98966	1902874126	DAVID	JACKSON	1902874126	JACKSON	Paid	Yes
02/13/2019	98966	1902874126	DAVID	JACKSON	1902874126	JACKSON	Paid	Yes
02/07/2019	98966	1902874126	DAVID	JACKSON	1902874126	JACKSON	Paid	Yes
01/03/2019	99495	1649350182	ROSE	AHMED	1679625875	AHMED FAMILY HEALTHCARE	Paid	Yes

All data is sample data (does not contain real patient information)

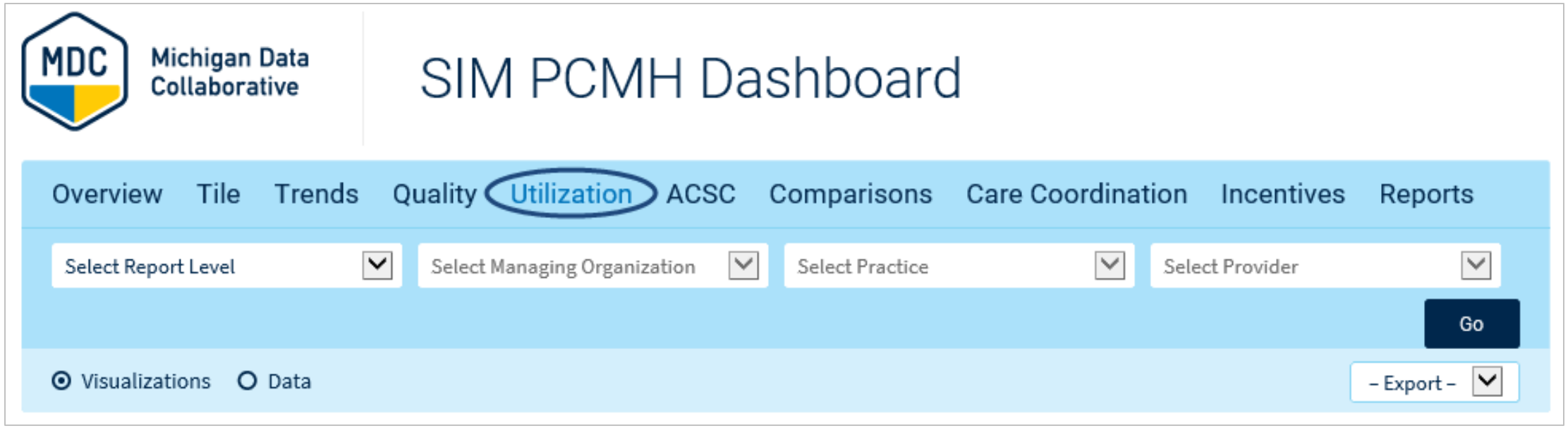
Measures included for PIP



Yellow line shows the benchmark. (Also shown numerically above.)

Select a time point to view additional reporting period details.

Utilization Page



Practice XYZ

Filter to Practice XYZ

Utilization Measures
Rate per 1,000 Qualifying Members
Measurement Period: January 1, 2018 - December 31, 2018

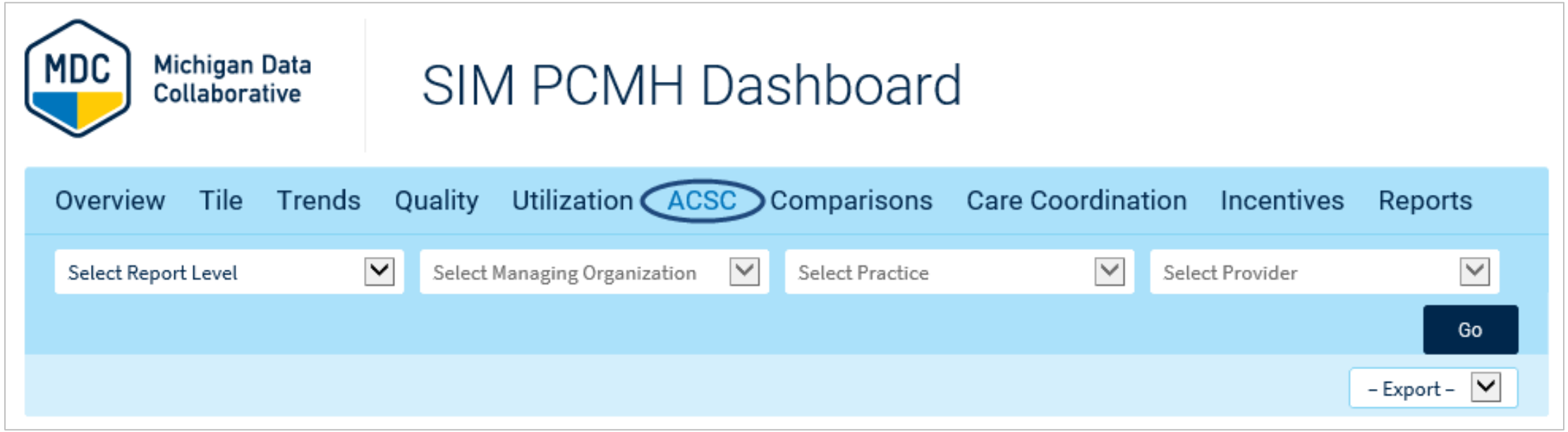
	Numerator	Denominator
Patient 1	15	1
Patient 2	12	1
Patient 3	12	1
Patient 4	11	1
Patient 5	9	1
Patient 6	9	1
Patient 7	8	1
Patient 8	7	1
Patient 9	7	1
Patient 10	7	1
Patient 11	6	1
Patient 12	6	1
Patient 13	6	1
Patient 14	6	1
Patient 15	5	1
Patient 16	5	1
Patient 17	5	1
Patient 18	5	1

Click on the Preventable ED Visits bar to view the patients for the Practice.

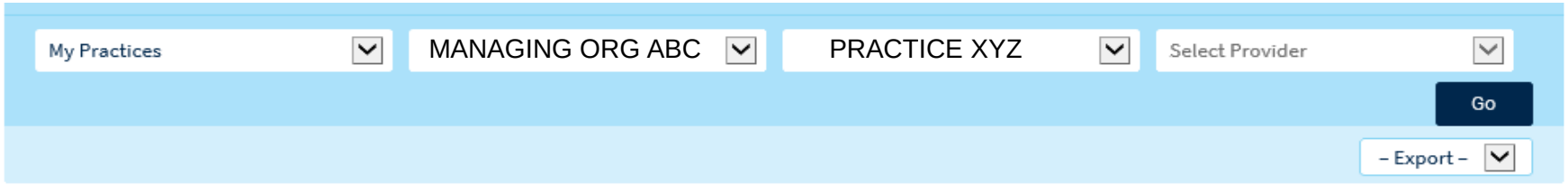
Confirm patients with high numbers of Preventable ED Visits are in Care Management.

(In the tool, actual patient names display.)

ACSC Page



- Displays Ambulatory Care Sensitive Condition Admissions
- Provides another potentially preventable utilization metric
- Helpful to look at patient level to ensure they are in Care Management



Executive Summary

POs/MSOs	Practices	Providers	Patients	Total Cost PMPM
MOABC	PRCXYZ	18	6,004	$263.99

Patient Demographics
Attribution: December 2018

Total Patients	6,004	
Avg. Member Age	20	
Patients by Sex		
Female	3,269	54%
Male	2,735	46%
Patients by Race		
Black	3,208	53%
White	1,879	31%
Other/Unknown	918	15%

ACSC Measures
Rate per 1,000 Qualifying Members
Measurement Period: January 1, 2018 - December 31, 2018

ADULT COMPOSITE - OVERALL
COMPOSITE - ACUTE
COMPOSITE
COMPOSITE
PEDIATRIC COMPOSITE
COMPOSITE
COMPOSITE

PREVENTION QUALITY CHRONIC

The percentage of patients age 18 years or older with unique hospital admissions in the following adult PQIs: Diabetes Short-Term Complications, Diabetes Long-Term Complications, COPD or Asthma in Older Adults, Hypertension, Heart Failure, Uncontrolled Diabetes, Asthma in younger Adults, and Lower-Extremity Amputation among Patients with Diabetes

Rate per 1,000 Qualifying Members: **13.46**

Numerator: **35**
Denominator: **2,600**

If a patient qualifies for multiple PQIs, only one of them is counted toward the numerator

For this practice, Chronic ACSCs are where they should focus. You can also see that diabetes are not driving the chronic admissions.

Select the Composite – Chronic bar to view more details.

Open the ACSC page and filter to Practice XYZ

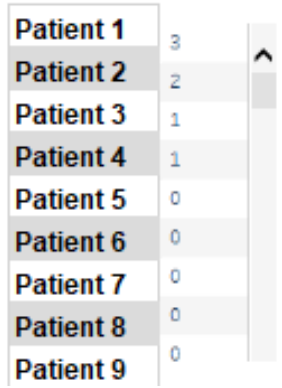
Practice XYZ

ACSC Measures

Measurement Period: January 1, 2018 - December 31, 2018

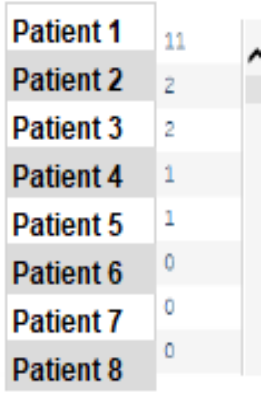
COPD and Heart Failure have the most admissions for this practice

		Rate per 1,000	Numerator	Denominator
ADULT	COMPOSITE - OVERALL	14.62	38	2,600
	COMPOSITE - ACUTE	1.15	3	2,600
	COMMUNITY ACQUIRED PNEUMONIA	0.38	1	2,600
	DEHYDRATION	0.77	2	2,600
	URINARY TRACT INFECTION	0.00	0	2,600
	COMPOSITE - CHRONIC	13.46	35	2,600
	ASTHMA IN YOUNGER ADULTS	0.00	0	1,674
	COPD OR ASTHMA IN OLDER ADULTS	7.56	7	926
	HEART FAILURE	6.54	17	2,600
	HYPERTENSION	0.38	1	2,600
	COMPOSITE - DIABETES	3.85	10	2,600
	DIABETES - UNCONTROLLED	0.77	2	2,600
	DIABETES - SHORT TERM COMPLICATIONS	0.77	2	2,600
	DIABETES - LONG TERM COMPLICATIONS	1.92	5	2,600
	DIABETES - LOWER-EXTREMITY AMPUTATION	0.38	1	2,600
PEDIATRIC	COMPOSITE - OVERALL	2.68	6	2,240
	COMPOSITE - ACUTE	0.89	2	2,240
	GASTROENTERITIS	0.00	0	3,397
	URINARY TRACT INFECTION	0.59	2	3,397
	COMPOSITE - CHRONIC	1.79	4	2,240
	ASTHMA	1.99	6	3,010
	DIABETES - SHORT TERM COMPLICATIONS	0.00	0	2,240



Click the COPD measure rate to view the patients.

Seven patients account for all of the admissions.

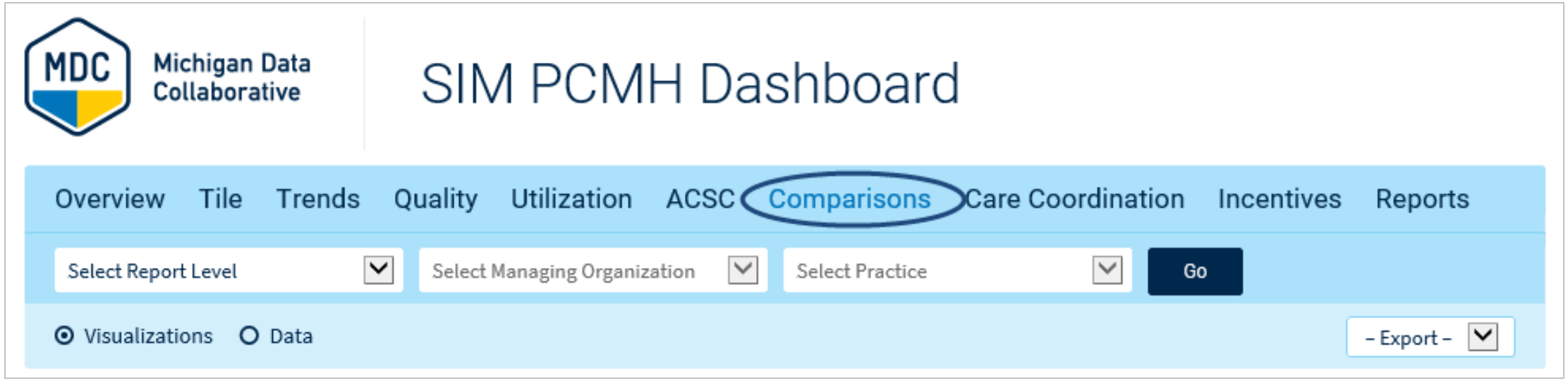


Click the Heart Failure measure rate to view the patients.

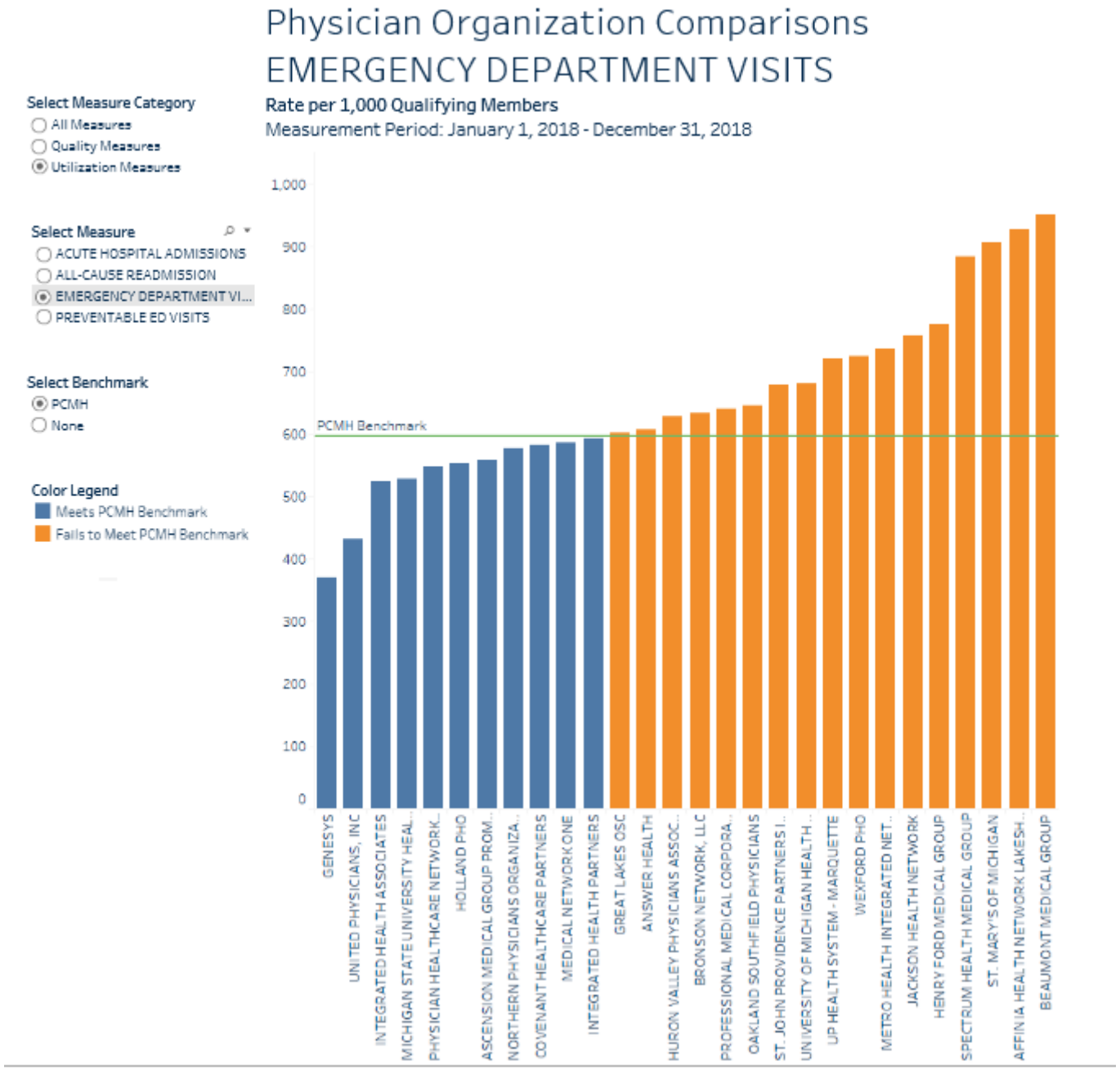
Patient 1 accounts for 11 of the 17 admissions.

Confirm these patients are receiving Care Management.

Comparisons Page



- Compare your physician organization to others
- Compare the practices in your physician organization

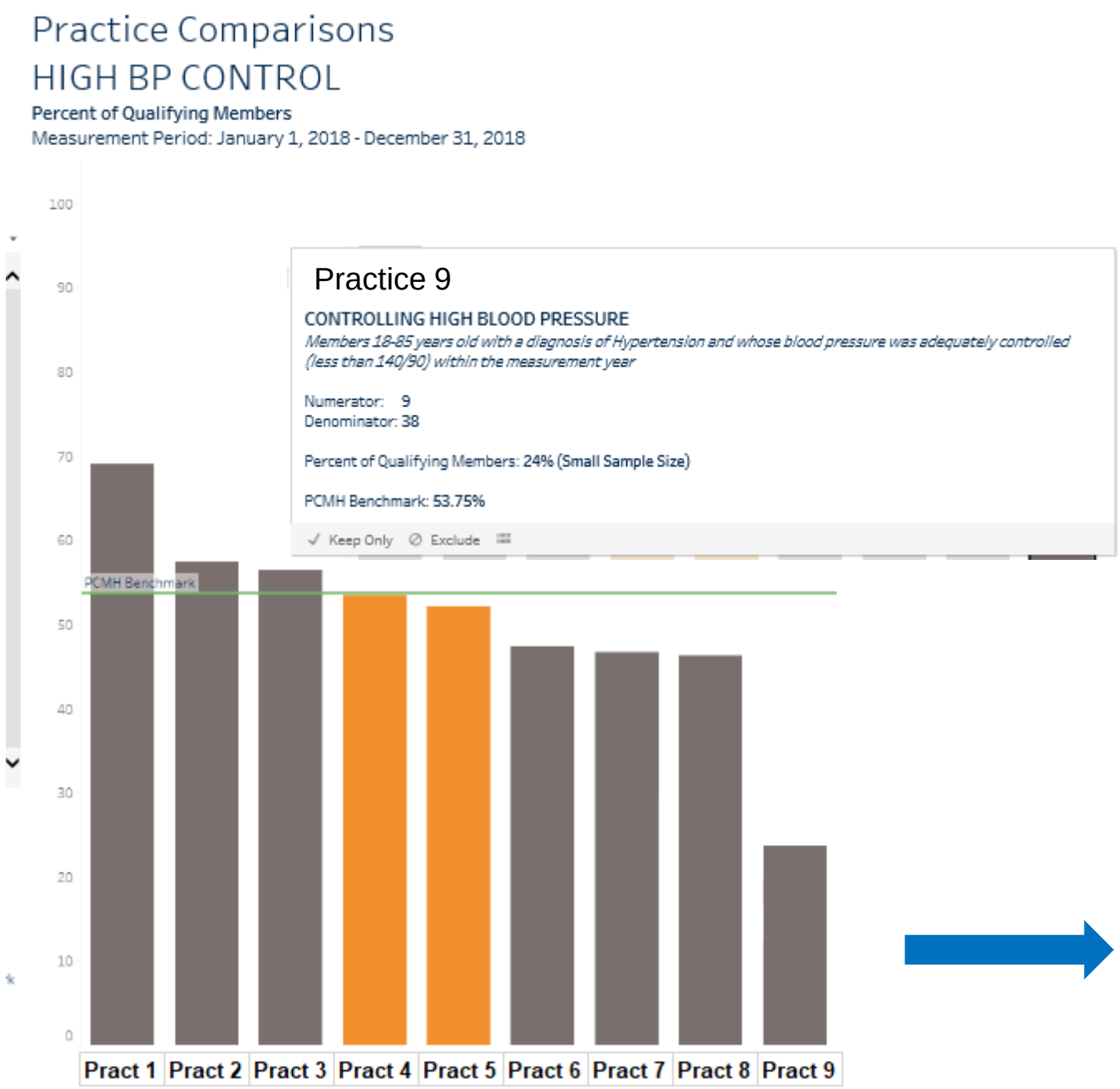


Quickly identify the best performing organizations.

Collaborate to identify best practices driving good results.

Can also compare practices within a managing organization.

