Complex Care Management

Linking Medicaid Health Plans, Community and Primary Care

Judy Avie, BSN, M.Ed. IT, RN
Marie Beisel, MSN, RN, CCM, CPHQ
Sarah Fraley, LMSW

January 29th, 2019

Michigan Institute for Care Management and Transformation (MICMT)

- Who we are:
  - Partnership between University of Michigan and BCBSM Physician Group Incentive Program
- Goal of MICMT:
  - To help expand the adoption of and access to multidisciplinary care teams providing care management to populations served by the physician community in order to improve care coordination and outcomes for patients with complex illness, emerging risk, and transitions of care

Objectives

- Define evidence based components of complex care management.
- Explore coordination of care across the community, showing the relationship of the primary care office, Maternal Infant Health Program and the Medicaid health plans.
- Describe team based care and techniques/tools for building effective communication and collaboration.

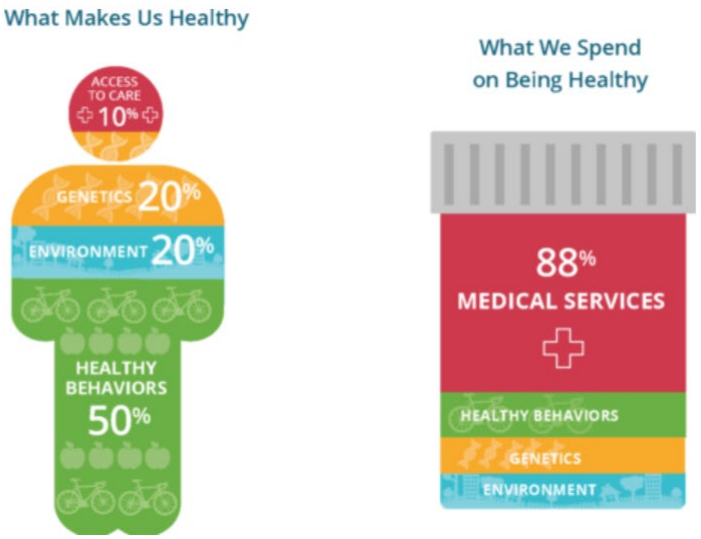
Care Management

in the Primary Care Setting

micmrc

The Michigan Care Management Resource Center

Reimagining Health Care in the US

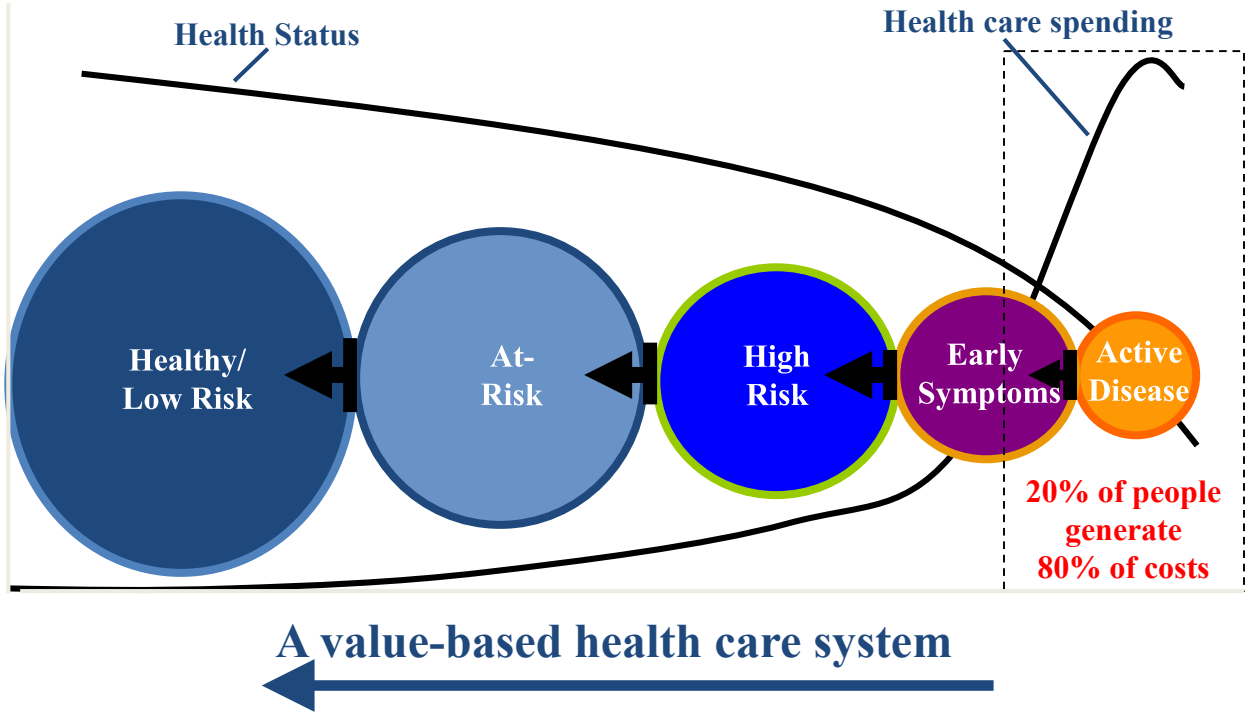


https://pccinnovation.org/connected-communities-of-care/

micmrc

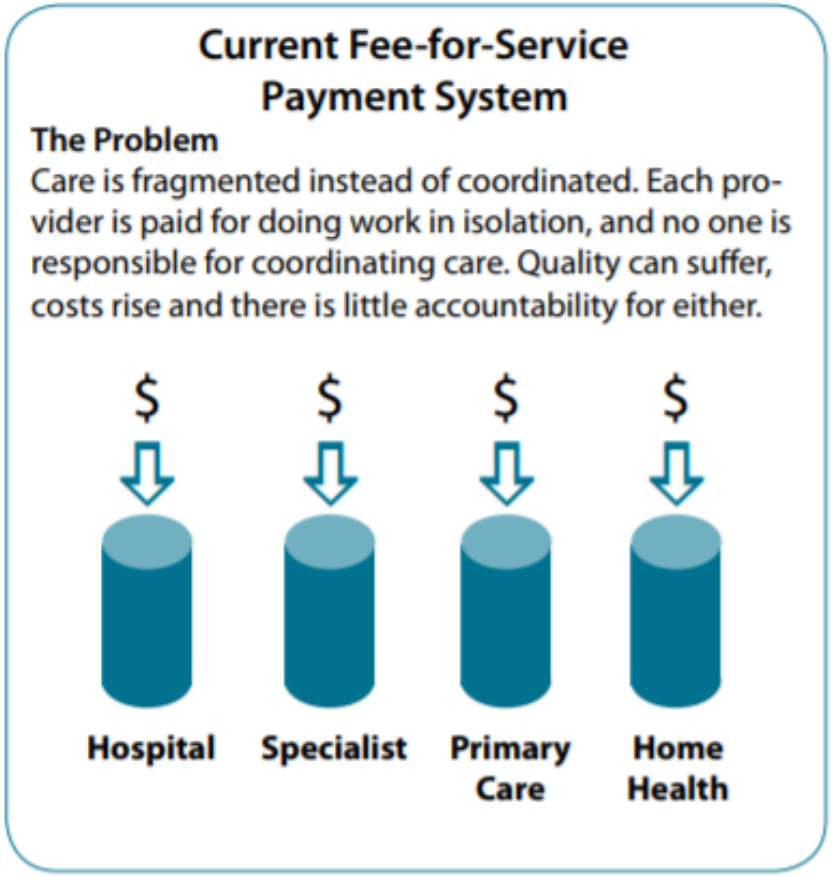
Moving to Value

A proactive, value-based health system should help move people from right to left – and keep them there.



Source: IBM Global Business Services and IBM Institute for Business Value

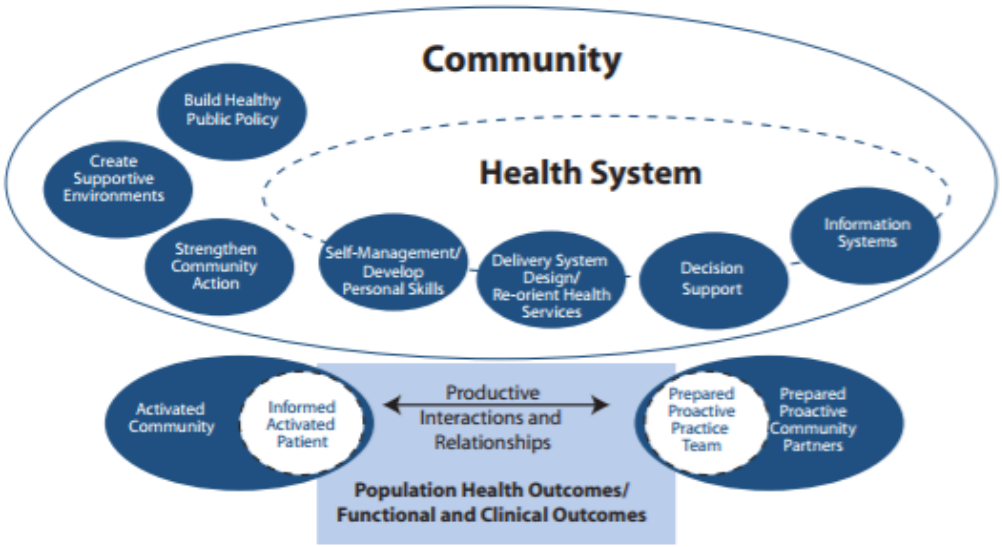
Cost without Coordination



- Higher cost
- Lower health
- Fee-For-Service
  - Method of payment for each activity performed, regardless of outcome or quality
  - Dominance as contributor to lack coordination
- Focus on acute care or "sickness" over prevention

Source: Massachusetts Special Commission on the Health Care Payment System, "Recommendations of the Special Commission on the Health Care Payment System," PowerPoint (Boston: SPHCP, July 16, 2009). Image accessed http://www.ncsl.org/portals/1/documents/health/GLOBAL_PAYMENTS-2010.pdf

Expanded Chronic Care Model



Created by: Victoria Barr, Sylvia Robinson, Brenda Marin-Link, Lisa Underhill, Anita Dotts & Darlene Ravensdale (2002) Adapted from Glasgow, R., Orleans, C., Wagner, E., Curry, S., Solberg, L. (2001). "Does the Chronic Care Model also serve as a template for improving prevention?" *The Milbank Quarterly*, 79(4), and World Health Organization, Health and Welfare Canada and Canadian Public Health Association.(1986). Ottawa Charter of Health Promotion.

Care Management Definition

A collaborative process of assessment, planning, facilitation, care coordination, evaluation and advocacy for options and services to meet the comprehensive medical, behavioral health and psychosocial needs of an individual and the individual's family, while promoting quality, cost-effective outcomes.