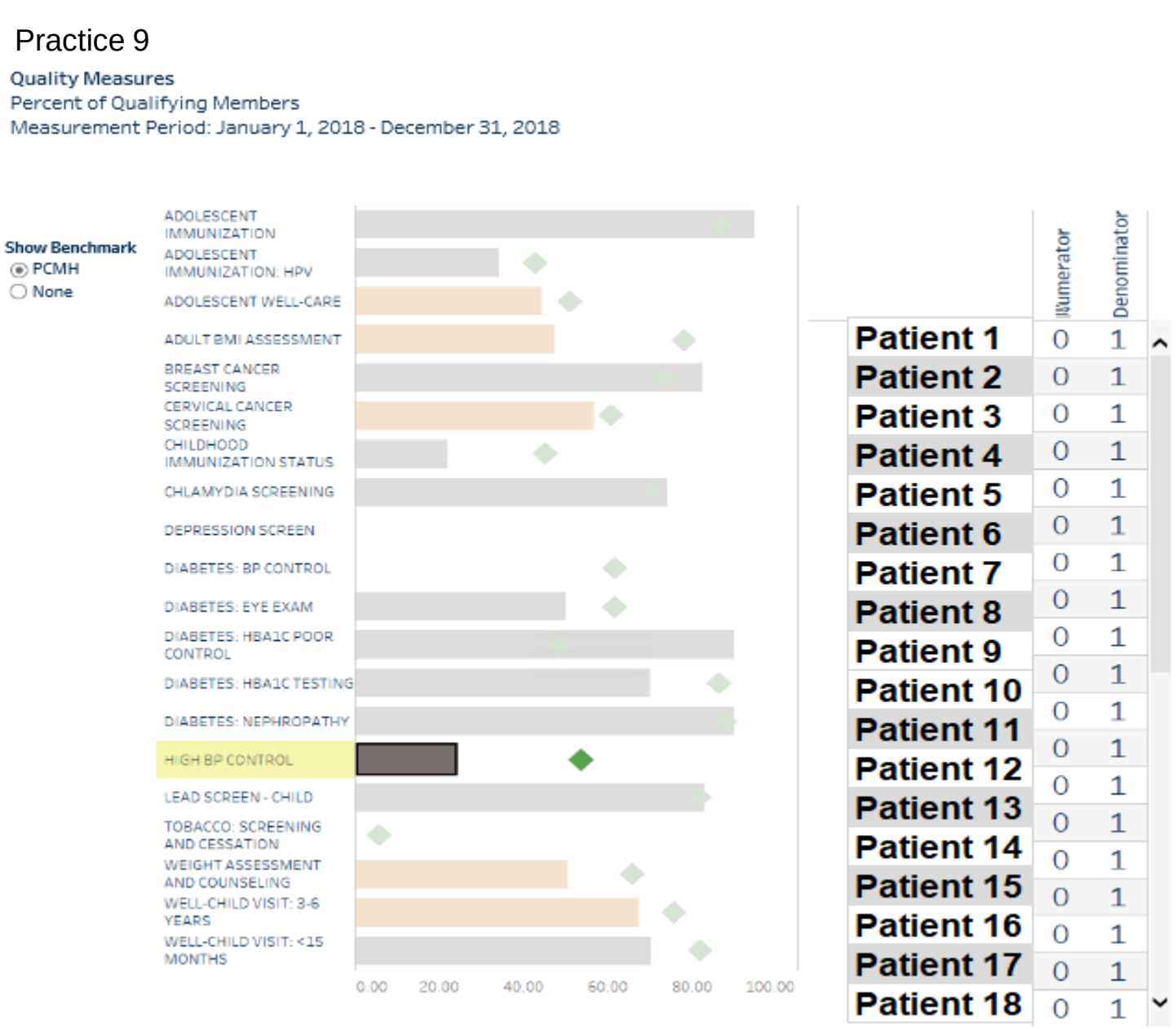
Practice 9 is behind the rest and could get pointers from the other high-performing practices.



Click the Practice 9 bar to view additional information.

Look at patients for this practice.

1. Open the Quality Page.
2. Filter to Practice 9.
3. Click the High BP Control bar.
4. View the patient list.



Links for More Information

Dashboard User Guide

Dashboard Release Notes

Technical Guide

Questions

Stories from Successful Collaborators

10:40 - 11:40 AM

Transitional Care Management: a toolkit for success

KERRIE BARNEY

CHERRY HEALTH

KERRIEBARNEY@CHERRYHEALTH.COM

Steps of Population Management

1. Define population
   (Who's Included?)
2. Determine ID process
   (How do we find them?)
3. Implement tracking
   (How do we monitor? Who keeps track?)
4. Set targets
   (What's the goal and how do we measure it?)
5. ID touchpoints
   (What's the workflow?)
6. Establish responsibilities
   (Who does what?)
7. Train the team
   (How do we make sure all know what to do?)
8. Implement process
   (When do we start?)
9. Revisit and Revise
   (What's working? What needs adjusting?)
10. Measure & Share
    (How are we doing? Who are we telling about it?)

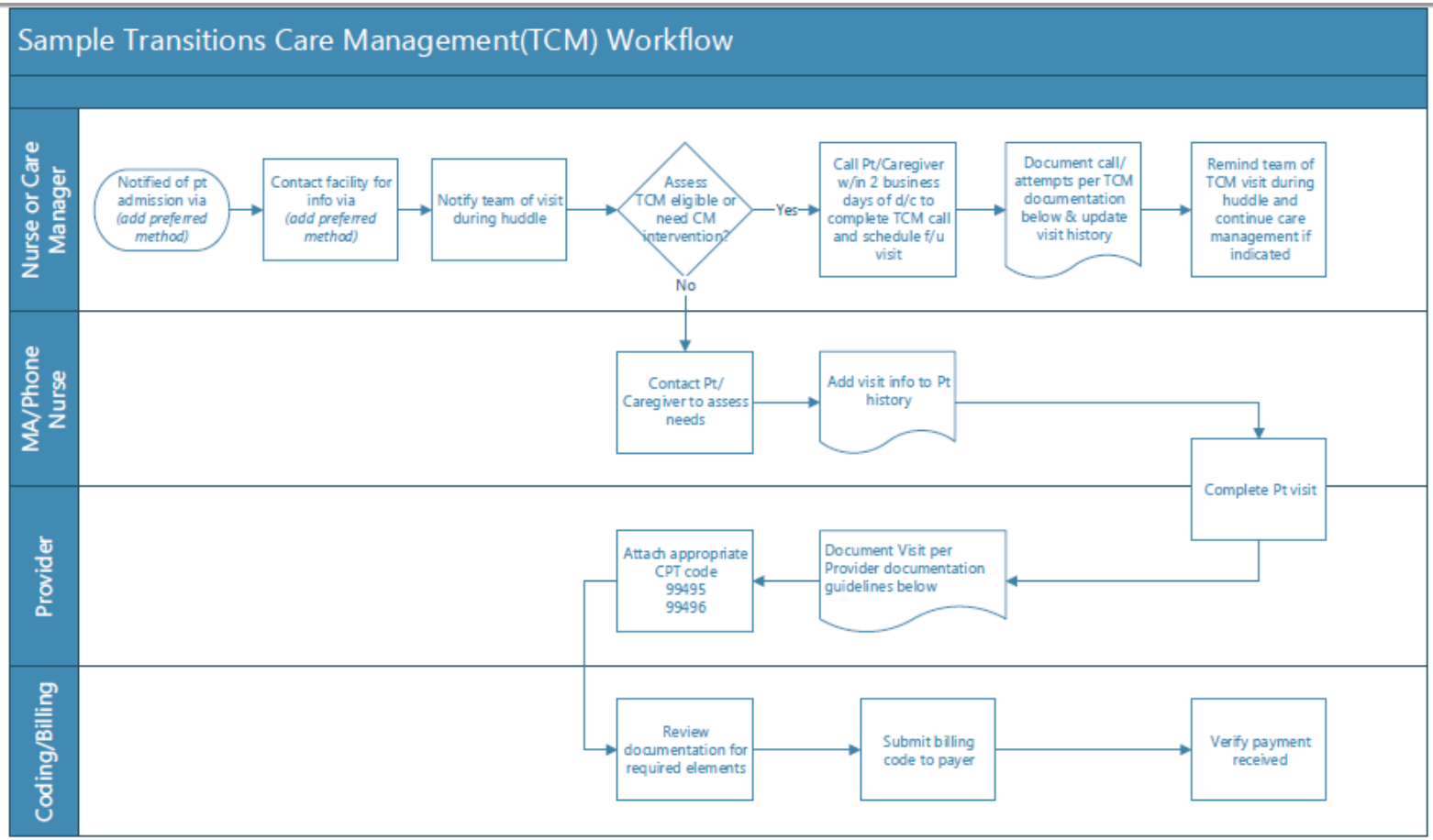
Population Tracker Sample

First Name	Last Name	Date of Birth	Admit Date	Physician	Admit Location	D/C Date	Facility D/C Summary on file?	Eligible for TOC Billing?	Complex 7day appt (TCM only)	Moderate 14 day appt (TCM only)	Phone contact w/in 2bus. Days (who, when)	Follow up appt. scheduled date	Diagnosis	F/u appt completed (date)	TCM code submitted (date)	TCM code paid?
Sample	Patient	1/1/1935	12/31/2018	Dr. Claus	Mercy IP	1/3/2018	y	y	y	n/a	1/4/19 EC	1/6/2019	COPD Exac	1/6/2019	1/6/2019	y
Sample2	Patient 2	2/1/2008	1/1/2019	Dr. Jones	Metro UC	1/1/2019	y	no	n/a	n/a	1/4/2019	prn only	ear infx	n/a	n/a	n/a

Sample Success Measures

Target/Measure	Goal	Considerations	Ways to Impact
# or % Unplanned Obs./ Inpt. Hospital stays	• Decrease over time • Decreased cost per pt stay (if data available)	• Total population or sub-population? • Behavior health too?	• Daily/weekly checks to detect rising risk • Clearly ID Pt./caregiver concerns and intervene prn • Reach in to hospital system
# or % ED or UC visits	Decrease over time	• Total population or sub-population? • PCP sensitive or all? • Behavior health too?	• Add after-hours # to Pt. Plans • Ensure after-hours number posted online, in rooms, etc. • Direct patient education • Tuck-in calls for high utilizers • Partner with area EDs for high utilizers
# or % after-hours calls	May increase initially	• What are most frequent call needs	• Proactive refill process • Anticipate concerns and tuck-in as appropriate

Establish Workflow



Need Determination

- Simple ED/UC to MA or Phone Nurse
- Complex ED/UC to RN or Care Manager
- Simple/Planned discharge (not TCM eligible) to MA or Phone Nurse
- Complex discharge to RN or Care Manager

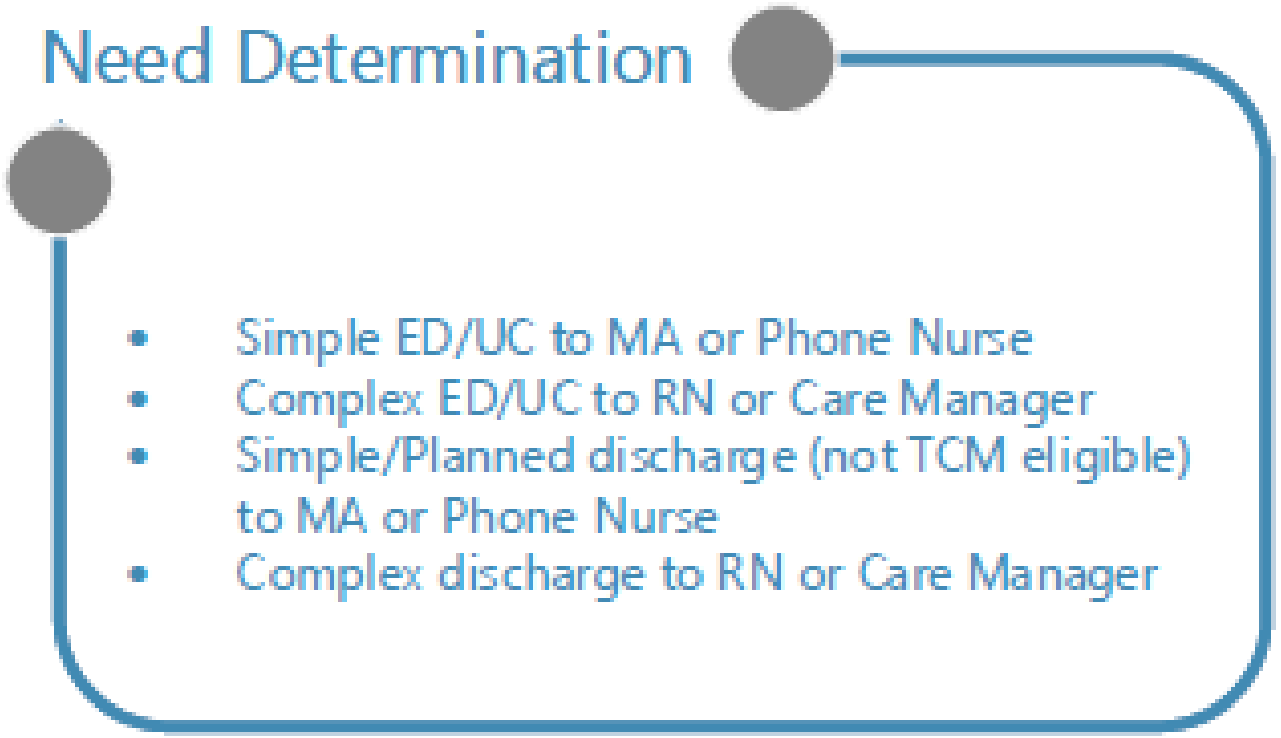
Provider Documentation

- Indicate TCM visit
- Indicate hospital/skilled nursing records reviewed
- Indicate complexity (via 99495 or 99496)
- Complete referrals/follow-up care prn

TCM Documentation

- Indicate TCM visit
- Indicate hospital/skilled nursing records reviewed
- Indicate complexity (via 99495 or 99496)
- Complete referrals/follow-up care prn

Establish Responsibilities



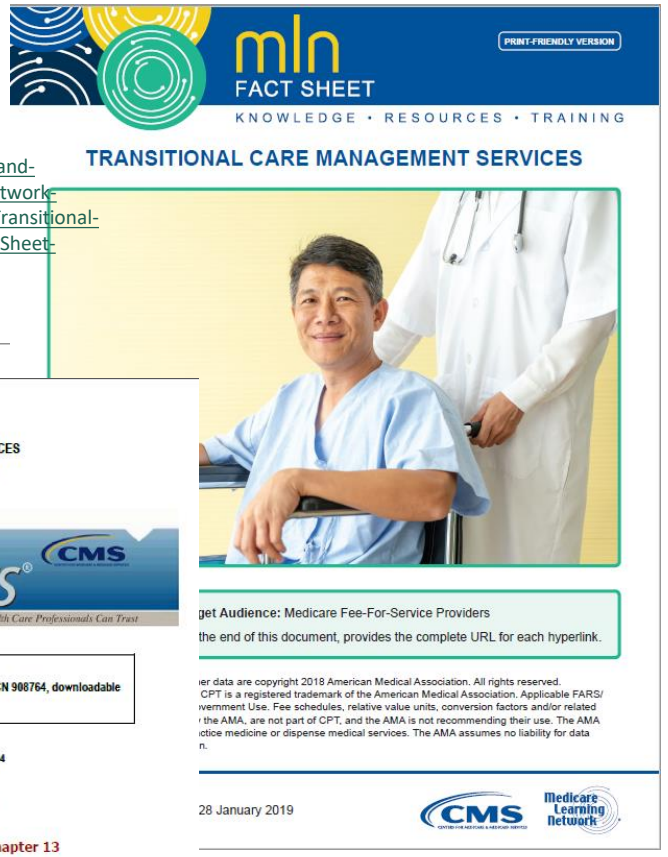
Train the Team

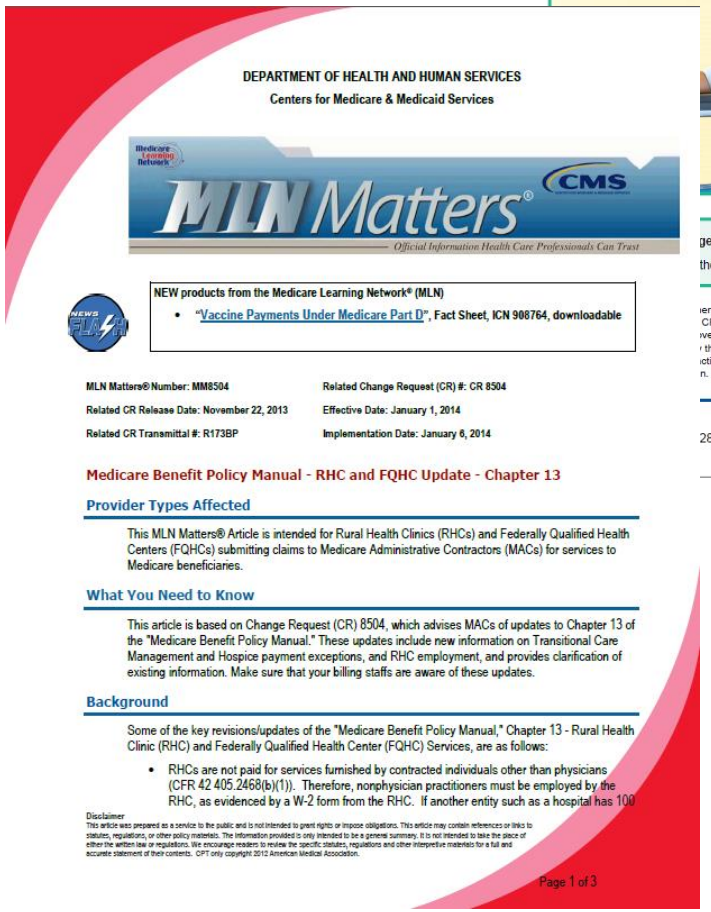
Consider the audience

Identify the right resources

Stack learning

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Transitional-Care-Management-Services-Fact-Sheet-ICN908628.pdf





https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8504.pdf

Implement the Process & Document it

TCM PHONE CALLS

Why is TCM Important? It is a new billable service to prevent patients' hospital re-admissions within 30 days of discharge. The clinical assistant's work and documentation is extremely important for billing purposes. Documentation must follow certain guidelines.

Goal: to transition the patient back into community setting following hospital, including mental health facility, or nursing home discharge without a gap in care.

What is Required? An interactive contact, providing non-face-to-face services (phone call) within 2 business days following discharge.

How to Accomplish the Service:

- Obtain and review discharge summary (If not available in NextGen, go to Power Chart for summary)
- Review with patient need to follow-up on pending diagnostic tests/treatments, i.e. pro-times, chest x-ray, etc.
- Phone patient – explain to the patient the service (calling patient post in-patient discharge to help them stay healthy and prevent a re-admission.) Explain we have a provider on call 24/7 to assist them if needed
- Be sure to verbally review each medication by having the patient read each med to you, including name of drug, dose, how frequently the patient is taking
- Confirm or schedule appointment for the face-to-face visit if not already done so before the patient left the in-patient setting
- Remind patient to bring all meds in a bag to the visit
- On average, the above process has taken approx. 10 minutes to complete

Required Documentation in NextGen

- Date of discharge, facility discharged from, reason for hospitalization
- Who you spoke with, i.e. patient, spouse, child, care giver
- State how the drug rec was accomplished, i.e. patient read drug name, dose, frequency from all bottles, etc.
- Record pain score, any SOB, nausea, vomiting, diarrhea, dizziness, etc., what is applicable for patient
- Record info regarding the face-to-face visit, who patient is seeing and when
- Assess for other needed services, i.e. VNS, oxygen, PT, OT, etc. as well as ability to care for self or need for assistance with ADLs, if so follow-up and refer as needed, and record
- All unsuccessful attempts to reach patient by phone must be recorded in NextGen including date and time. In order for the provider to charge for the TCM code, there must have been a non-face-to-face conversation or two attempts to reach patient were made within 2 business days of in-patient discharge

My Phrases related to Transitional Care Management Billing

Use following documents to complete call:

- Discharge summary
- Patient instructions
- PCP med list
- Inpatient case management notes

Phone contact within 2 business days (by care manager) my phrase

Inpatient at (facility) for: (List dx and important events)
Pt reports:
Outpatient services in place/needed:
Assistive Devices needed/in use:
Support System: (who helps pt)
PCP FU: (appt. date)
Specialist FU: (appt. date)
Self-management goal: Pt knows what to do for urgent/emergent needs. Gave afterhours #.

Intake Note (completed by rooming staff in addition to medication reconciliation*) my phrase

TCM visit s/p hospitalization for (List dx)
Pt concerns/needs: (list patient needs)
Med rec completed as documented in intake.

Physician Visit Note Submission my phrase

FTF visit s/p inpatient stay. Reviewed records for medical status, ADLs, psychosocial and coordination/service needs. Med reconciliation completed by (staff name).

30 Day Billing Submission (by care manager) my phrase

TCM Summary
Admitted to (hospital) on (date) for dx:
Discharged (date) to (location…home, ALC, etc.)
Pt contact made on (date)
Follow-up visit (date)
Medication reconciliation completed & documented (date)
No readmit as of 30 day discharge date (date)

***To complete Medication Reconciliation**

- Enter medications through Intake screen
- Check "Include in document" on top right corner
- Check "Completed for transition of care"
- Complete med rec verifying each medication with documentation of patient's report regarding how they are taking the medication
- At completion of rooming, generate Intake note. ***Medication reconciliation appears in intake note but is NOT reflected on Master IM.***

Thank you!

What questions do you have?

Right Place, Right Care

CHERIE BOSTWICK, RN CARE MANAGER

MUNSON HEALTHCARE FAMILY PRACTICE CENTER

CBOSTWICK@MHC.NET

Emergency Room Over Utilization

Emergency department overuse: $38 billion in wasteful health care spending. *New England Healthcare Institute (NEHI), How Many More Studies Will It Take? A Collection of Evidence That Our Health Care System Can Do Better, Cambridge, MA: NEHI, 2008.*

Nationally, 56 percent, or roughly 67 million ER visits, are potentially avoidable. *Weinick R, Billings J, Thorpe J, Ambulatory care sensitive emergency department visits: a national perspective, Abstr AcademyHealth Meet, 2003;20(abstr no. 8):525-526.*

The average cost of an ED visit is $580 more than the cost of an office health care visit. *Machlin, SR, Medical Expenditure Panel Survey (MEPS), Statistical Brief 111: Expenses for a Hospital Emergency Room Visit, 2003, Adjusted to 2007 Data. Rockville, MD: Agency for Healthcare Research and Quality (AHRQ), 2006. Available at www.meps.ahrq. gov/mepsweb/data_files/publications/st111/stat111.pdf Last accessed November 2010.*

Who are the drivers of ER over utilization?

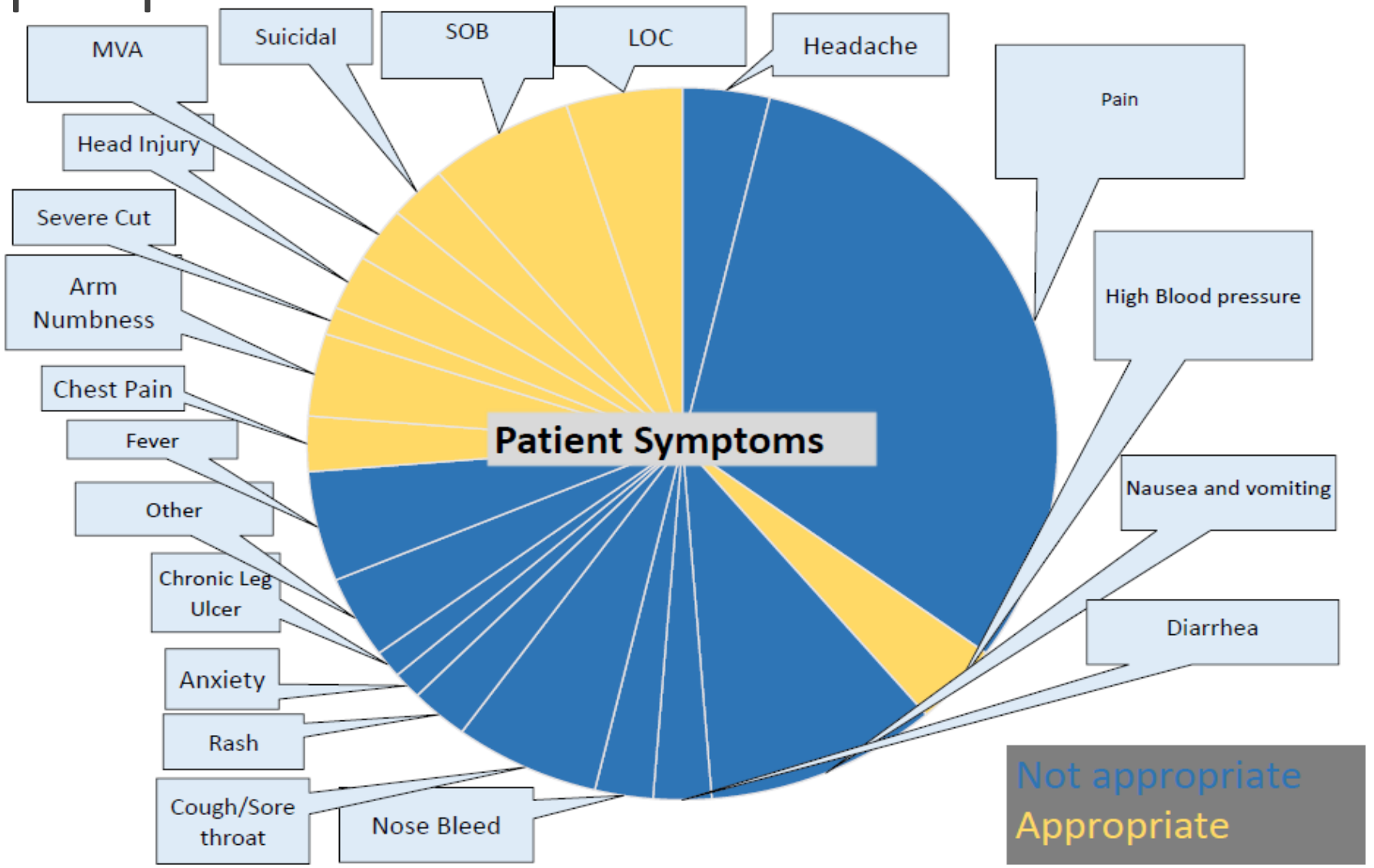
Data collection Post ER Visit

- Determine the reason for the ER visit in the patients own words
- Determine whether patient called clinic for triaging prior to going to ER
- Determine patient knowledge of same day appointment availability
- Determine patient knowledge of physicians on call after hours
- Schedule a clinic follow up appointment

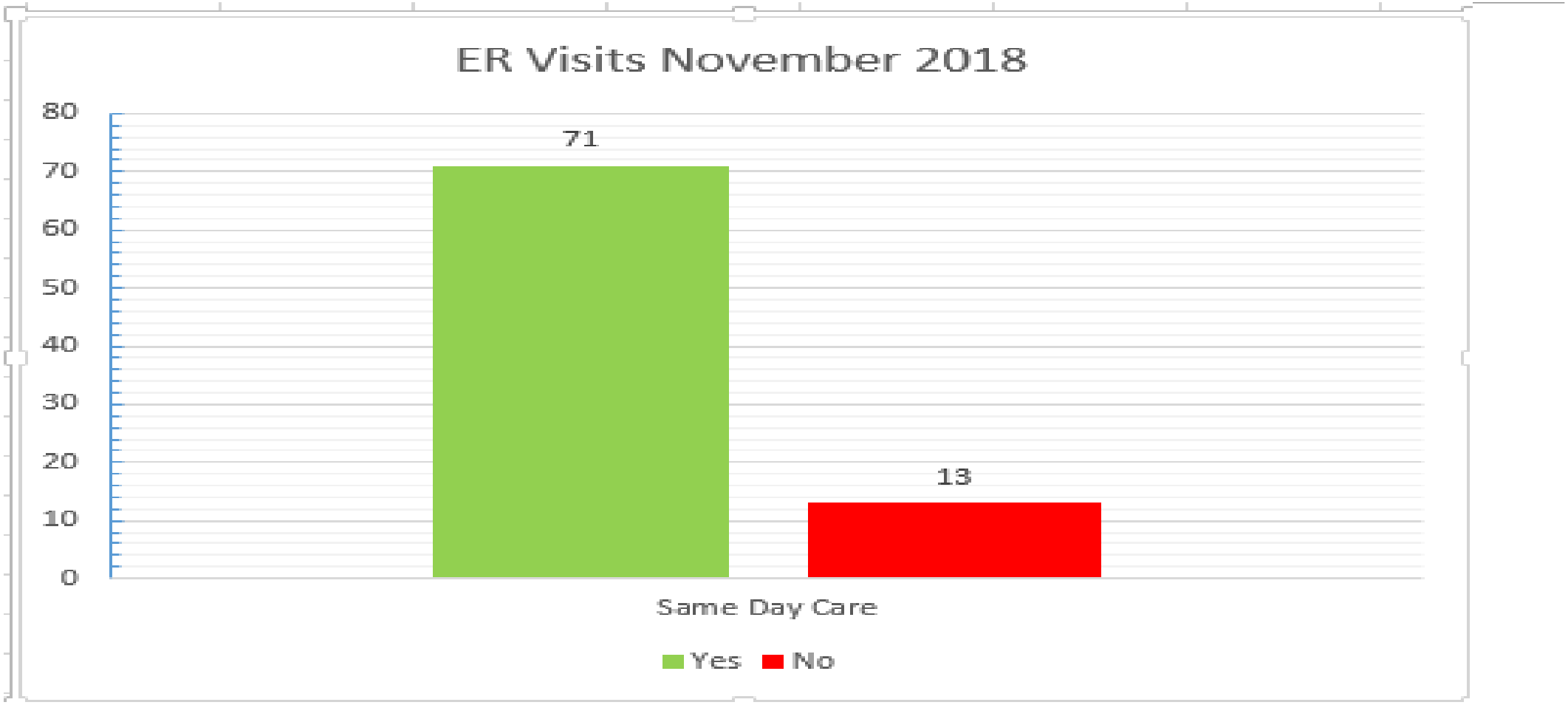
Post ER Visit Chart Review

- Day of the week and time patient presented to the emergency room
- Whether the patient had health insurance and if so who is the payor
- Whether the patient followed up in the clinic post ER visit

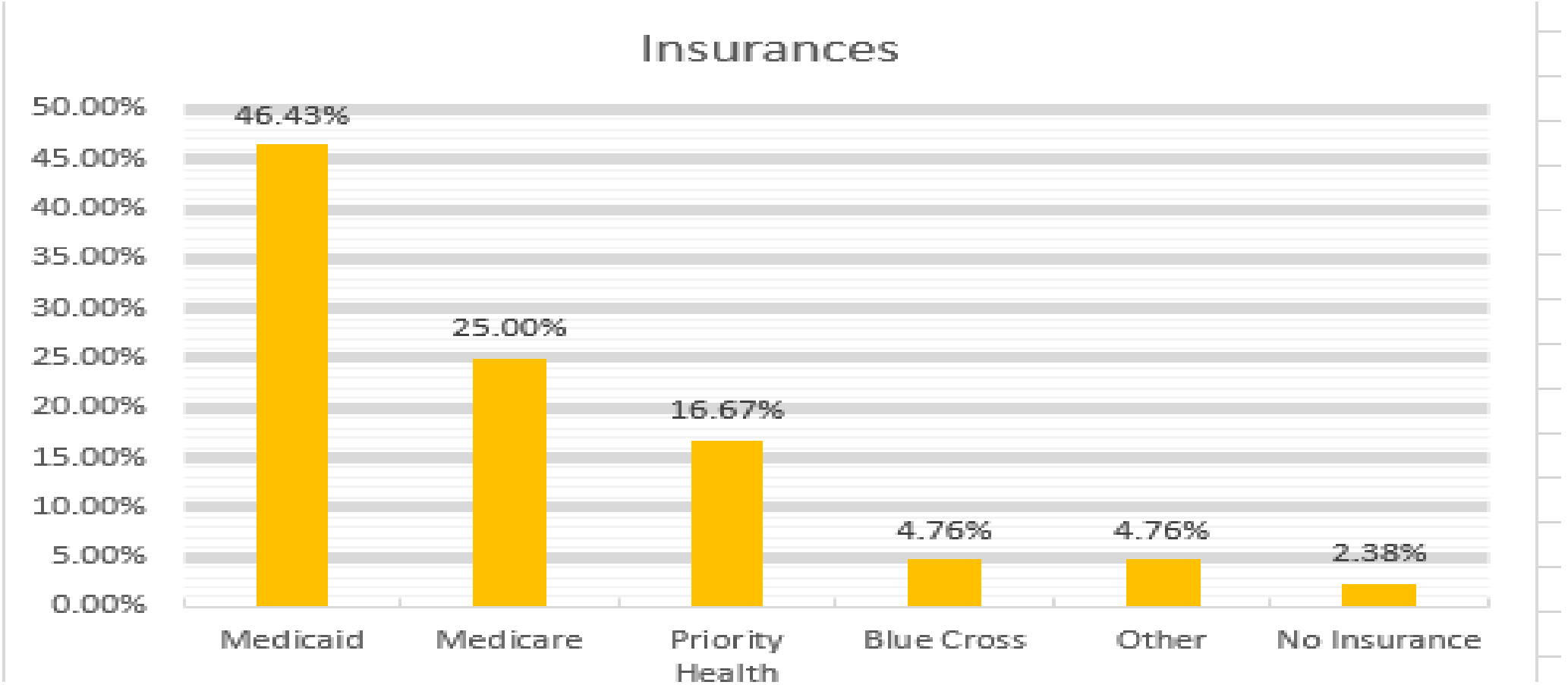
Symptom Appropriate



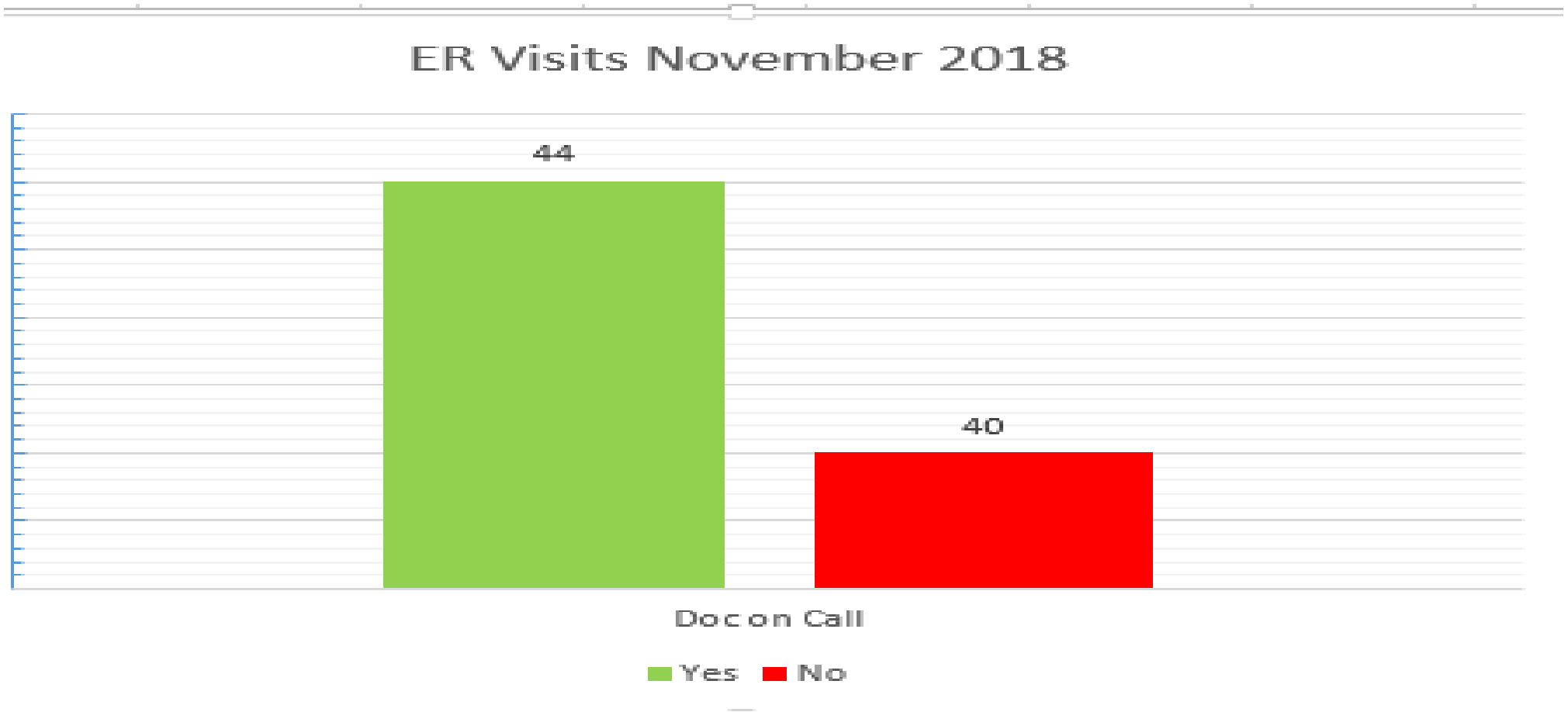
Patient's knowledge of same day care



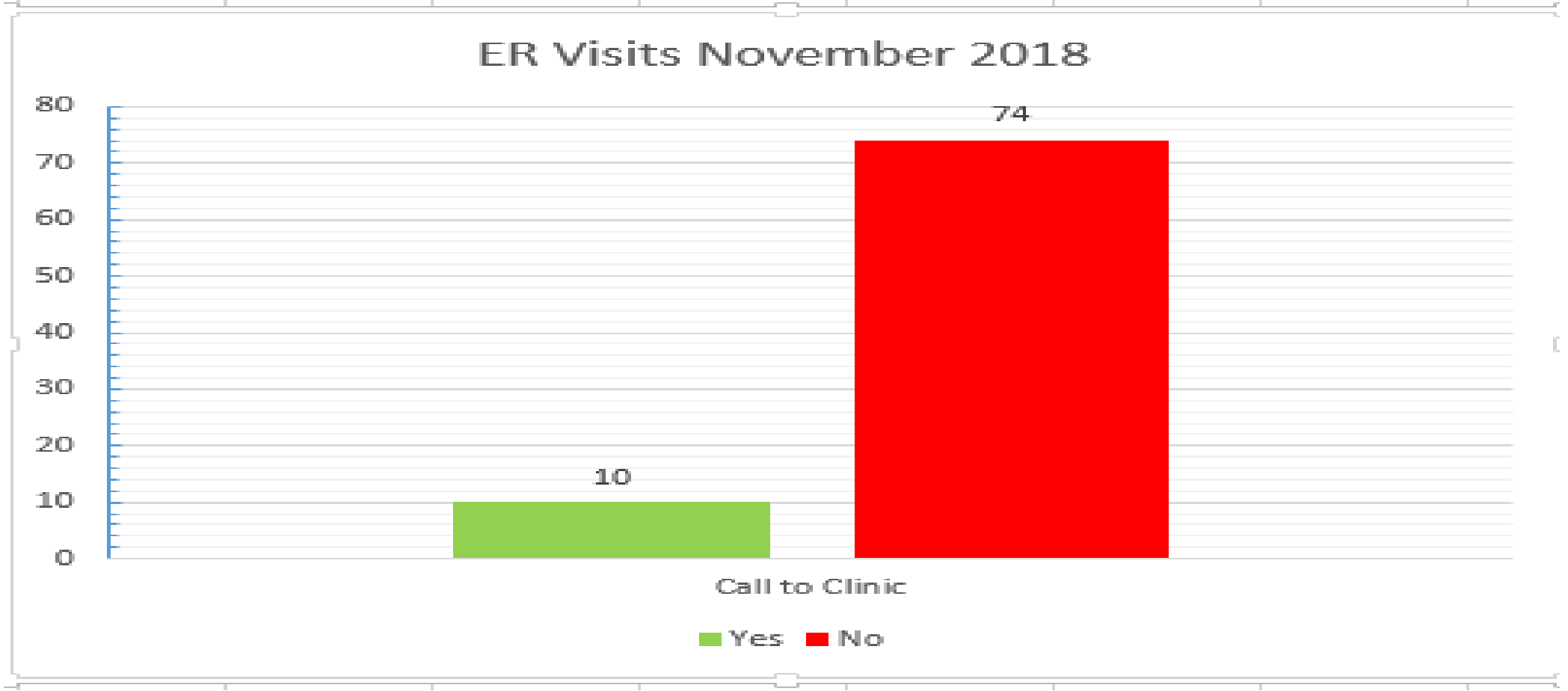
Health Insurance/Payor Information



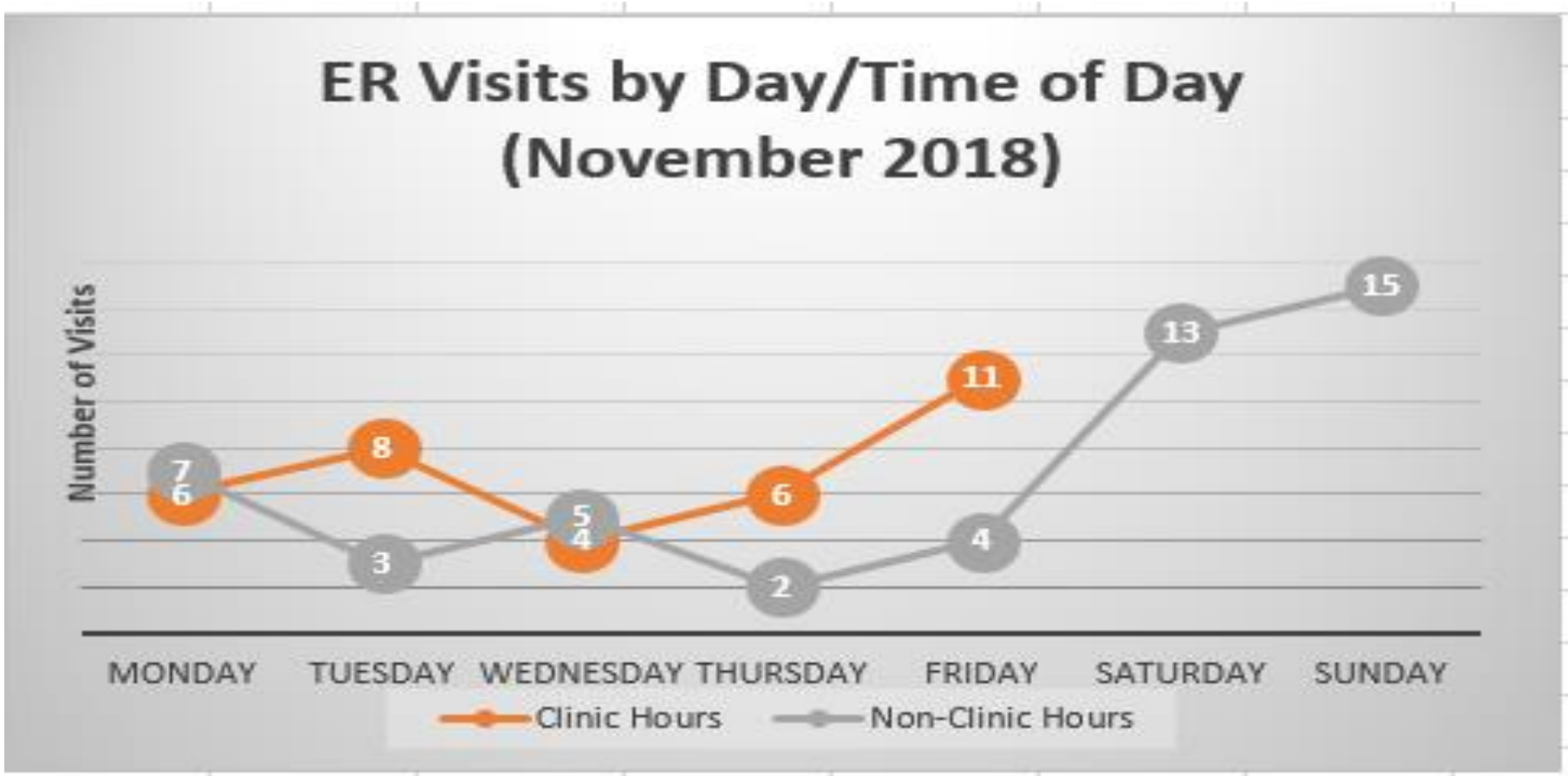
Patient's knowledge of after hours physician on call