Source: NCQA 2016 Health Plan Standards and Guidelines

Care Management Goals

- Increase patient engagement in self care
- Improve patient's functional health status
- Enhance coordination of care
- Minimize fragmentation of care
- Eliminate duplication of services
- Reduce the need for unnecessary, costly medical services

Characteristics of Successful Complex Care Management Models

- Target individuals most likely to benefit from intervention
- Comprehensive assessment of patients' health-related risks and needs
- Evidence-based care planning and routine patient monitoring
- Promotion of patients' and family caregivers' engagement in patient self-care
- Coordination of care and communication among the patient and care team
- Facilitation of transitions
  - ***from hospital to post- acute care and referral to community resources***
- Provision of appropriate care in accordance with patients' goals and priorities

Reference: McCarthy Douglas; Ran, Jamie; Klein, Sarah "Models of Care for High-Need, High-Cost patients: An evidence Synthesis", Commonwealth Fund pub 1843 Vo 31; October 2015

micmrc

Care Management in the Primary Care Setting the Michigan Landscape

- 2012-12/31/2016 Michigan Primary Care Transformation demonstration (MiPCT)
- 1/1/2015 Centers for Medicare & Medicaid Services (CMS): Chronic Care Management Services
- 2015 and ongoing: Michigan Health plans have Care Management programs for practices who meet criteria
- 1/1/17: Michigan State Innovation Model (SIM) and the Comprehensive Primary Care Plus (CPC+)

What *is* PCMH?

- Model of primary care that includes the following core principles
  - Patient-centered
  - Comprehensive
  - Coordinated
  - Enhanced access
  - A systems-based approach to quality and safety

micmrc

*https://www.jointcommission.org/assets/1/18/Joint_Commission_PCMH_model.pdf, https://www.pcpcc.org/about/medical-home,

Blue Cross Blue Shield of Michigan Provider-Delivered Care Management

- Provider-Delivered Care Management is an integral part of BCBSM Patient-Centered Medical Homes.

- This model promotes care management delivered in the context of the doctor-patient relationship, which extends care management services into the clinical setting.

- Provider-Delivered Care Management is delivered by a highly qualified care manager and a clinical team.

BCBSM Physician Group Incentive Program: Patient Centered Medical Home Capabilities

- Patient-Provider Partnership
- **Patient Registry**
- Performance Reporting
- **Individual Care Management**
- Extended Access
- Test Results Tracking and Follow-Up
- Electronic Prescribing and Management of Controlled Substance Prescriptions

- Preventive Services
- **Linkage to Community Services**
- **Self-Management Support**
- Patient Web Portal
- **Coordination of Care**
- Specialist Pre-Consultation and Referral Process