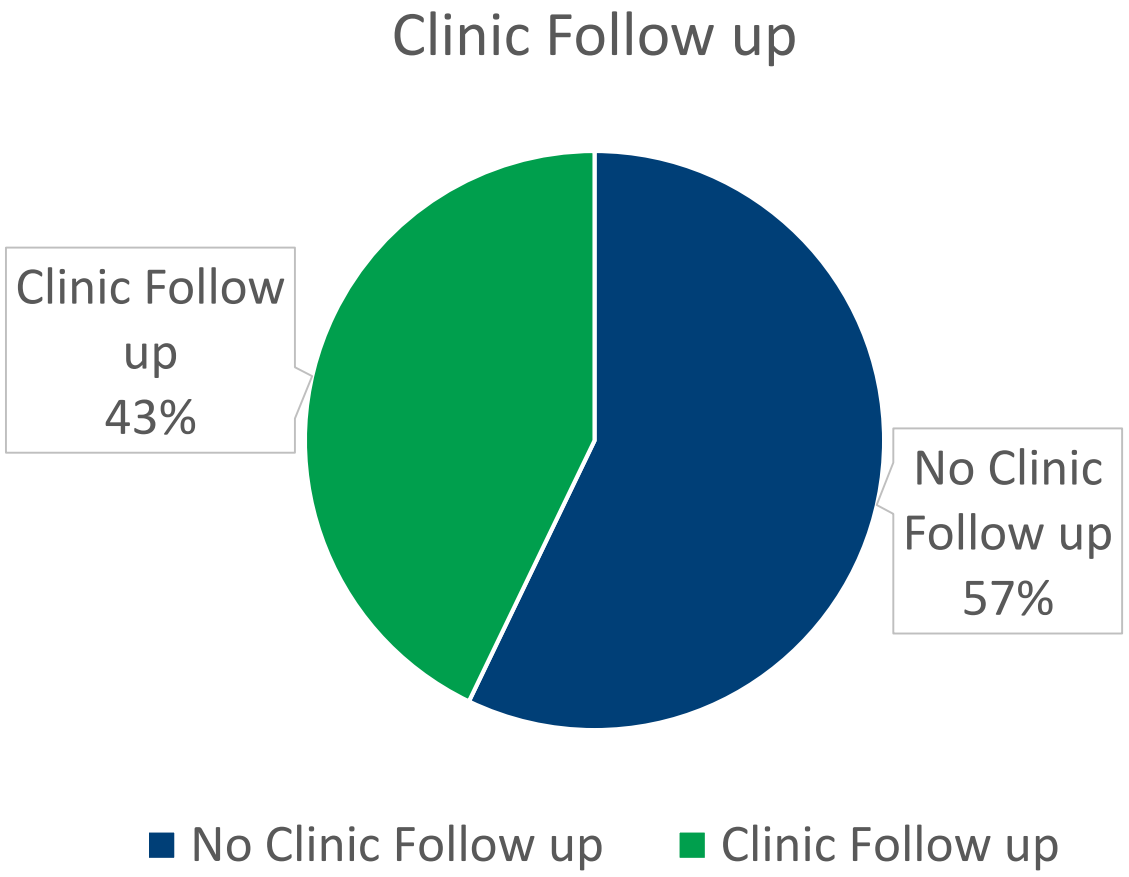
Call to clinic for triaging



Day and Time


ER Visits by Day/Time of Day
(November 2018)
Number of Visits
7
6
8
3
5
4
6
2
11
4
13
15
MONDAY
TUESDAY
WEDNESDAY
THURSDAY
FRIDAY
SATURDAY
SUNDAY
Clinic Hours
Non-Clinic Hours

Clinic Follow up

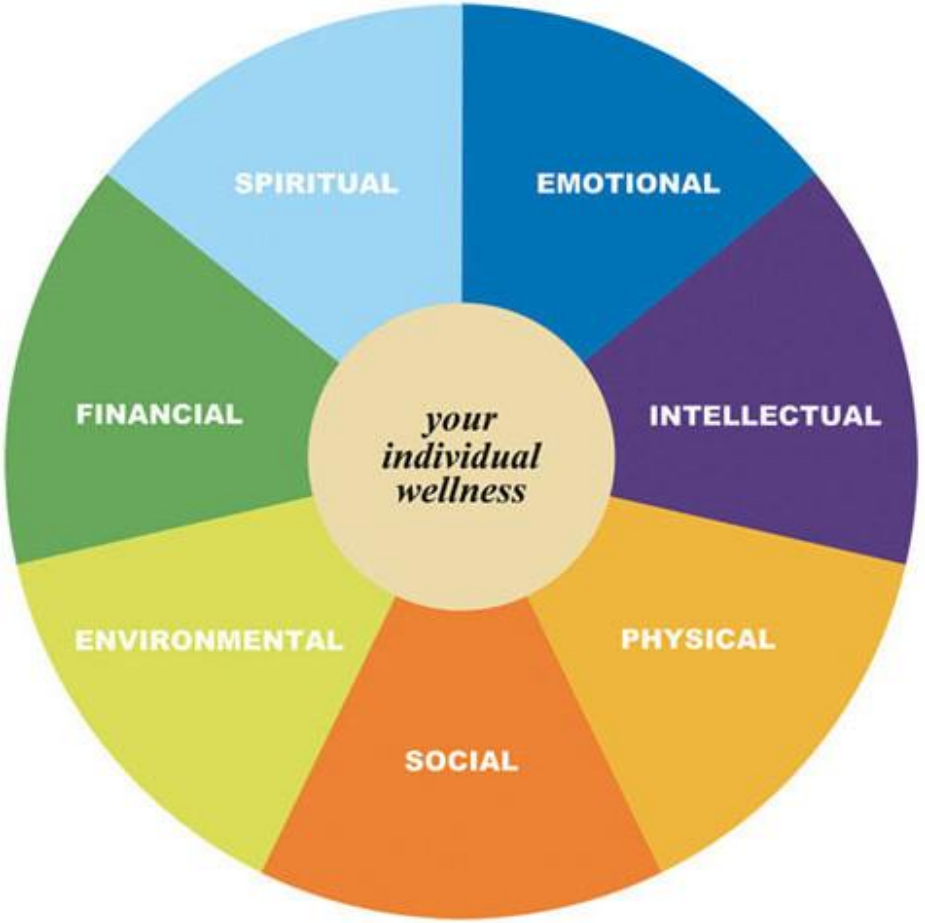


Action Steps Taken

1. Interdisiplinary Team
2. Individualized Care Plans
3. Enrollment in Care Management
4. Post ER calls

Future Action Steps

1. Telephone nursing triage
2. Access to clinic
3. Improve after hours telephone
4. Evaluate need for follow up letter
5. Continue to work as a team



Questions?

Coordinating The Coordination of Care & Addressing Social Determinants of Health

LORI KUNKEL & CHRIS WISE, PHD

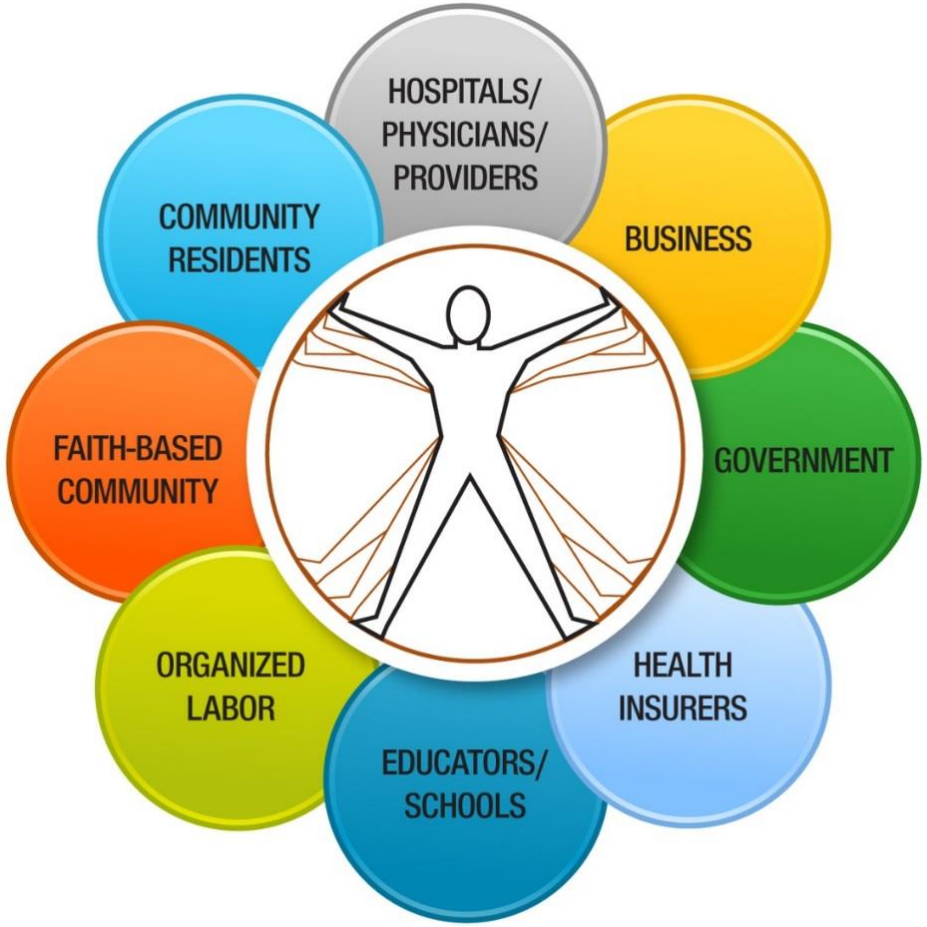
GREATER FLINT HEALTH COALITION | WISE HEALTHCARE

LKUNKEL@FLINT.ORG (810 232-2228)

CWISEHEALTHCARE@GMAIL.ORG (734 972-1632)

Greater Flint Health Coalition

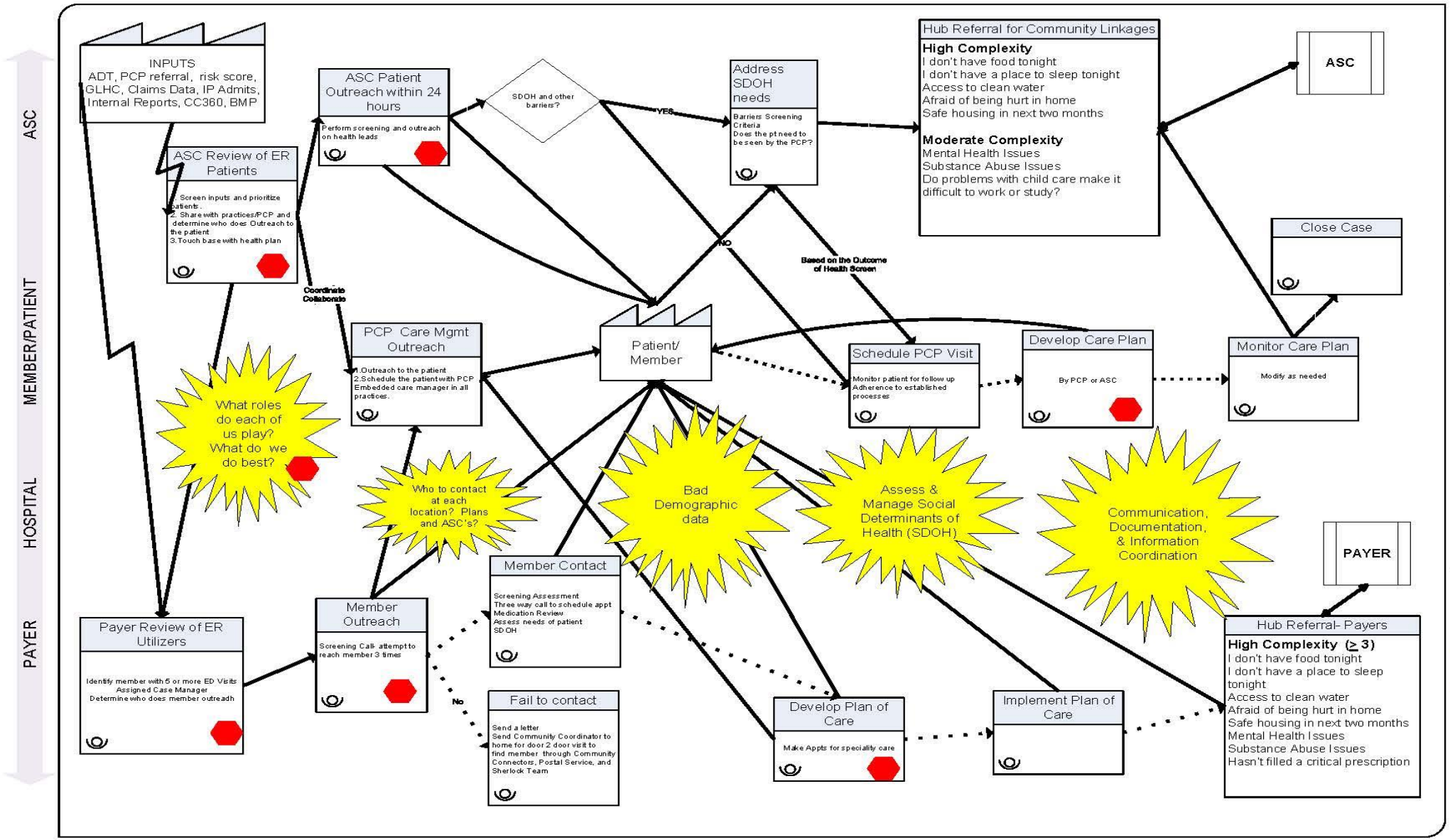
Established in 1996, the Greater Flint Health Coalition is a 501(c)3 non-profit health coalition – a true partnership between Genesee County hospitals, physicians, business, insurers, public health professionals, policymakers, government leaders, educators, organized labor, residents, and all those concerned about the well-being of our community and its residents.



Genesee SIM Region

- Three Accountable Systems of Care (ASCs)
  - Professional Medical Corporation
  - Genesys PHO
  - McLaren Physician Partners (not officially designated, but actively participating)
- Six Medicaid Health Plans
- Two FQHCs
- Greater Flint Health Coalition is the backbone organization for the CHIR
- Over 40,000 Medicaid members
- MDHHS Priorities:
  - Managing ED utilization
  - Assessing for, and addressing, Social Determinants of Health

Process Map of Management for Genesee County patients with High ER Utilization and Referrals to Hub for Community Linkages



Map Legend

- Customer or Supplier
- Process Box
- Kaizen Burst (opportunity for improvement)
- Work Flow
- Information Flow
- Electronic Information
- Reference to Starburst

Participant Organizations

ASCs: Professional Medical Corp., McLaren Physician Partners

Medicaid Plans: McLaren Health Plan, HAP - Midwest, Molina H/C of Michigan, Blue Care Complete

Genesee CHIR Backbone Organization: Greater Flint Health Coalition

ICC Workgroup Future State

Coordinate What We Are Doing

Patient

ID Patient
(ED Utilizers)

Health Plans Reports Preventable Inappropriate

SDOH

Great Lakes Health Connect High ED Utilizers

ADT/ MiHIN

Greater Flint Health Coalition

ASC
Panel Management: High, Non-emergent and Preventable ED Use

Improved access & willingness of Hospitals to provide this Info

Is patient actively engaged with other care management plan? Health Plans, PIHP, BMP, Other?

Practice Embedded Care Managers
Address issues within 30 days
(including SDOH)

ASC assumes lead role of managing patient

Plans know if patient is being managed from billing codes (12 of them) Is there a better way?

Patient informed of who will contact them for which purposes

Patient responsibility for managing care plan

PCMH
Neighborhood

Develop & Implement Care Plan by Embedded ASC Care Coordinators

CCL Hub Specialty Hubs

Specialist

Anyone else

Various Community Resources

We need to build stronger communication & documentation across our medical neighborhood

Other Care Management Plans

Challenge of how Sub Hub can inform embedded care management and coordinate

1

2

3

4

Patient Requirements
- Who is already being managed ASC vs Payer?
- Reasons for utilization
- Barriers/SDOH
- SDOH
- Positive approach/nonjudgmental
- Non-duplicative explanation
- ID of who is doing outreach
- Coordinated communication
- Standardized Stratification
- Proactive Identification

Outreach Building/ Patient Accountability
- Overutilization of phone minutes
  - Texts vs voice calls
  - Preferred method of contact
- Single point of contact
- Everyone on our team knows my health history; common care plan
- Why do I have to repeatedly tell my story
- Consent for confidential diagnosis release (for all relevant partners)
  - Standardized consent process
- We need to define who the team is
- Understand next steps
  - Understand my obligations (rules of engagement)
- Continuous shared communication of outcomes

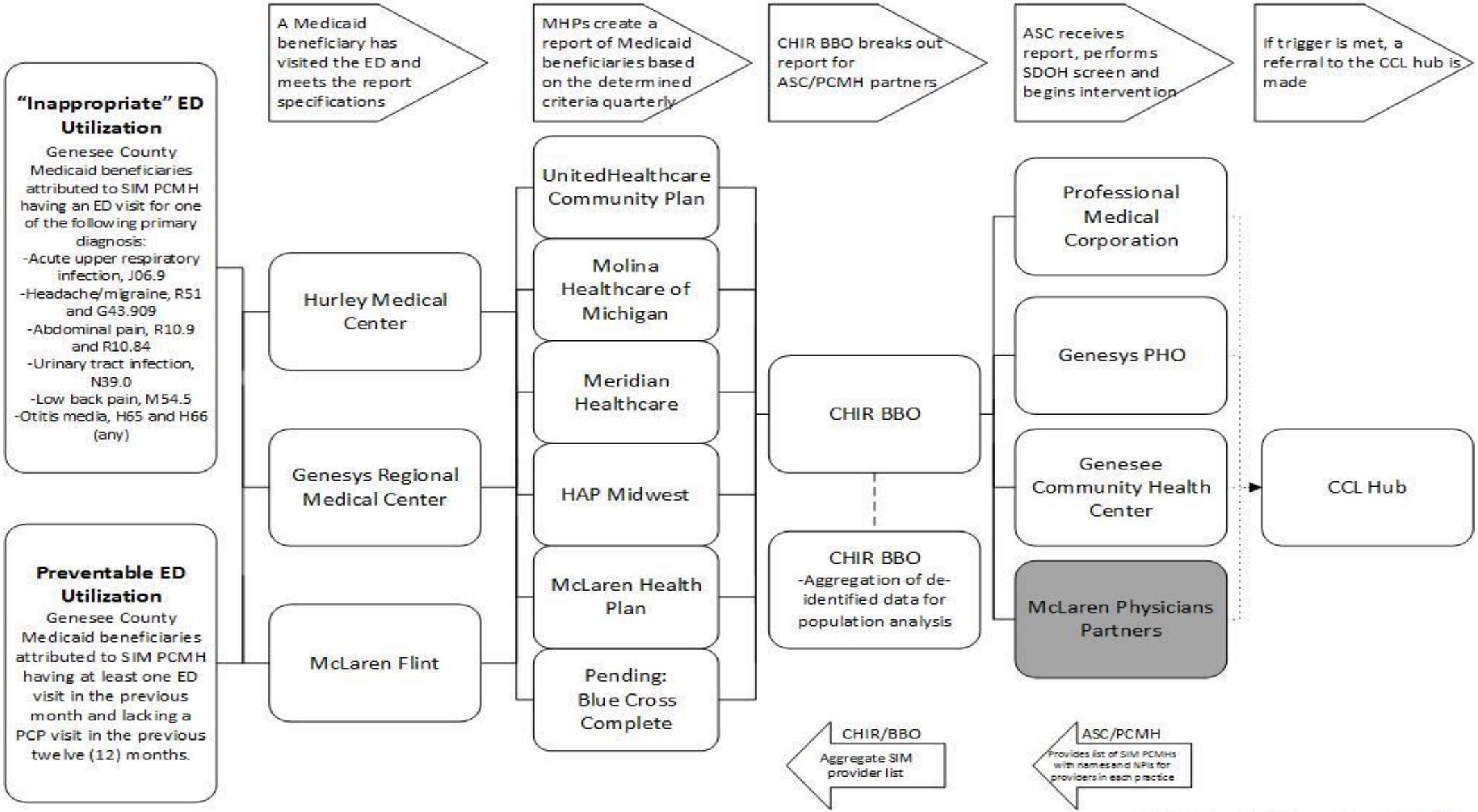
Care Plan Development
- Interactive/Shared Common Care Plan
- Define team, responsibility and time frames
- Patient centered obtainable goals
- Patient education/comprehension buy-in
- Team approach
- Team review process of goals
- Identify barriers
  - Review SDOH (& address)
- Refer to Hub
- Standardized/common care plan
- Role Based
- Minimum standards of care plan accessible to the team for sharing and collaboration
- Patient perspective
- Identify what patents does not want to do
  - Aversion/choice/preference
- Effective/Efficient engagement of team
- Available resources
- Understanding team hand-offs (who/when/what)
- Outbound referrals
  - Tracking

Implementing Care Plan
- Identify priority interventions
- Progress on goals
- Motivational interviewing
- Menu of options
- Evaluate progress
- Set value
- Documentation of action plans, resources, tools
- Who will do what, when (patient knows point of contact)
- Follow up on next steps (referrals, calls, provider comm.)
- Establish points of communication across team members
- Provider knows what insurance plans can provide and vice versa
- Reduced lost contact

Follow Up Actions Toward Future State

1. Monthly rounding calls between ASCs, practices, Health Plans, and CCL Hub Care Coordinators
2. Medicaid Health Plans provide monthly ED utilization reports to Genesee CHIR BBO
   - Submitted to Genesee CHIR
   - CHIR combines plan reports into one ‘all payer’ report
   - CHIR send ‘all payer’ report to ASCs
3. Ongoing education by CCL Hub to primary care practices regarding available services
4. Monthly in-person CCL workgroup meetings hosted by the Genesee CHIR
5. Continued Development of Standard SDoH screening tool
   - Data collected and aggregated by Genesee CHIR
6. Investigating Care Coordination actions that might be delegated by Medicaid Health Plans to either ASCs or CCL Hubs in order to reduce duplication of services and address ‘current state chaos”

"Inappropriate" & Preventable ED Utilizer Report Process Map



CLINICAL-COMMUNITY LINKAGE INITIATIVE

Genesee Community Health Innovation Region

Greater Flint Health Coalition

Great Lakes Health Connect Community Referral Platform

SIM MDHHS State Innovation Model

SIM MDHHS State Innovation Model

Presenters to Provide Overview of Genesee CHIR Clinical Community Linkage (CCL) Process

QUESTIONS?