Alignment

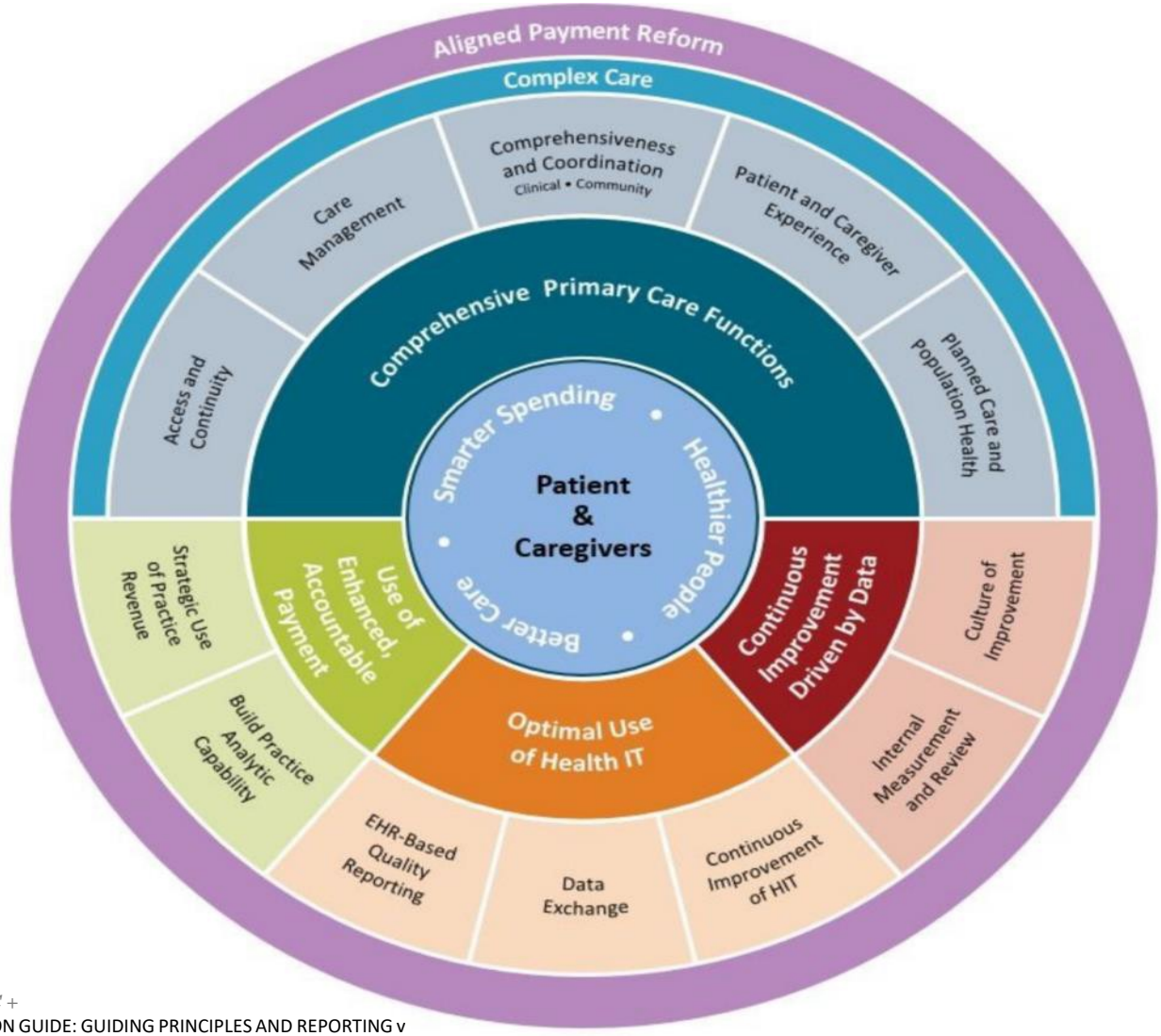


Image Credit: CMS , CPC +

2017 CPC+ IMPLEMENTATION GUIDE: GUIDING PRINCIPLES AND REPORTING v
May 10, 2017 accessed at **2017_CPCPlus_Implementation_Guide_FINAL**

Care Management Process

In the Primary Care Setting

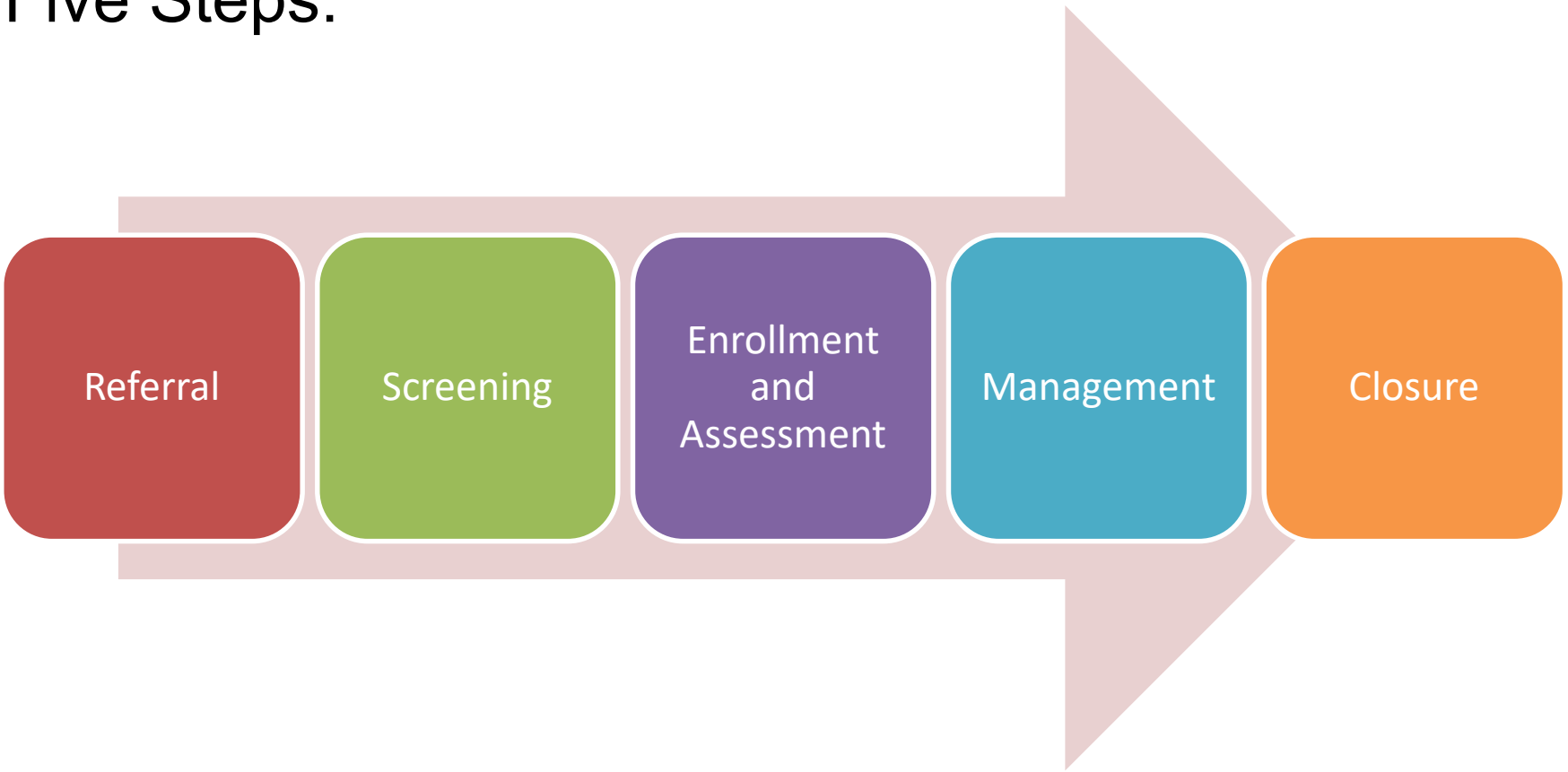
Care Management

- Care Management Program
  "Care management programs apply systems, science, incentives, and information to improve medical practice and assist consumers and their support system to become engaged in a collaborative process designed to manage medical/social/mental health conditions more effectively."
  http://www.chcs.org/media/Care_Management_Framework.pdf

- Care Management Process
  Care Management is "a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocating for options and services to meet an individual's health needs through communication and available resources to promote quality cost effective outcomes."
  Care Management Society of America

Care Management Process

Five Steps:



Referral

Not everyone will benefit from Care Management Services
So how do we find appropriate patients:

- Providers or practice staff
- Transition of Care calls after Hospital discharge, Emergency room or urgent care discharge
- Review of targeted populations, chronic conditions not in control
- Quality or Registry Report noting *Gaps in Care* reports

Screening

Medical record

Claims

- High utilization
- High costs

Current clinical conditions, chronic conditions

- High risk

Resource utilization

- Recent ED visit(s)
- Recent hospitalization (example: >2 admissions within last 12 months.)
- Skilled nursing facility with goal to transfer to home setting

Significant health events

- Chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline

Primary Care Physician input

Social Determinants of Health screening flags

Self-Care inability

Medication Management issues

Support System

- ER use
- Hospitalizations
- High tech radiology
- Rehab
- Cancer Treatment
- Organ Transplant

Enrollment and Assessment

Warm handoff from PCP is best

"I work with Dr. Smith, she asked me to meet/call you."

Quick Tools (CM Phone script) (Care Management Flyer)

- Obtain patient consent, document
- Complete initial assessment
- Comprehensive assessment may take time
- Level of risk and care management needs

Management
Plan of Care and Interventions

Develop the individualized plan of care

- Patient, PCP, team and Care Manager agree on the goals and plan of care
- Care Manager and patient agree on actions/strategies to carrying out the plan
- Care Manager collaborates with team members inside and outside of the office and across the medical neighborhood to carry out specific interventions
- Care Manager maintains longitudinal relationship
    - Frequency of contact, face to face or telephonic is based on patient's acuity, agreement, monitoring needs, and reassessment
    - Each contact is an opportunity to update the individualized care plan
    - Address advanced care planning and if appropriate Palliative care or Hospice

Case Closure

Close case when:

- Patient has met their goals and is discharged from care management services
- Patient moves out of region/state
- Patient expires
- Patient is admitted to hospice care

Review plan to close with team and primary care physician assuring agreement

Care Manager Services

The Care Manager provides the following services to patient, family and care givers

1. Identify patients and populations appropriate for care management
2. Completes Comprehensive Assessment of healthcare, educational, and psychosocial needs
3. Creates and maintains patient-centered individualized plan of care that targets interventions and monitoring for early detection of acute exacerbations to avoids hospital and emergency room visits
4. Provides medication management support
5. Provides self-management support / coaching– empower patient/family
6. Provides education and teach back for patient/family/care giver
7. Provides Care Giver support
8. Implements evidence based care
9. Close gaps in care; addresses prevention, chronic condition management
10. Coordinates care across the team and across the medical neighborhood
11. Assists with transitions of care between settings
12. Assists with advance care planning and advanced directive
13. Maintains a longitudinal relationship, as long as CM services are needed

Team Based Care

In the Primary Care Setting

micmrc

The Michigan Care Management Resource Center

Team Based Care Definition

The provision of health services

to individuals, families, and/or their communities

by at least two health providers who work ***collaboratively*** with patients and their caregivers,

to the extent preferred by each patient,

to accomplish shared goals within and across settings to achieve coordinated, high-quality care

https://www.pcmh.ahrq.gov/page/creating-patient-centered-team-based-primary-care#fig1

Team Based Care Goals

According to the Agency for Healthcare Research in Quality (AHRG):

"The primary goal of medical teamwork is to optimize the timely and effective use of information, skills and resources by teams of healthcare professionals for the purpose of enhancing the quality and safety of patient care"

Who is the Team?

- Team *may* include:
  - Physician
  - Nurse Practitioner
  - Physician Assistant
  - **Nurses**
  - Care Manager
  - Dietitian
  - Pharmacist
  - **Social Worker**
  - Receptionists
  - Licensed Practical Nurse
  - Licensed Professional Counselor
  - Licensed Pharmacist
  - Bachelor's Social Worker
  - Certified Community Health Worker
  - Panel Manager, Referral Coordinator
  - Social Services Technician
  - Health Plan Care Manager
  - Community Agencies
  - CM from acute care, skilled care, home care

Goals of Team Based Care

- Well-implemented team based care has the potential to improve:
  - Comprehensiveness
  - Coordination
  - Efficiency
  - Effectiveness
  - Value of care
  - Satisfaction of patients and providers

Benefits of Team Based Care

- Practices with a team based environment report:
  - Increased office efficiency (63%)
  - Improved quality of care (53%)
  - Increased patient satisfaction (50%)
  - Increased staff satisfaction (36%)
  - Improved financial outcomes (19%)

Study: American College of Cardiology 2011

Outcomes of Team Based Care MIHP

- Process:
  - Care Coordinator review of charts for appropriate care
  - Team meetings
- Outcomes:
  - Social Worker and RN seeing beneficiaries – appropriate discipline seeing beneficiary, ex: RN for mom with chronic dx or SW for Mom with depression
  - Appropriate visits – mom receives 9 visits throughout pregnancy and one postpartum home visit is required in the 9 visits. Need to coordinate this with all disciplines
  - Appropriate referrals and follow up for beneficiaries needs
  - Appropriate communication with HP/PCP/Referral resources

CHALLENGE	OPPORTUNITY FOR CHANGE
Lack of role clarity among health care providers	1. Each team member clearly communicate his/her role to the other team members including patient and family 2. All providers should work to the top of their scope 3. Practices should develop or seek out and agree on evidence based protocols
Lack of role clarity with the patient and family about team members roles	1. Practices provides written information to ensure that patients and families can easily understand team member's role and identify which provider is responsible for various aspects of their care 2. Each team member should consistently and clearly communicate their role to the patient
Lack of role clarify by the patient/family and the team to shape their goals and outcomes	1. Patient and Family needs to understand their role in developing their goals, interventions, monitoring their condition and when to contact care manager and/or practice. 2. Clinical information should be presented in terms that are easily understood and culturally relevant.