&

THANK YOU!

Intensive Working Session (in small group tables)

11:40 AM - 12:10 PM

Working in Your Group: The Morning's Mission

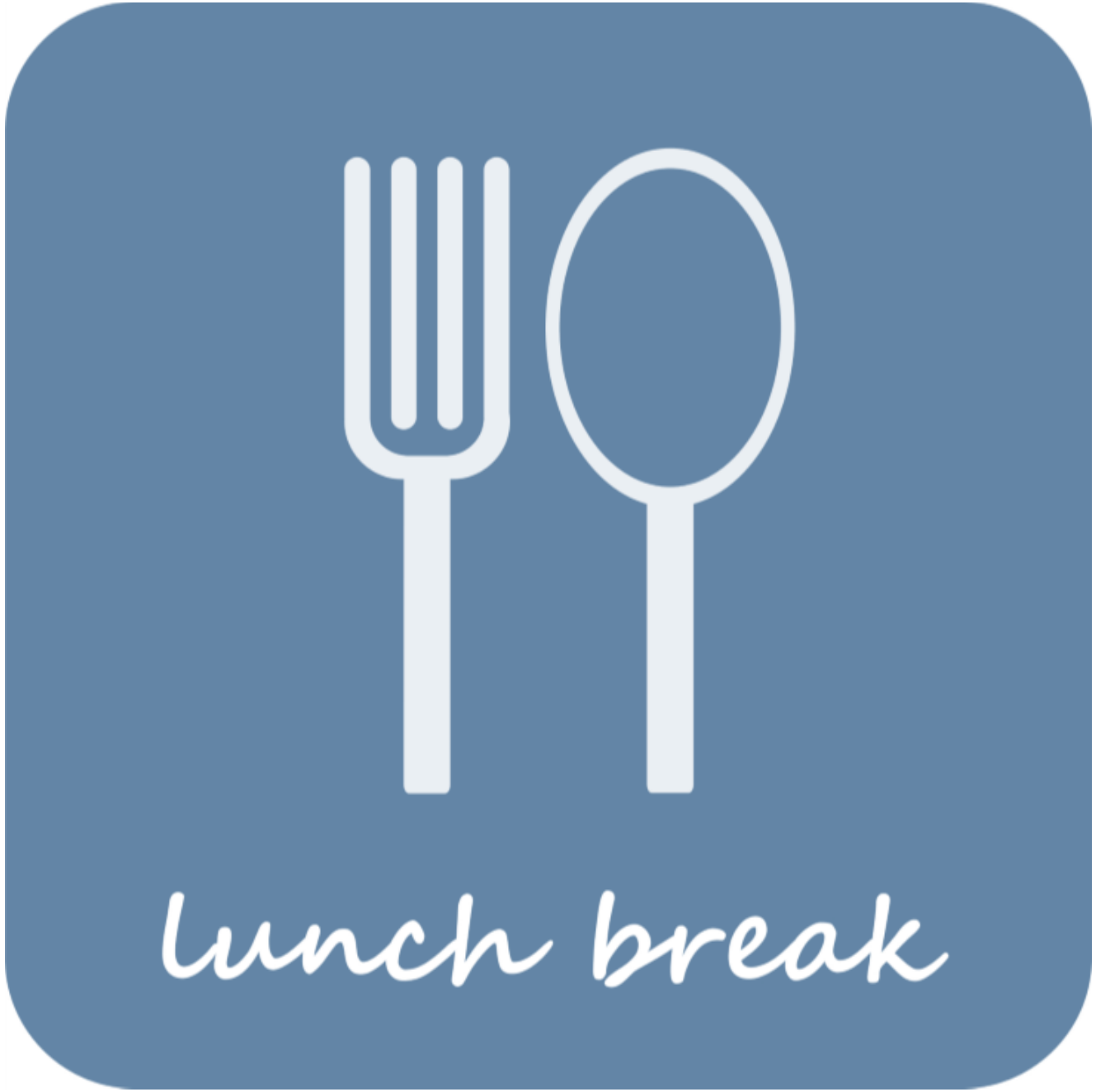
1. Get to know each other (round robin introductions)
2. What care coordination data do you have access to?
   - Which is most useful?
   - How do you use it?
   - How is it helpful in determining who needs care coordination or management?
   - Is your organization trying new approaches to better use data? What are they?
3. What was of greatest interest to you from the morning's presentations? Why?

LUNCH
(in common EHR table groups; with an MDC table & MHP table)

12:10 PM - 1:10 PM

12:10 - 1:10 PM

LUNCH



SIM
MDHHS State
Innovation Model

Using Internal Data for Improved Coordination and Value: Case Studies and Step-by-Step Solution Finding

1:10 PM - 2:10 PM

SIM ED Intervention Predictive Model

LEAH CORNEAIL

MICHIGAN MEDICINE

LEAHHV@MED.UMICH.EDU OR 734-615-6578

SIM ED Intervention Overview

Intervention

- Intensive case management for residents of Washtenaw/Livingston counties who are expected to be high utilizers of the ED.
- 11 community agencies have been identified as “hublets.”
- Patients are assigned to a “lead hublet,” which serves as the primary point of contact for care coordination.
- PCE Systems, also called “MiCareConnect,” is used as shared web-based portal to track patients across hublets. All hublets can view who lead hublet is, case notes, care plans, etc.
- The individuals with the highest predicted ED use during the next six months were randomized 1:1 to immediate versus delayed intervention (6 month delay), stratified by county.
- Center for Health and Research Transformation (CHRT) serves as administrative backbone organization.

SIM ED Intervention Overview Continued

Hublets

- Avalon Housing
- Home of New Vision
- IHA
- Jewish Family Services
- Livingston County Catholic Charities
- Livingston County Community Mental Health
- Michigan Medicine Complex Care Management Program
- Packard Health
- St. Joseph Mercy Health System
- Washtenaw County Community Mental Health
- Washtenaw Health Plan

How are patients identified?

SIM ED Intervention Predictive Model

- Data from three health systems:
  - Michigan Medicine
  - St. Joseph Mercy Health System
  - Integrated Health Associates (IHA)
- Data aggregated and de-duplicated by Michigan Data Collaborative
- Random forest model built and run by University of Michigan Department of Learning Health Sciences
- The model is updated every two months
- 16 patients (a mix of intervention and control cases) are released to hublets each week. The hublets are blind to the intervention versus control status of patients from the predictive model.

Referral Source (as of 6/8/19)

- 74% predictive model
- 20% provider referral (defined set of criteria)
- 6% both predictive model and provider referral

Predictive Model Outputs

Version 5 of the model includes 441 predictors. Top 5 predictors of future ED use:

#	Variable
1	Total number of ED visits
2	St. Joes number of ED visits
3	Standard error of the slope of ED visit: the value when available Definition: Standard Error - the average distance that an observed value deviates from the regression line, a line that best fits the trend of the data
4	Number of ED visits in the Spring
5	Standard error of the slope of ED visits: was the variable missing? (yes/no)

Data from August 2018

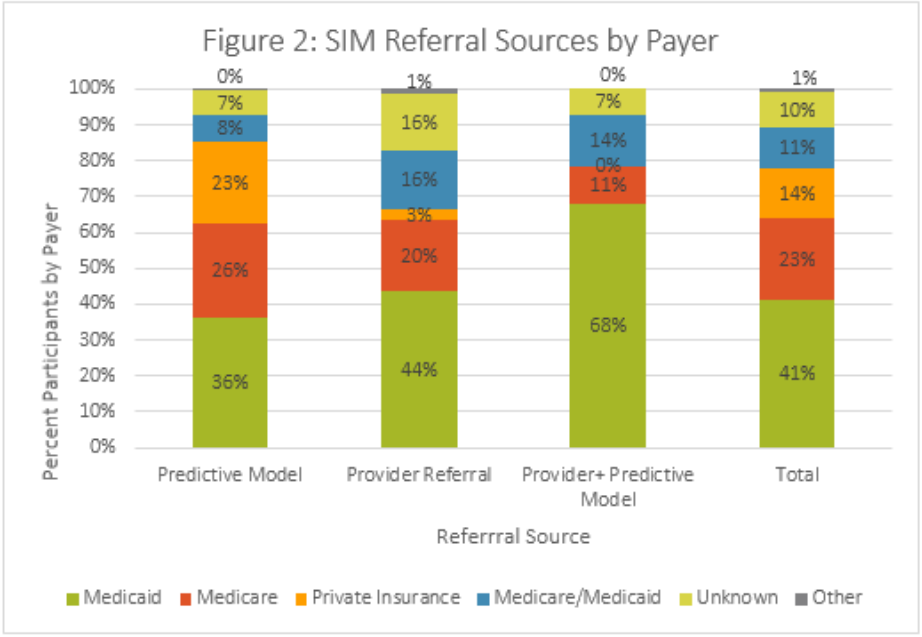
Top 5 diagnoses:

#	Diagnosis	Variable
1	Nausea and Vomiting	ICD10_R11
2	Problems related to lifestyle (tobacco use, lack of exercise, inappropriate diet, high risk sexual behavior, gambling, sleep problems, etc.)	ICD10_Z72
3	Alcohol related disorders	ICD10_F10
4	Headache	ICD10_R51
5	Legal intervention (injury sustained as a result of an encounter with any law enforcement official)	ICD10_Y35

Predictive Model Outputs – Continued

Payer

- The top payers were Medicaid (41%), Medicare (23%), and Private (14%).
- Few private insurance patients were referred by providers: 55 of the 60 private insurance patients were referred through the predictive model.

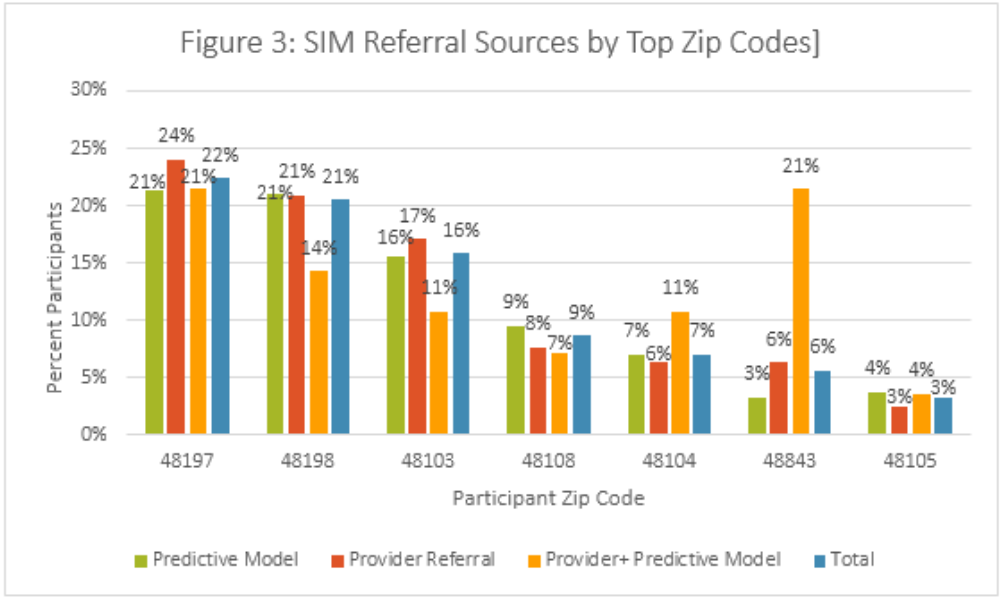


Data from August 2018

Predictive Model Outputs – Continued

Geography

- The top seven zip code areas represented 83% of total referrals and included Ypsilanti (43%), Ann Arbor (35%) and Howell (6%).
- Howell referrals (zip code 48843) were predominantly from provider referrals and combined provider and predictive model referrals.



Data from August 2018

SIM ED Intervention Current State

- As of June 8, 2019, there were 382 active participants in MiCareConnect (PCE Systems)
- Of those participants active for more than 14 days, 60% had completed an initial screening
- Of those participants active for more than 21 days, 58% had completed a concrete needs assessment
- Of those participants active for more than 31 days, 40% have a care plan on file

Participant Status	Number of Participants
Number of Active Participants	382
Number Paused	11
Number of Inactive	807
Declined/Refused	*346*
Unable to Contact	*153*
Needs Met	*100*
Deceased	*113*
Ineligible by SIM Criteria	*77*
Closed by Admin	*9*
Brief Assist/Hand-off to other	*9*
Total	**1200**

SIM ED Intervention Next Steps

Predictive Model

- Social determinants of health data will be added to the model.
- SDoH data from IHA, HVPA, and Michigan Medicine is also being aggregated by MDC
- SDoH data cannot be added until there are a full two years of data to enable model training and testing
- Data collection began in fall of 2017.

Evaluation

- In addition to the State of Michigan's overall SIM evaluation, CHRT is working with evaluators at the UM School of Public Health to evaluate the SIM ED Intervention
- Data collection ended June 30, analysis expected by October 2019
- CHRT seeking funding to continue intervention until evaluation results are available

“Chasing” Elusive Data to Enhance Outcomes

MARIE WENDT RN, MSN

GREAT LAKES OSC (GREAT LAKES PHYSICIANS ORGANIZATION

MWENDT@GLPO.ORG 989-529-1957

Great Lakes OSC

30 **Private Practice** PCP's

10 counties

25 different EMRs

Care Managers hired/managed **by practices**

- 32 CM's
  - 3 LMSW
- 5 Care Coordinators
- 2 SIMs Practices

Great Lakes
PHYSICIANS ORGANIZATION

Our Team!

Population of Chronic Conditions

ALMA FAMILY PRACTICE

Chronic Condition	189	42%
Asthma	39	9%
Diabetes	25	6%
Hypertension	37	8%
Obesity	151	34%
Overweight	47	10%
Moderate	31	7%
Severe	92	20%

CLINTON COUNTY MEDICAL CENTER

Chronic Condition	704	34%
Asthma	177	9%
Diabetes	66	3%
Hypertension	161	8%
Obesity	557	27%
Overweight	198	10%
Moderate	119	6%
Severe	344	17%

Obesity Success Example #1:

Group Diabetes Weight Management Classes

Physician Assistant: medical education disease process

RN Care Manager: diet/exercise education & disease process

Social worker: Counseling on mindful eating

Pre Class hemoglobin A1c of participants

- 3 months after

Obesity Success Example #2

50 year old male

Physician assisted weight management

- Get diabetes and cholesterol controlled before referring to surgeon.

Warm Handoff

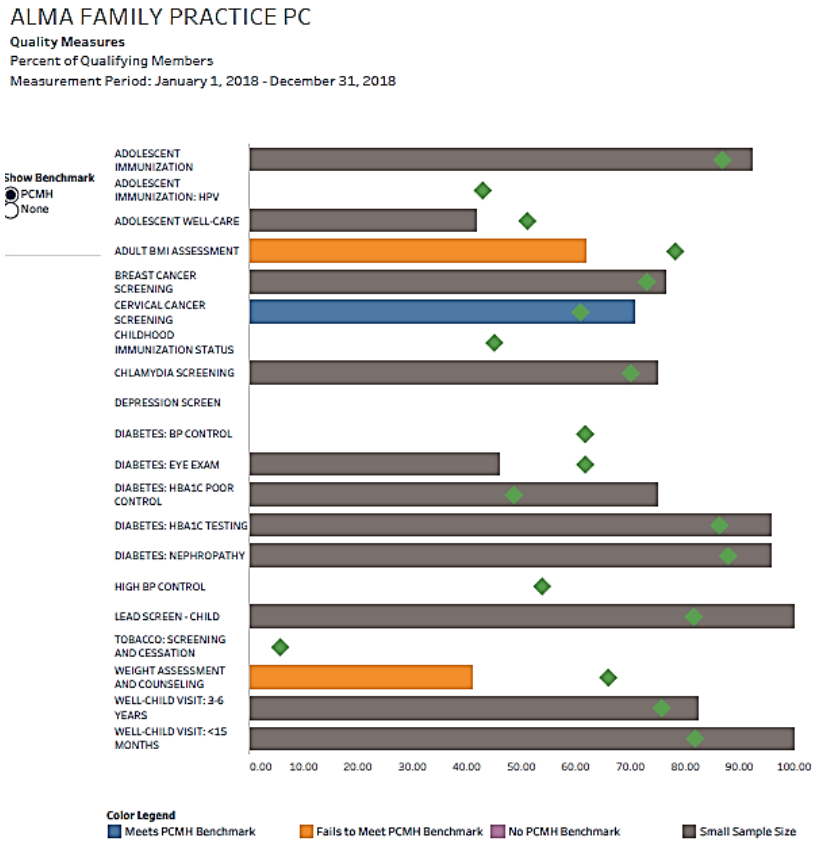
Care management for nutritional and diabetes.

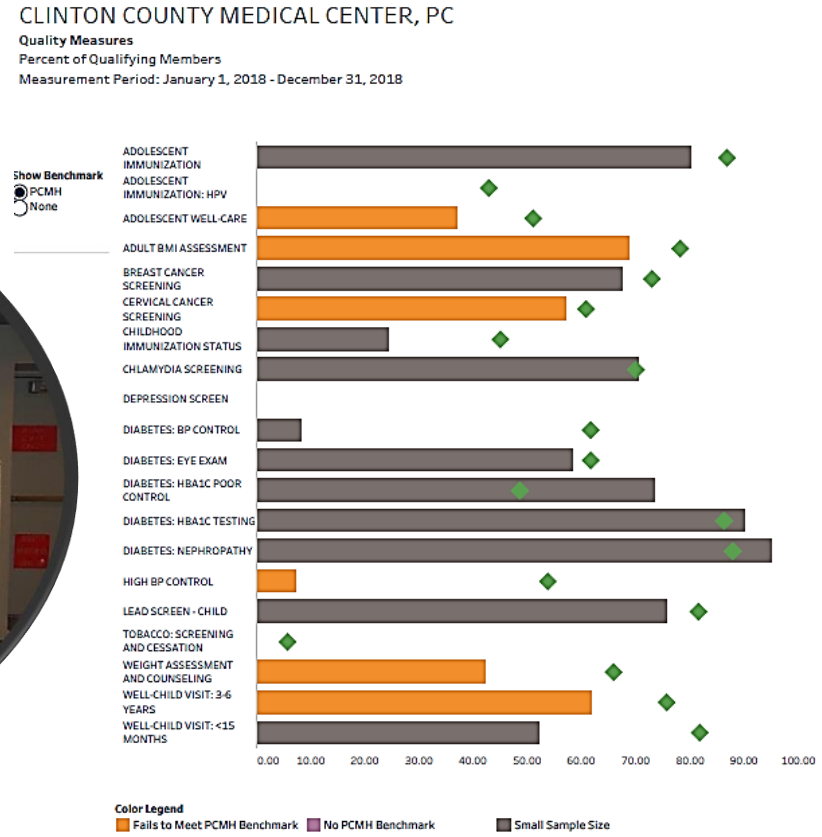
- helping to meet goals that surgeon will require before doing surgery anyway.

Outcome: Cholesterol is now controlled, diabetes continues to improve and weight is down 15+ lbs.

Patient continues with regular follow up visits to meet goals.