Evaluation of Team Based Care in Primary Care Setting

What is Important to Evaluate?

- **Process**
  - Program Description
    - Who makes up the team?
    - What are the team's protocols and procedures?
    - What are the core components of the team's successes?
- **Process**
  - Engagement Description
    - How successful has our health system engagement been as it relates to expanding team based care?
    - What are the core components to integrating health care extenders into a clinical team?
- **Outcomes**
  - Clinical Outcomes
    - Blood pressure control
    - Hemoglobin A1C
    - Medication adherence
- **Outcomes**
  - Clinical Outcomes
    - Policies that promote a team approach
    - Systems that promote a team approach

https://www.ucsf.edu/news/2014/08/116856/team-based-approach-primary-care

Question

- Who do you consider to be part of your team of care?

Coordination of Care

Care Coordination

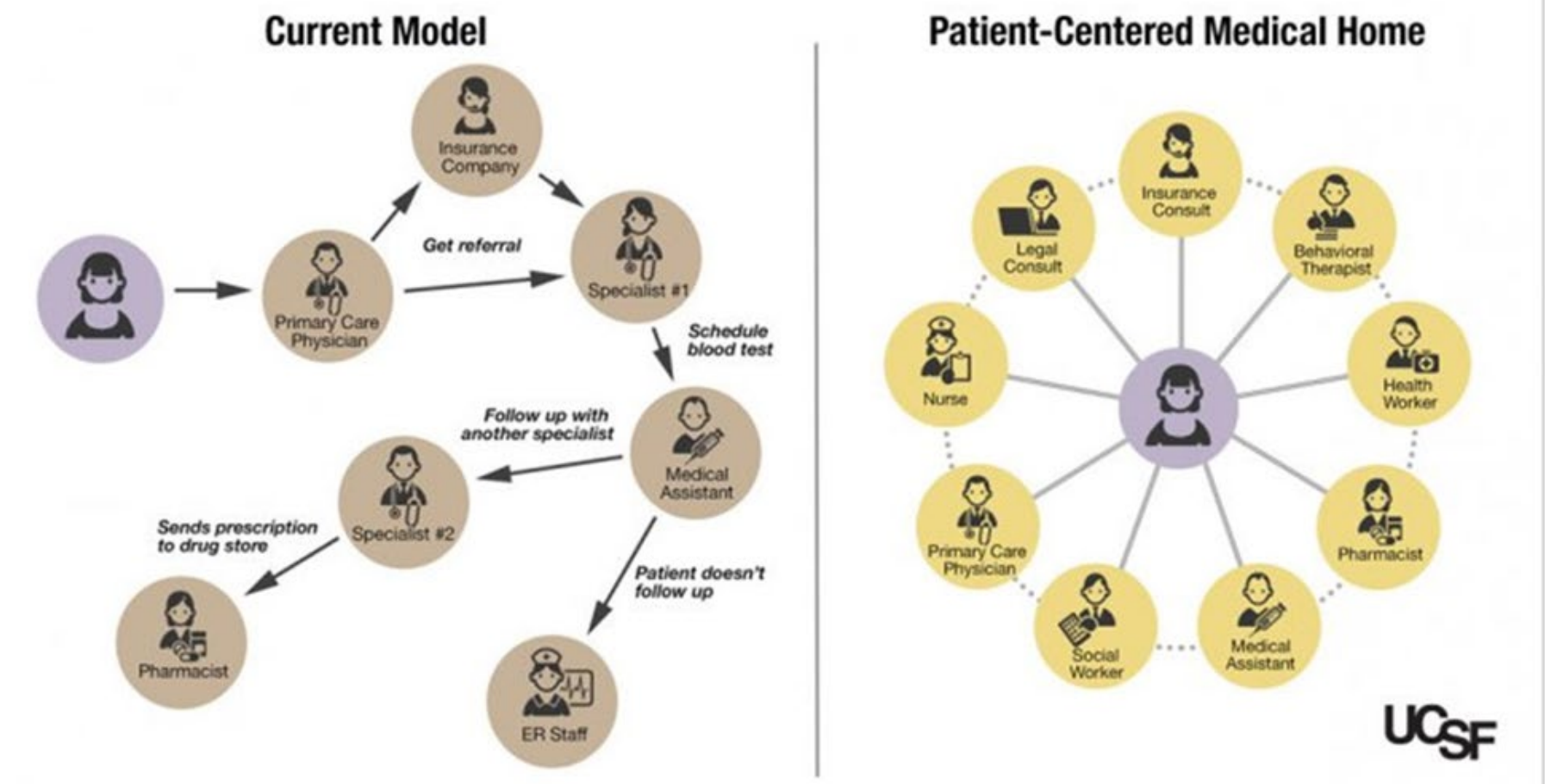
- Care coordination is the cornerstone of many healthcare redesign efforts, including primary and behavioral healthcare integration. It involves bringing together various providers and information systems to coordinate health services, patient needs, and information to help better achieve the goals of treatment and care. Research shows that care coordination increases efficiency and improves clinical outcomes and patient satisfaction with care.