Quality Measure





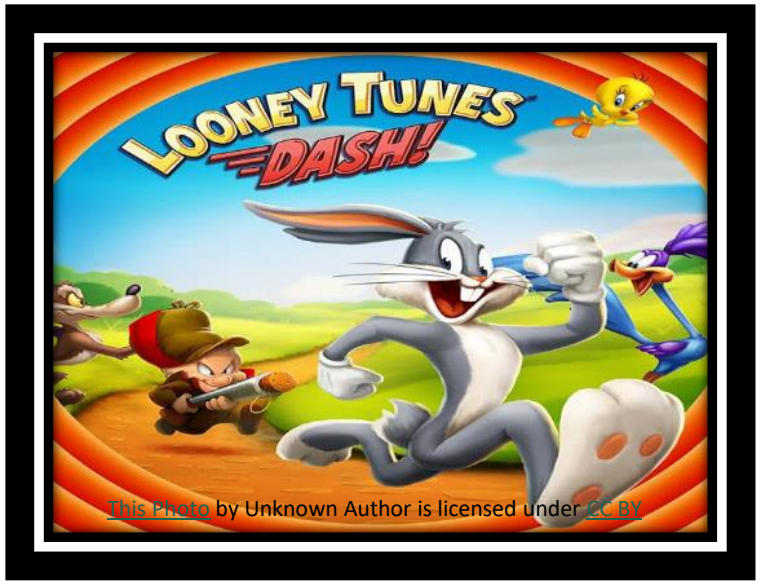
SIM
MDHHS State Innovation Model

Great Lakes PO Process

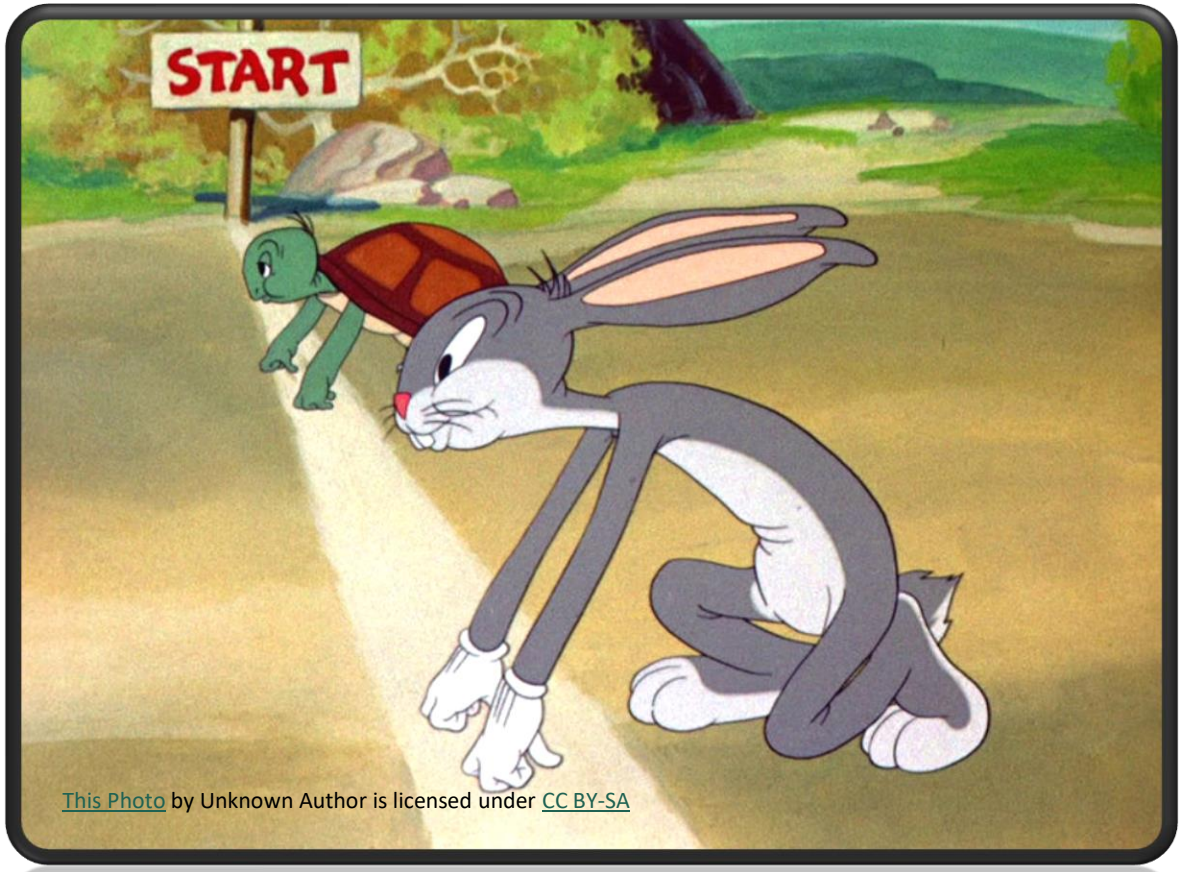
Ongoing Practice Assessment

Focus on workflows to achieve goals for individual practices

- Meet the practice “where they are at”
- Collaborate to help identify priority based on
  - Patient population
  - Competing priorities
  - Barriers
  - Engagement level
  - Care Management team in relation to patient population



And we're off!…



“Engaged” % Reports

Care Management
01/01/2019 through 05/31/2019 paid through 05/31/2019

Accountable Care Network: GREAT LAKES PHYSICIAN ORGANIZATION

PriorityHealth

# of Distinct Patients with 2 or more Care Management visits (all product lines) :
Average Membership (all product lines) :
Percentage of Patients ...

PU Name	# of PCP Providers in PU	# Providers with Paid Claims (Included all providers)	CPC+ PU	PDCM VBR 2018	Does the practice have at least 1% of the avg eligible attributed members with 2+ PAID PDCM (12 claims on 2+ different dates of service?	# of PDCM Claims	# of Transitions of Care Claims	# of Medication Reconciliation Claims	# of HICM Claim	# of CCM Claims	Total # of All Claims	# of Unique Members with 1 or More Paid Claims (PDCM/TOC/Med Rec/HICM/CM)	# of Unique Members with 2 or More Paid Claims with different Service Date (PDCM/TOC/Med Rec/HICM/CM)	# of Unique Members with 2 or more Paid PDCM Claims with Different Dates of Service	PDCM Eligible Attribution	% Engagement - Meeting PDCM 1% threshold	Approx # to Meet 3%
Clinton County Medical Center, P	4	9	Yes	Yes	Yes	452	12	28	0	0	492	305	46	39	2,454	1.59%	74
Rosewood Health Care	1	1	No	Yes	Yes	226	12	32	0	0	270	165	26	19	1,322	1.44%	40
Midland Family Physicians, PC	4	4	Yes	Yes	Yes	152	30	46	0	0	228	109	37	33	1,979	1.67%	59
Alma Family Practice PC	3	4	Yes	Yes	No	35	8	1	0	0	44	37	6	5	1,646	0.30%	
Walter J. Gruber, MD	1	1	No	No	No	24	12	11	0	0	47	33	3				
Pleasant Pediatrics	1	1	No	No	No	15	0	0	0	0	15	14					
Jeffrey Potts, MD	1	4	No	Yes	No	13	11	17	0	0	41	32					
Great Lakes Medical Associates, P	2	2	Yes	No	No	6	6	6	0	0	18	12					
Great Lakes Medical Center	1	3	No	Yes	No	5	9	1	0	0	15	12					
Prism Medical Associates, P.C. Pri	1	2	Yes	No	No	2	3	5	0	0	10	7					
Riverview Medical Associates, PC	2	5	Yes	Yes	No	1	6	5	0	0	12	7					
Sacred Heart Mercy Health Care C	1	3	Yes	Yes	No	1	4	6	0	0	11	7					
Auburn Clinic	1	1	No	No	No	0	1	0	0	0	1	1					
Bay Area Health Clinic, PC	4	3	No	Yes	No	0	23	0	0	0	23	23					

Quarterly Care Management, Percent of Patients

Inpatient Follow-Up
Percent of Patients

Percentage of Patients with a Care Management Claim
Reporting Period: 01/2019 through 03/2019

Managing Organization and Practice Name	Number of Members with a Care Management Claim	SIM Membership	Percentage of Patients with a Care Management Claim
GREAT LAKES OSC	11	471	2.34%
ALMA FAMILY PRACTICE PC	91	2338	3.89%
CLINTON COUNTY MEDICAL CENTER, PC	102	2809	3.63%
Total			

SIM MDHHS State Innovation Model

“Patient Lists” Risk Profile

High Risk Patient? (1=Yes)	Has Patient Accrued more than $25K in past 12 mos	Has Patient Accrued more than $50K in past 12 mos	Has Patient Accrued more than $100K in past 12 mo	Congestive Heart Failure	COPD	Coronary Artery Disease	Diabetes	Depression	Asthma	Chronic Renal Failure	Hypertension	Cerebrovascular Disease	# IP Discharges in Past 6 Mos	# IP Discharges in past 12 Mo	# ED Encounters past 6 Mos	# ED Encounters past 12 Mo	# Primary Care Sensitive ED Encounters past 12 Mo	Cancer Treatment	Dialysis	# Pharmaceutic past Mo
0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	
0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	
1	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1	1	1	0	0	
1	0	0	0	0	0	0	1	0	0	0	1	0	0	0	0	0	0	0	0	
0	1	0	0	0	0	0	0	0	0	0	0	0	1	1	0	0	0	0	0	
0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	2	0	0	
0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	
0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	
0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	1	0	0	
0	0	0	0	0	0	0	0	0	0	0	1	0	1	1	0	0	0	0	0	
1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	2	0	0	0	
0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
1	1	0	0	0	0	0	1	0	0	0	1	0	0	0	0	0	0	0	0	
1	0	0	0	0	0	0	1	0	0	0	1	0	0	0	0	0	0	0	0	
0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	
0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	
0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
0	0	0	0	0	0	0	1	0	0	0	1	0	0	0	0	0	0	0	0	
0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0	0	0	
1	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	1	1	0	0	
1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	

SIM MDHHS State Innovation Model

Diabetes Success Example #1

Nov 2018 HbA1C 8.0

- Recently widowed
- Diet habits, New Significant other, Baking Cookies
- Leaving for FL for winter

Warm Handoff

- Care manager calls every 2-4 weeks while in FL

- April 2019 A1C 6.3

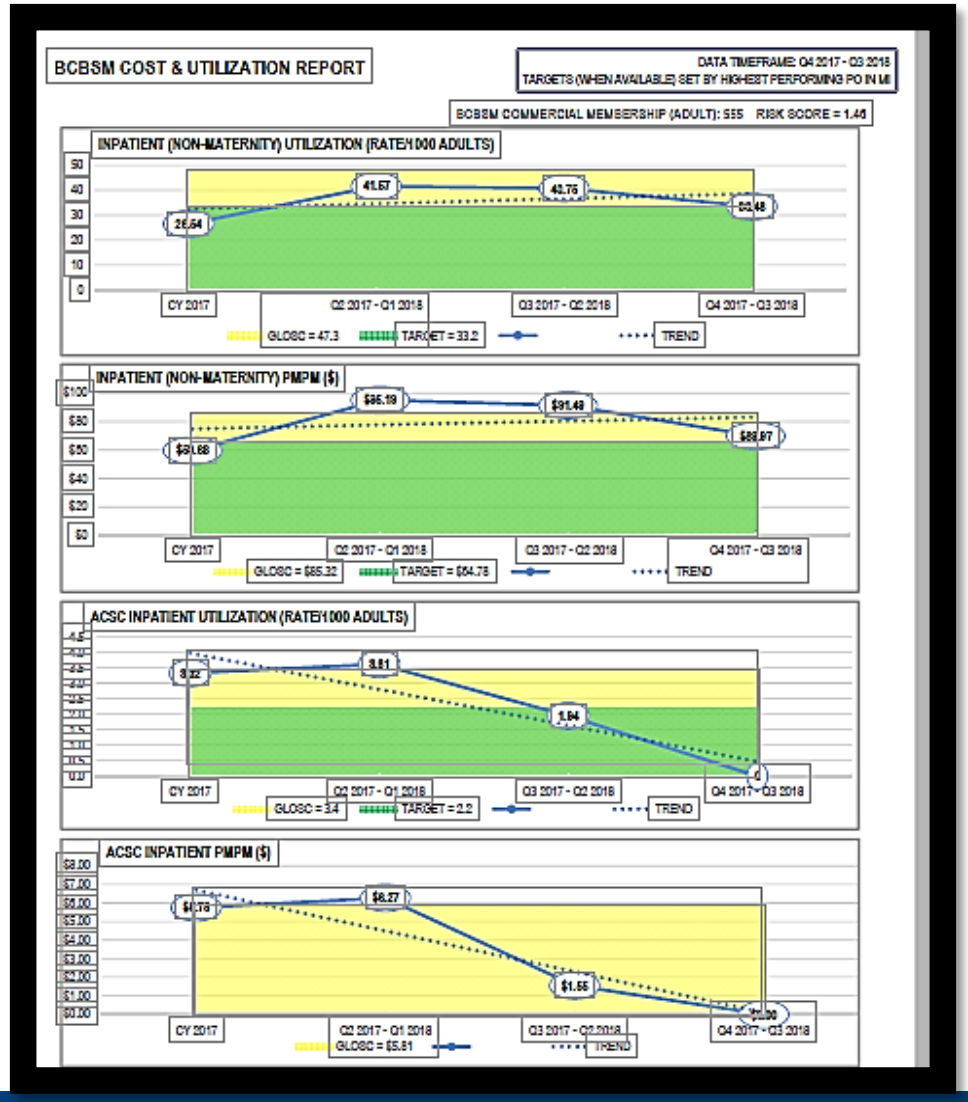
Diabetes Example #2

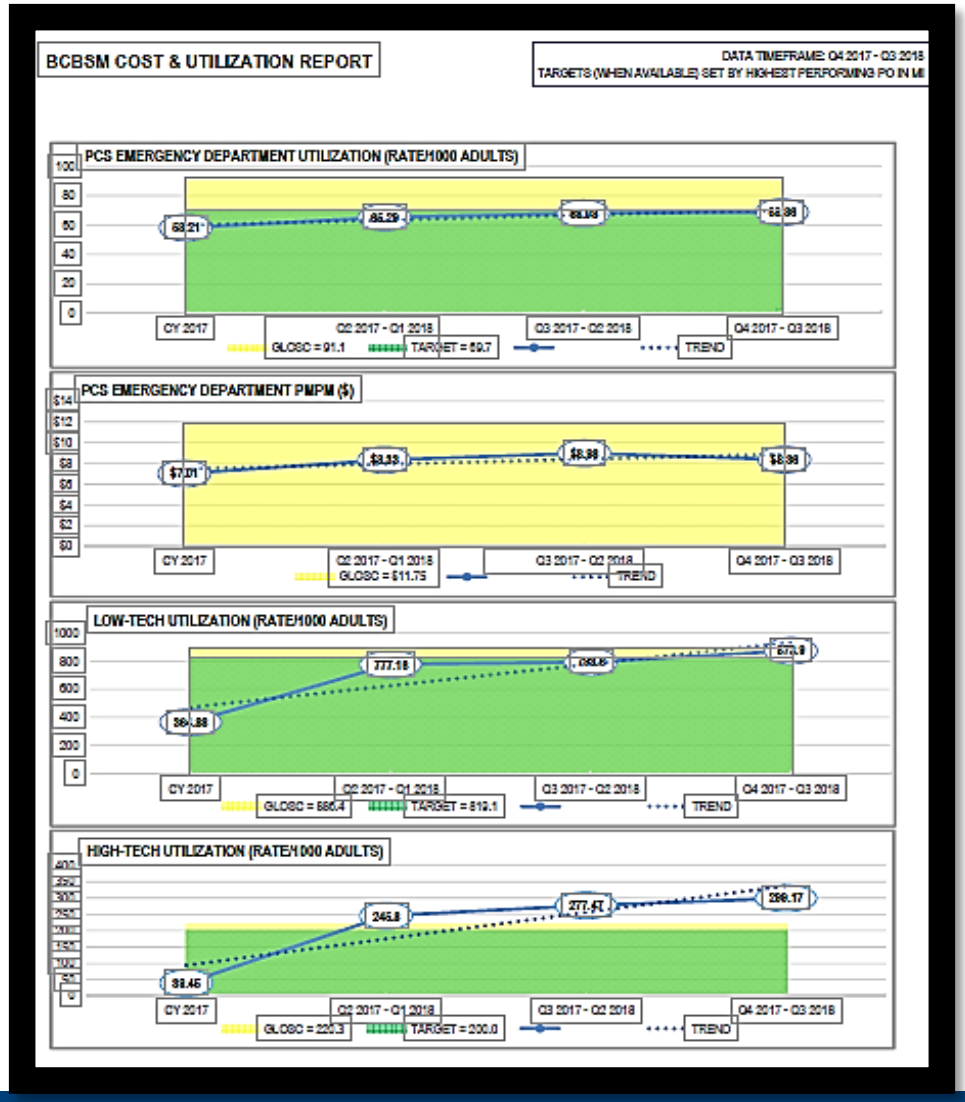
47 year old female
- Elevated Hgb A1C 10.9
- Poor dentation
- Multiple list of needs after not being seen for over 5 mos.

Warm Hand-off for coordination and collaboration.

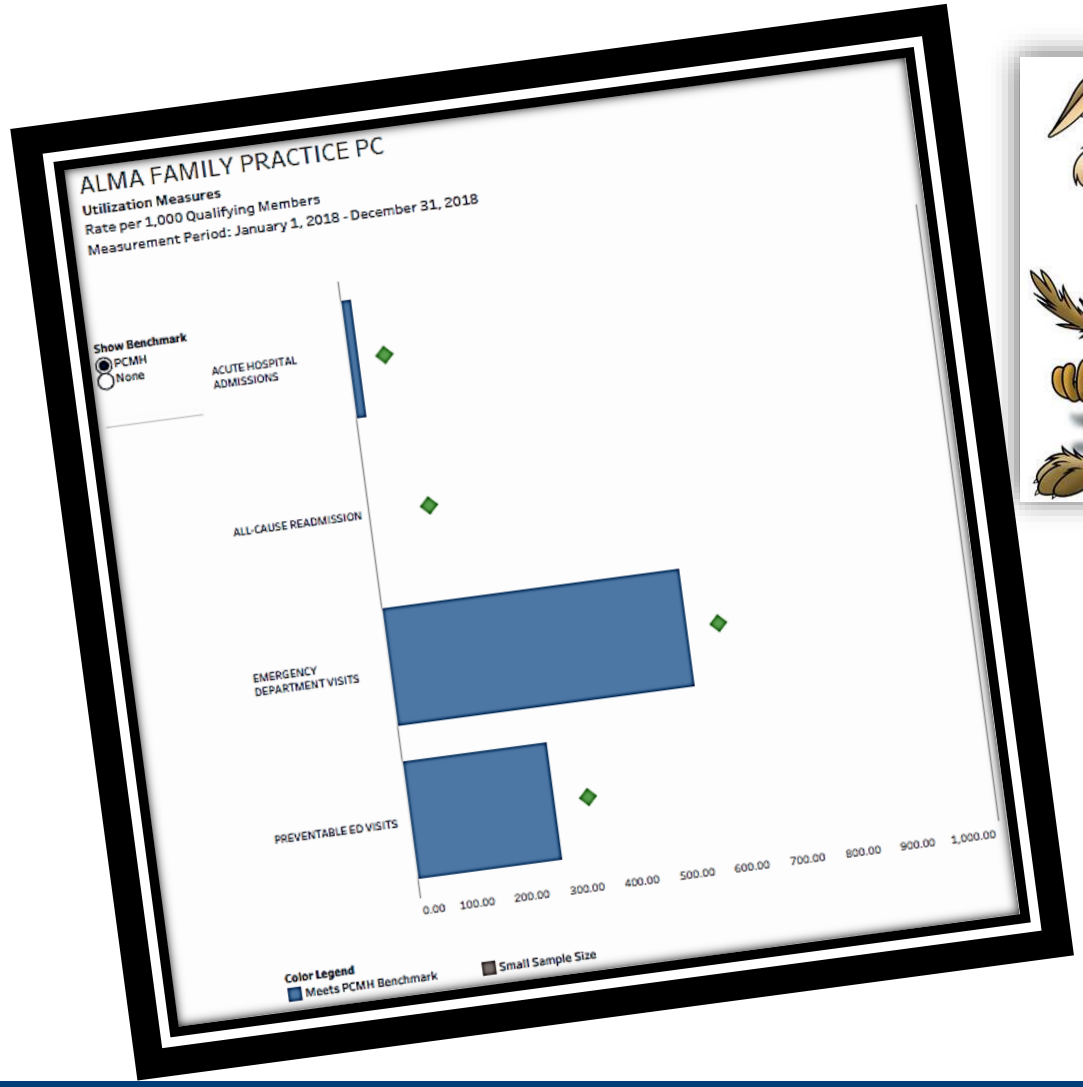
Soft diet of potatoes, pasta and breads due to extensive dental concerns
- Medicaid dentist (MIBridges)
- A1C reduced 9.3% within 4 months

Cost & Utilization





Utilization Measure



TCM follow up Success Case

Spring 2018

- 53 year old male STEMI
- Hgb A1C 11.8%
- Daily pack per day smoker

Enlisted pt during TCM call

- Developed anxiety & CHF
- stopped smoking and monitors blood glucose more closely.

Hgb A1c 6.8% during summer 2018

Frequent ED Case Study

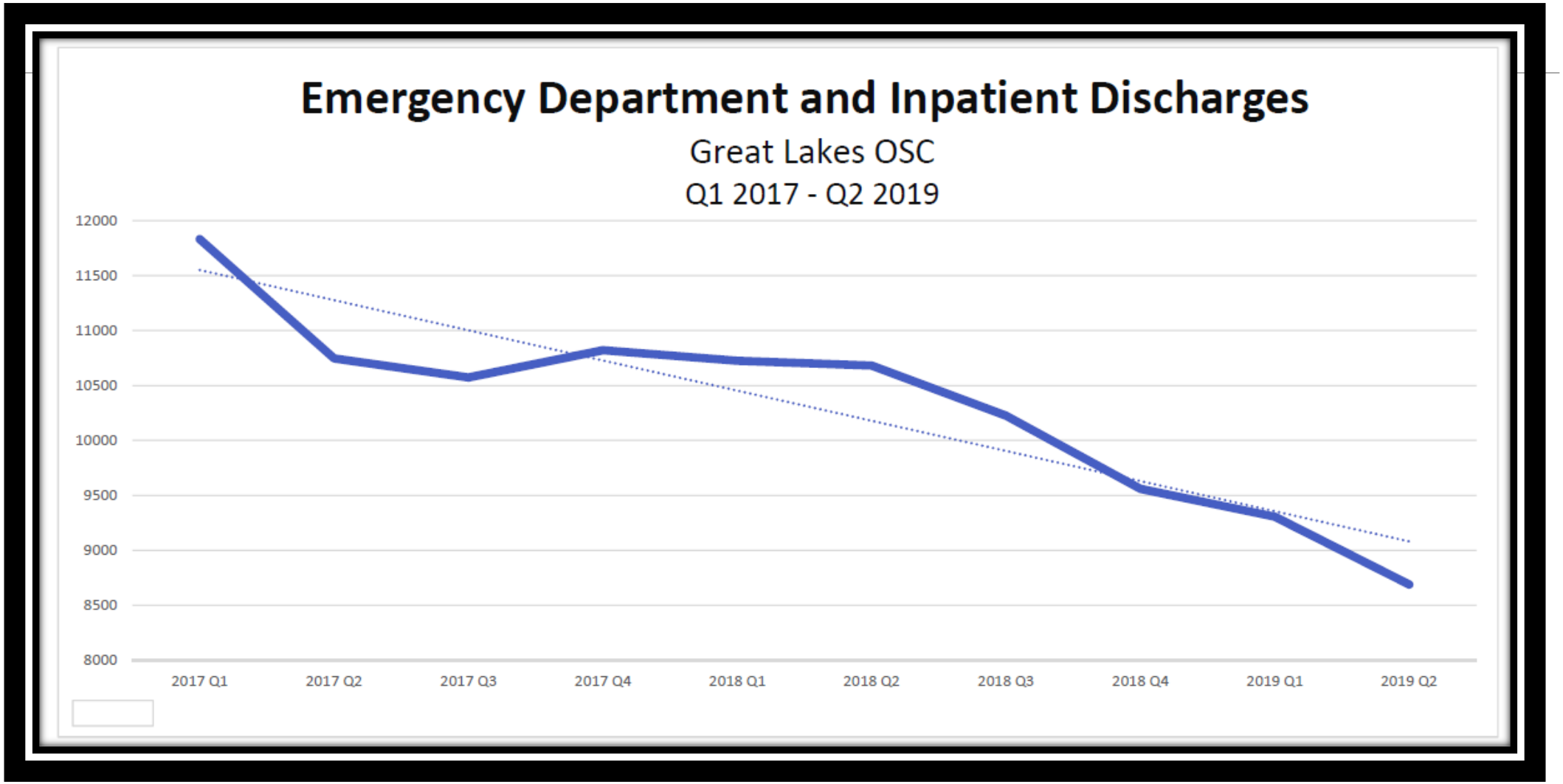
56 year old male Home Care Patient

- Multiple co-morbid diagnoses
- Calls an ambulance
- Admit to hospital
- Leaving against medical advice

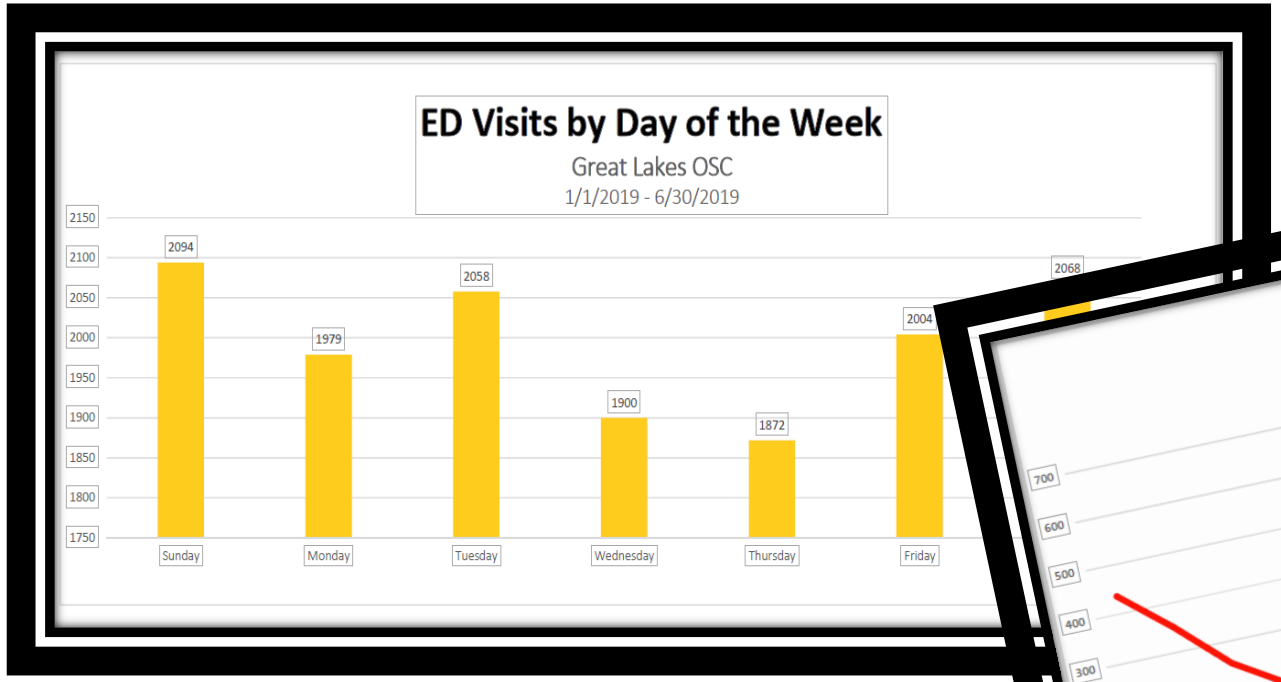
Warm Handoff to evaluate situation.

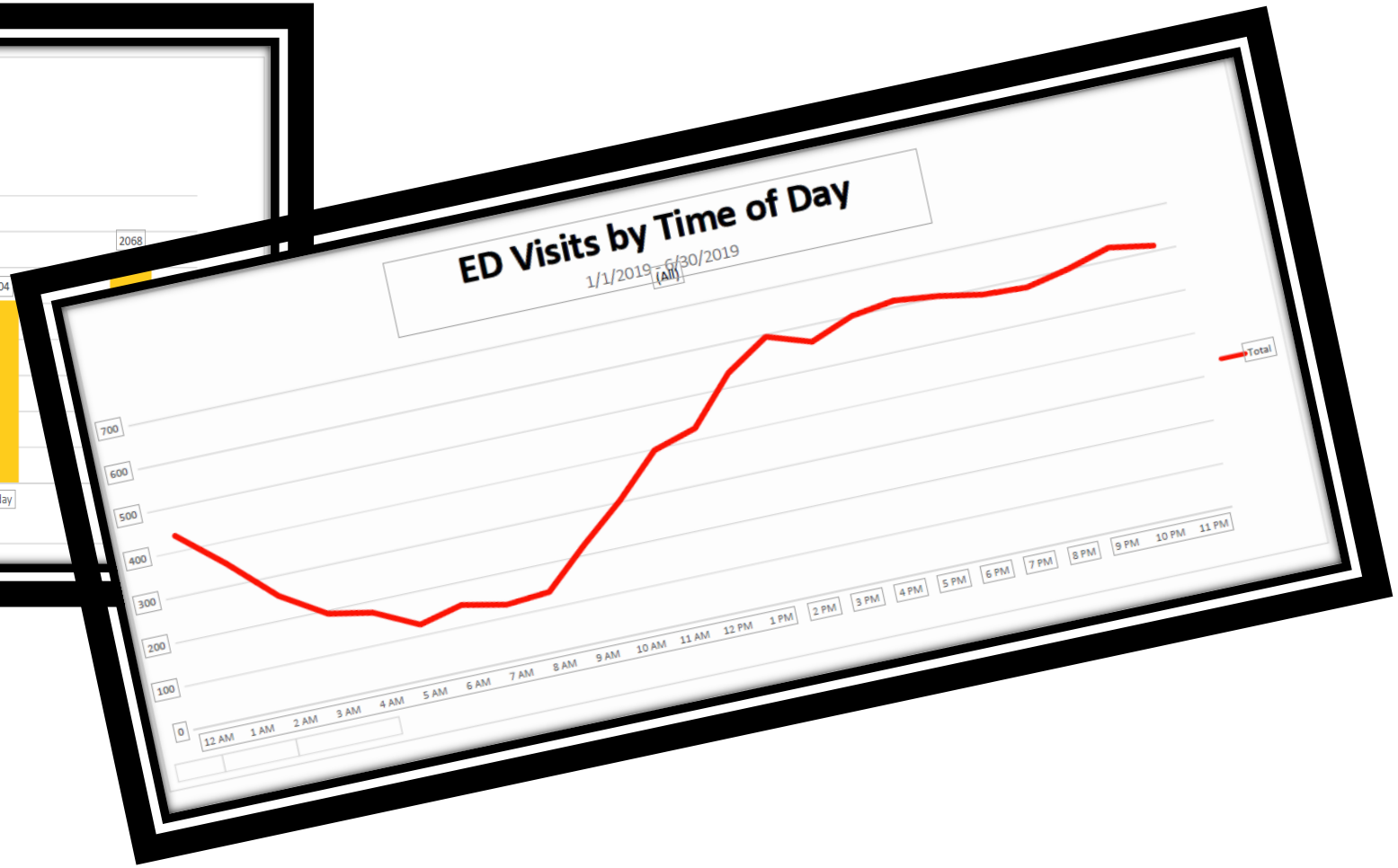
- Anxiety about being home alone during week was too much
- Wanted to be home on weekends
- Education on Palliative Care & initiated
- No hospital admission in over 4 months.

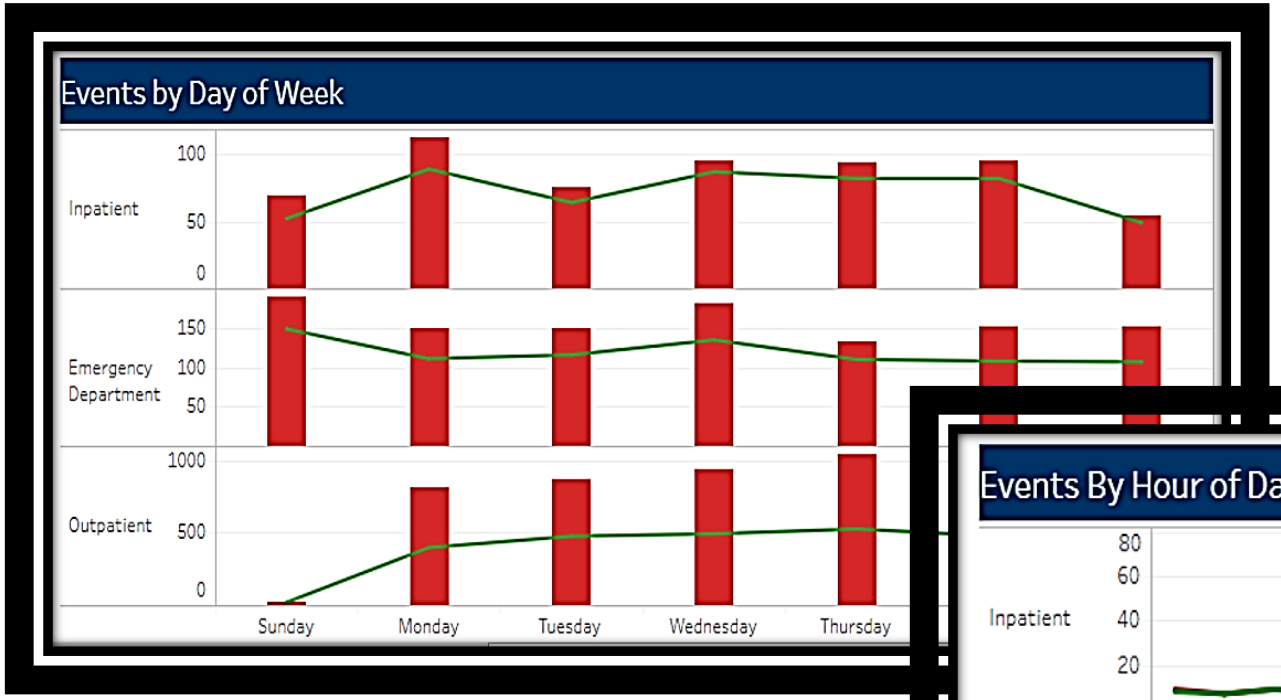
Patient Ping

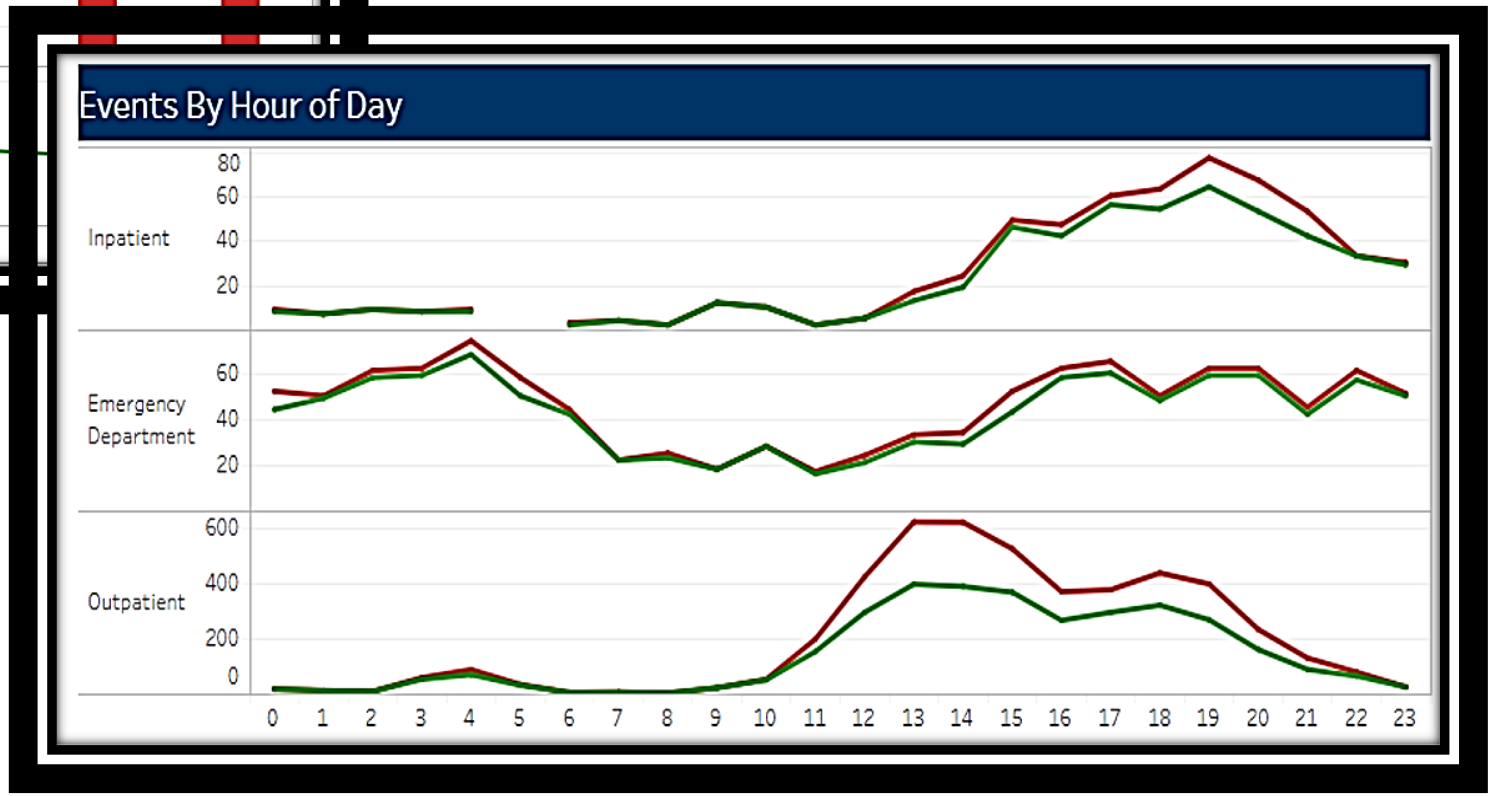


Patient Ping






Events by Day of Week
Inpatient
100
50
0
Emergency Department
150
100
50
Outpatient
1000
500
0
Sunday
Monday
Tuesday
Wednesday
Thursday


Events By Hour of Day
Inpatient
80
60
40
20
Emergency Department
60
40
20
Outpatient
600
400
200
0
0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23

TCM Care Management

Strategy to Manage RISK
(Role of Care Manager versus MD, PA, NP)

MD, PA, NP

CARE MANAGER

- Introduce Self/CM during 48 hour call
  - Identifies “red flags”
- Inform patient would like to see at TCM appt
  - CM + Provider Huddle
  - Provider “Elevator Speech”

BOTH: **Provide personalized CM flyer
**5 W’s

- Permission to call in 1-2 weeks
  - Follow up on medical plan of care
  - Set up longitudinal care management
    - (After 29 days-start billing)

ED Utilization & Obesity Success Case

40 year old female

- Anxiety, depression, insomnia, GERD, hypothyroidism, others
- She was frequenting ER for non-emergency concerns

Warm hand-off February 2017.

- Medication management and compliance.
  - Not reading her medication bottle labels
  - Continued taking her meds as before and was not aware of any adjustments that had beer

- Goal: weight loss & Improve a poor self-image.
  - She began by walking short distances twice daily to build up endurance.
    - Increase to walking 2-3 miles several days a week.
  - Stress in her life
    - BH provider and counselor twice a month.

Continued

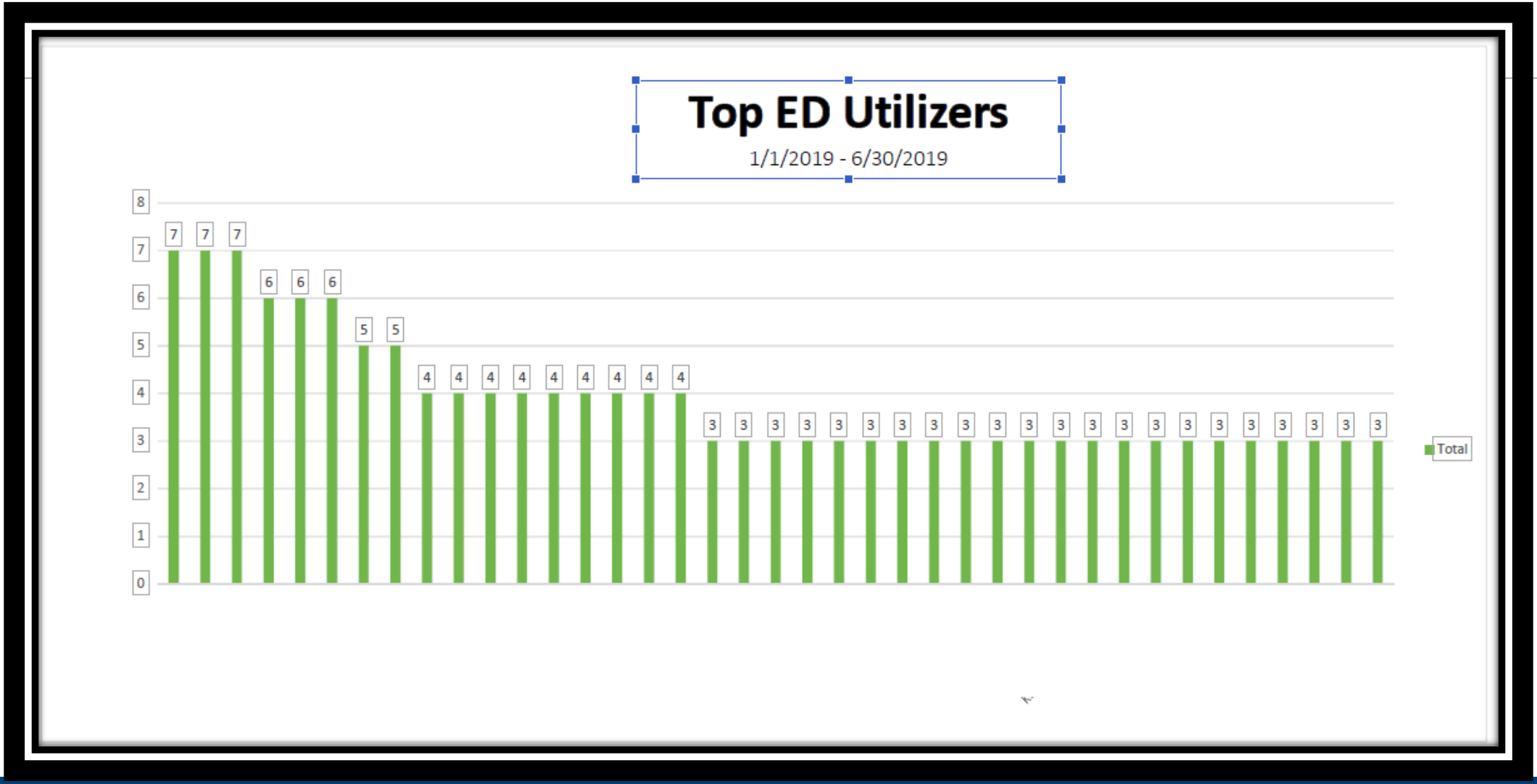
Maintaining 49# weight loss

keeps a pair of pants

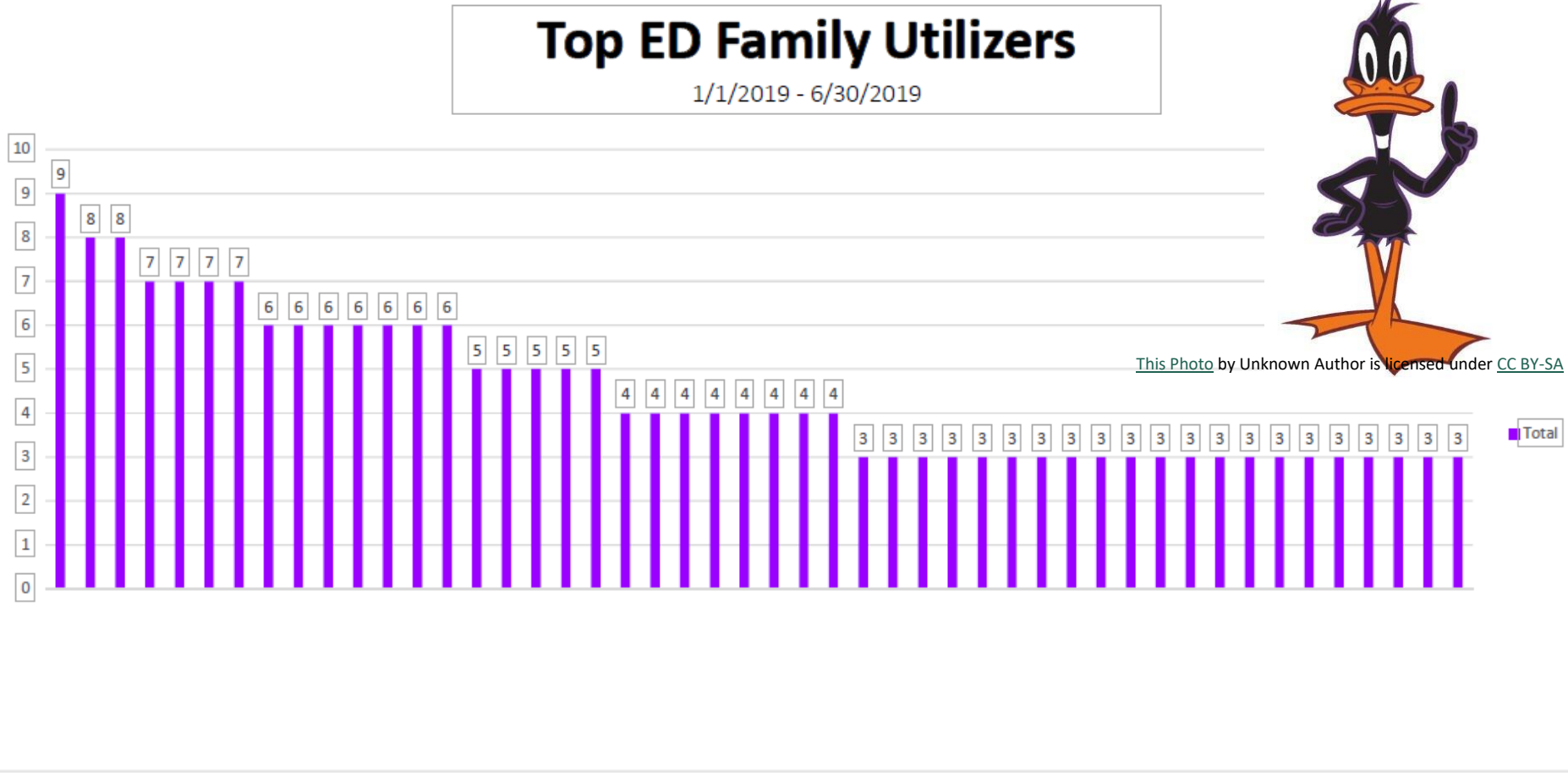
Improved ER utilization & decreased the frequency visits with her PCP.