https://www.integration.samhsa.gov/workforce/care-coordination

Today's Theme: Overcoming Challenges and Barriers to Coordination

Rethinking Primary Care

Clear communication and effective coordination among health care providers are vital for patient health, but the current primary care structure makes collaboration incredibly difficult. See the difference:



https://www.ucsf.edu/news/2014/08/116856/team-based-approach-primary-care

13.0 Coordination of Care

Goal:

- Patient transitions are well-managed and patient care is coordinated across health care settings through a process of active communication and collaboration among providers, patients and their caregivers

Capabilities:

- Process is in place for exchanging necessary medical records and discussing continued care arrangements with other providers, including facilities, for patient population selected for initial focus
- Process is in place to systematically flag for immediate attention any patient issue that indicates a potentially time-sensitive health issue for patient population selected for initial focus
- Process is in place to coordinate care with payer case manager for patients with complex or catastrophic conditions
- Practice is actively participating in the Michigan Admission, Discharge, Transfer (ADT) Initiative

Benefits of Care Coordination

Primary Care Environment

- Reduced hospital admissions
- Improved quality of chronic disease management
- Improved patient satisfaction
- Better access to specialty care
- Reduced cost

MIHP

- Improved infant health and Maternal Mortality
- Improved Social Emotional well being of mom/family
- Improved access and follow through of referrals
- Increased beneficiary knowledge
- Increased beneficiary empowerment
- Improved patient satisfaction

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4809054/

Michigan SIM Care Coordination Collaborative

Goal: Optimize the effective partnering of plans, practices, POs, community organizations and CHIRs (i.e., the multi-stakeholder partners) for the purpose of:

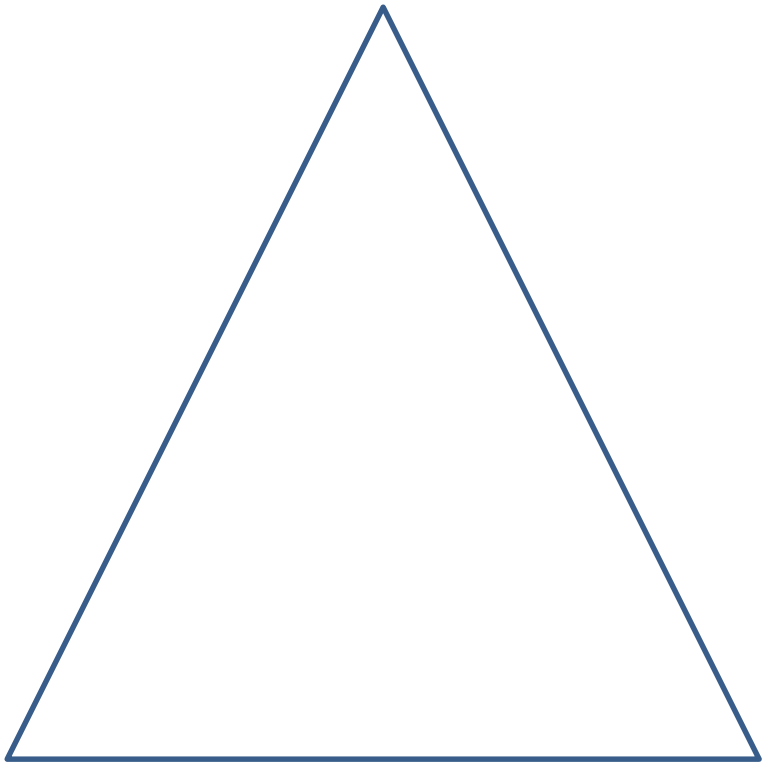
- Addressing the closing patient/member/beneficiary social determinant health needs
- Improving population overall health status, efficiency and effectiveness of care delivery

Successful stories of joint coordination with a health plan

- **UnitedHealthcare Community Plan:**
  - Had twin babies that needed a particular shot that the SIM CM did not know how to obtain. We worked with the SIM CM to get the medication approved and get the babies what they needed.
  - Assisted a SIM CM with getting a member into Home Health Care when the SIM CM was having difficulty finding a provider in the area.
  - Completed a case review and accepted a referral from a SIM CM to refer a member into Medicaid Health Plan case management because the SDOH needs were greater than what the SIM CM could provide as the member had an eviction notice, CPS involvement, psych issues, and potential for domestic violence.