Year	ER	PCP	CM
2017	9	16	6
2018	7	12	9
2019 to date	4	5	10

Patient Ping



Patient PING



Cost & Utilization Example

70 yr old female- in wheel chair at Senior living

BH Dx, Polypharmacy, High risk meds, Pain Meds, DM, CHF, COPD

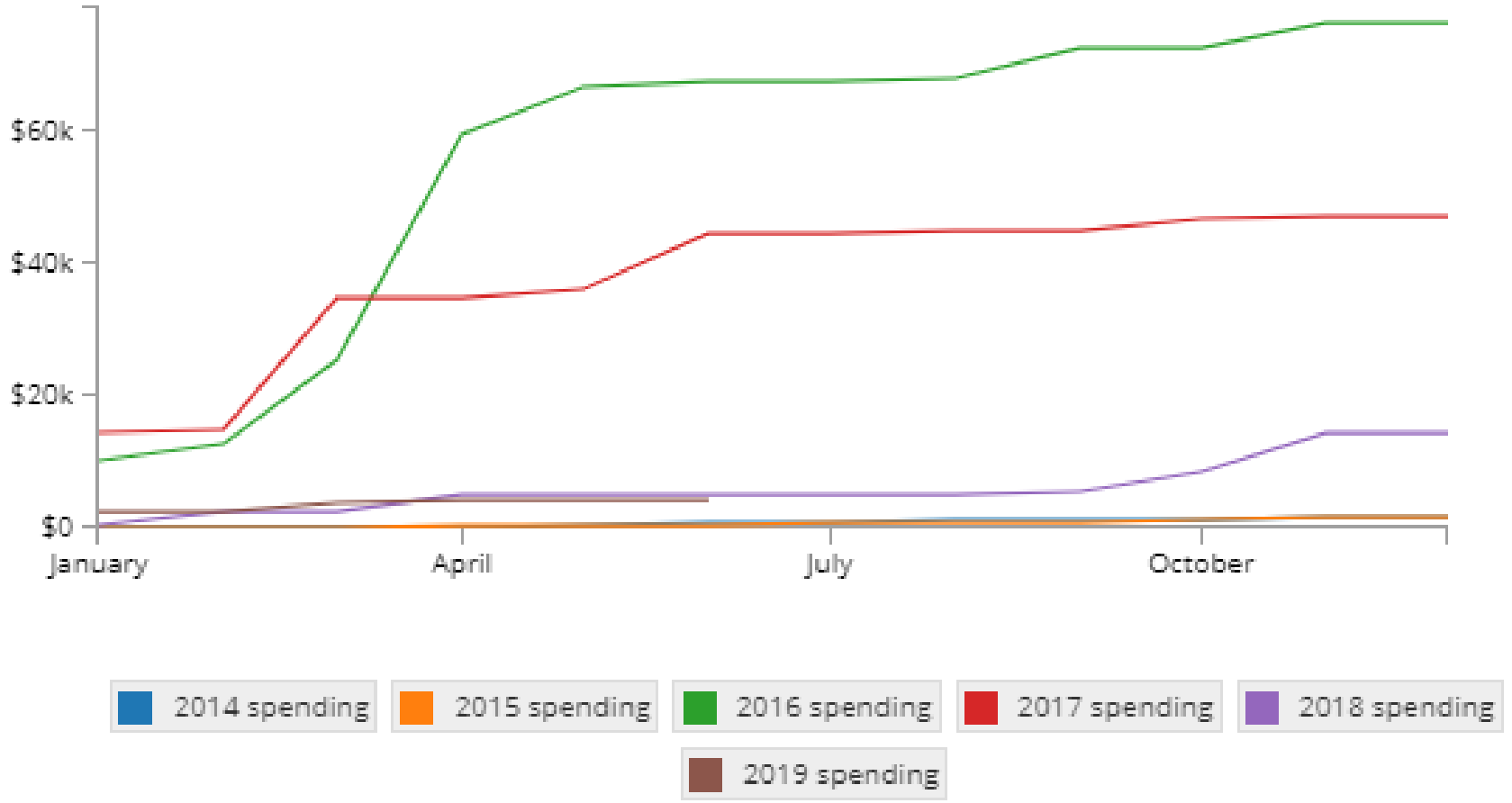
Daughter demanding $ otherwise would not take to appt, get meds, etc. Living in patients house.

Pt running out of money

Care management-**referral**

- Low income housing
- Medication assistance-Med Rec

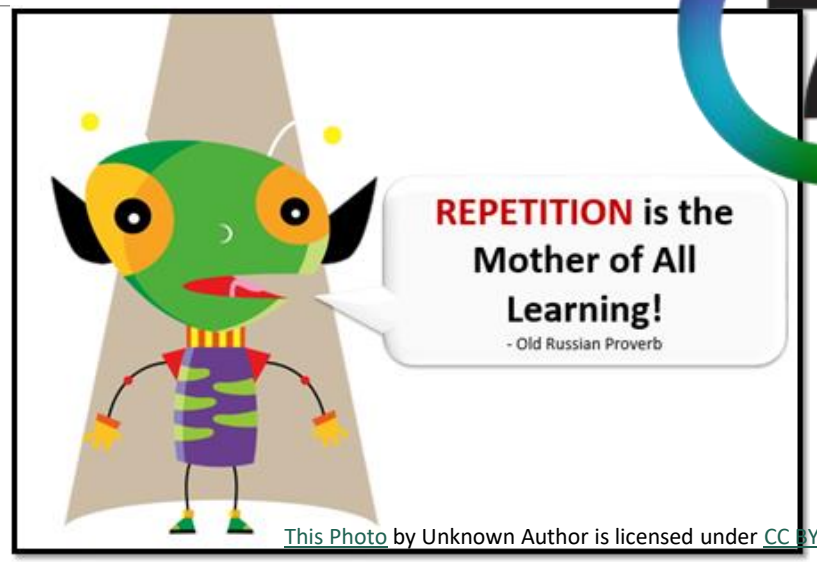
YEARLY SPEND COMPARISON

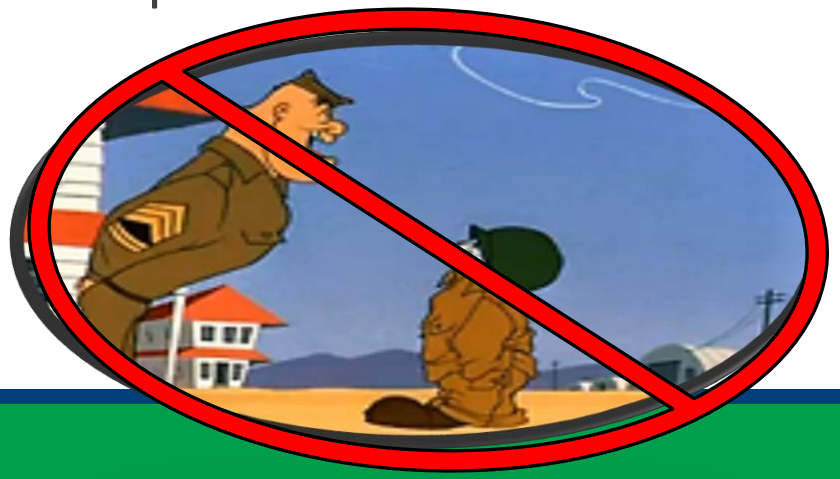


Strategies (Influencing & Advising)

Treat all payor patients in similar fashion

- Focus on workflow
- Advise efficiencies
- Work at top of licensure
- Ease into what workflow is already occurring
- Naturally come to conclusions that make sense for their practice





GLOSC BCBSM Commercial Final Scores

2016

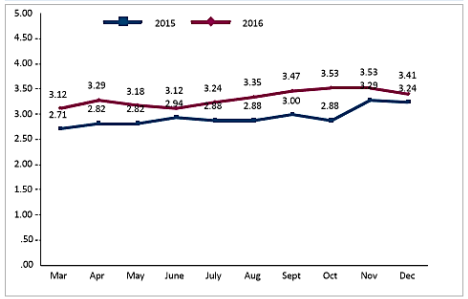
Commercial PPO - Clinical Quality Performance and Improvement

Blue Cross Blue Shield of Michigan

Clinical quality scores are based on two components - performance (70%) and year over year improvement (30%). Scores are developed for the population based on performance as compared to PGIP PO peers at the measure level and will be used to assess the PGIP clinical quality incentive.

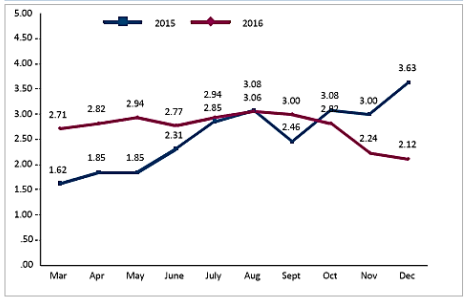
Component	Performance Score (70%)	Improvement Score (30%)	Commercial PPO Overall Score
Current Score	3.41	2.12	**3.02**
Current Ranking among PGIP POs	6 out of 43	14 out of 43	**5 out of 43**

Performance Score Trend



Great Lakes OSC, LLC Quality score as of Dec 2016 is 3.41 which is above the PGIP PO average of 2.65

Improvement Score Trend



Great Lakes OSC, LLC Quality Improvement score as of Dec 2016 is 2.12 which is above the PGIP PO average of 1.79

2017

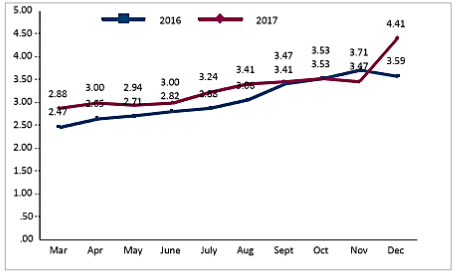
Commercial PPO - Clinical Quality Performance and Improvement

Blue Cross Blue Shield of Michigan

Clinical quality scores are based on two components - performance (70%) and year over year improvement (30%). Scores are developed for the population based on performance as compared to NCQA Benchmarks at the measure level and will be used to assess the PGIP clinical quality incentive.

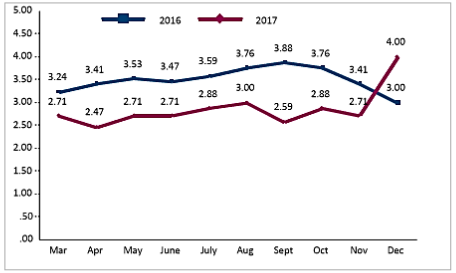
Component	Performance Score (70%)	Improvement Score (30%)	Commercial PPO Overall Score
Current Score	4.41	4.00	**4.29**
Current Ranking among PGIP POs	1 out of 41	1 out of 41	**1 out of 41**

Performance Score Trend



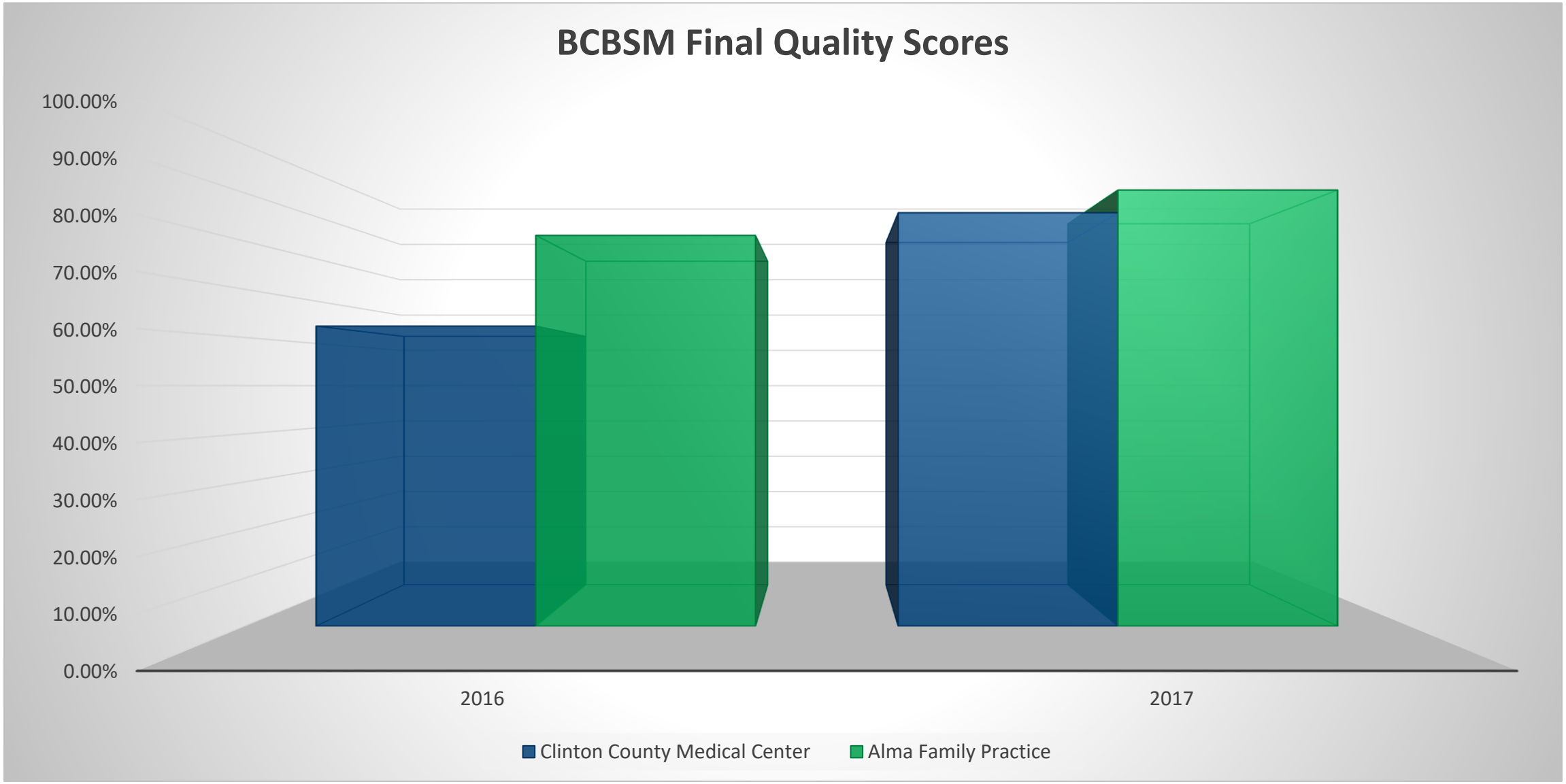
Great Lakes OSC, LLC Quality score as of Dec 2017 is 4.41 which is above the PGIP PO average of 3.43

Improvement Score Trend

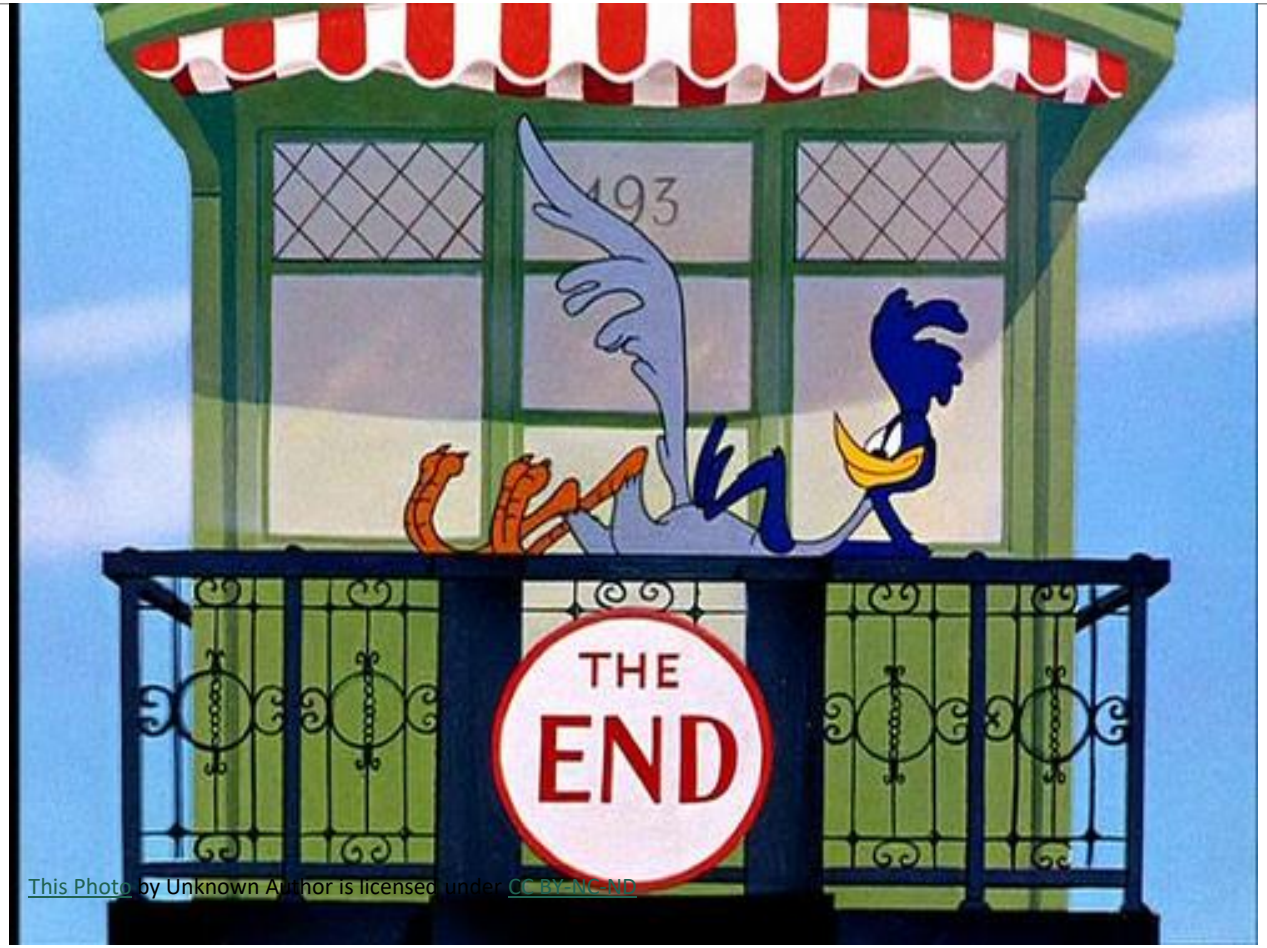


Great Lakes OSC, LLC Quality Improvement score as of Dec 2017 is 4.00 which is above the PGIP PO average of 2.67

SIM MDHHS State Innovation Model


BCBSM Final Quality Scores
100.00%
90.00%
80.00%
70.00%
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
2016
2017
Clinton County Medical Center
Alma Family Practice

Next Steps:
Building “Community Health Cloud”



Great Lakes
PHYSICIANS ORGANIZATION

SIM
MDHHS State
Innovation Model

Marie Wendt

Director of Quality & Care Management

Mwendt@glpo.org

989-529-1957

Report-Outs and Group Sharing on Intensive Working Session and Case Study Findings

2:10 PM - 2:50 PM

Working in Your Group: The Afternoon's Mission

1. What technique or learning from the panel presenters (from Great Lakes and U of M) did you find most valuable to your work? How might you apply it to your work?

2. What have you tried regarding care coordination that didn't work and what did you learn from it?

3. What is your best tip for using care coordination data?

Table Report-Outs

What Was Your ONE Best Learning or Idea from Today?

- Can be an idea within a presentation, or
- Something that a table member shared, or
- Something that your table developed from putting the best thinking of all together

Wrap - Up and Closing Remarks

2:50 PM - 3:00 PM