Triangle of Coordination

MIHP RN/SW



Primary Care
Specialty Care

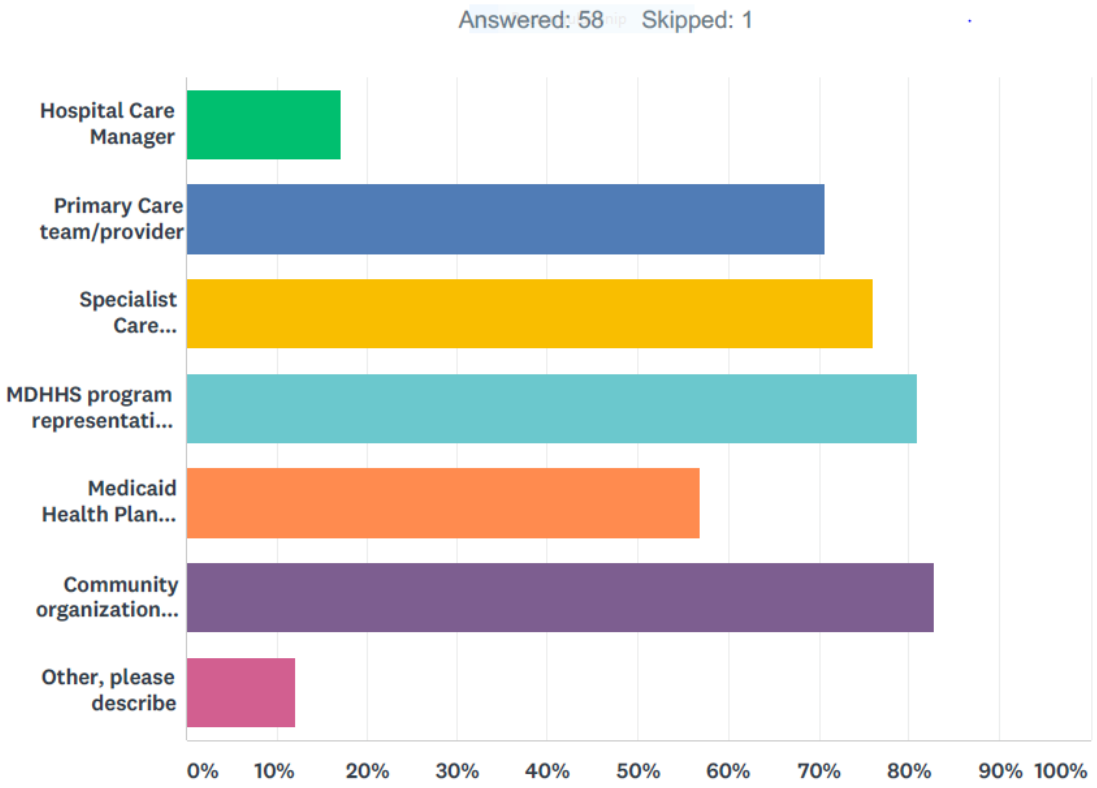
Medicaid
Health Plan

MIHP Survey

- Intention:
- Sent out to this many people (SW, RN, and RD?)
- This many responses
- Opportunities for comments….

MIHP Survey

Q2 Who do you contact to coordinate care for patients? Select all that apply



How do you communicate with the following personnel?

	ELECTRONIC MEDICAL RECORD	ENCRYPTED E-MAIL	FACE TO FACE	PHONE	OTHER	I DON'T COORDINATE	TOTAL
Hospital Care Manager	12.24% 6	2.04% 1	4.08% 2	38.78% 19	2.04% 1	40.82% 20	49
Primary Care team/provider	17.86% 10	8.93% 5	8.93% 5	46.43% 26	16.07% 9	1.79% 1	56
MDHHS program representatives: ex. W.I.C., Children Special Health Care Services, Community Mental Health	1.69% 1	11.86% 7	18.64% 11	59.32% 35	8.47% 5	0.00% 0	59
Medicaid Health Plan Care Manager	3.45% 2	22.41% 13	0.00% 0	37.93% 22	15.52% 9	20.69% 12	58
Community organizations/resource staff (not MDHHS)	1.69% 1	10.17% 6	5.08% 3	69.49% 41	13.56% 8	0.00% 0	59

What information do you request most often from other organizations

ANSWER CHOICES	RESPONSES	
Medication list (1)	0.00%	0
Status of placed referral or appointment (2)	66.10%	39
Information to determine eligibility for community resources (3)	69.49%	41
Identify who is part of the care team for the client/patient (4)	20.34%	12
Emergency room discharge summary (5)	3.39%	2
Hospital discharge summary (6)	10.17%	6
Other (please specify (7)	15.25%	9
Total Respondents: 59		

Other:

1. Medicaid/assistance info.
2. Resource assistance
3. Assisting with making or advocating for appointments
4. Phone numbers/addresses
5. Emergency interventions and enrollment or discharge notification
6. Requesting info from DHHS regarding why benefits were cut off
7. Notifying them of client needs
8. Information on the organization/coordinating an appt.
9. Coordination of care with infants PCP

Survey Results

In thinking about the coordination of care you have worked on in the previous 6 months, how satisfied are you with the communication?

	Highly Satisfied	Satisfied	Sometimes Satisfied	Dissatisfied	Extremely Dissatisfied	N/A
Medicaid Health Plan care manager	8.2% (5)	39.66% (23)	24.14% (14)	5.17% (3)	3.45% (2)	18.97% (11)
Primary Care team/ provider	12.28% (7)	54.39% (31)	24.56% (14)	1.75% (1)	0	7.02% (4)
Hospital care manager	10.91% (6)	23.64% (13)	20% (11)	1.82% (1)	0	42.64% (24)
Community organizations/resource staff, (not MDHHS)	13.79% (8)	60.34% (35)	18.97% (11)	0	5.17% (3)	1.72% (1)
MDHHS program representatives// Ex: WIC	15.52% (9)	53.45% (31)	18.97% (11)	3.45% (2)	6.90% (4)	1.72% (1)

Comments about Challenges	Comments about Successes
Access to the right person	Social Workers give us full details and concerns about clients
Change of contact person	Hospital CMs provide us with needs assessment
Often get voicemail	Detailed information about client's family situation
Not always aware of what we do	Increased referrals
Getting a return call	Help with identifying family needs
Staff changes and shift changes	Transportation assistance
Language barriers	Help locating needed resources
Release of information concerns on their end	Positive communication
Can't get through to a real person	Patients can see collaboration
Unsure when to contact HP CM	Work together to make a plan
Lack of on-going communication/ Clarity	Positive response from nurses

Ensuring Appropriate Care Provision

MIHP	PRIMARY CARE
Utilize needed MIHP disciplines	Team Based Care
Continuous Monitoring of the Care Plan	Goal: Shared Care Plan
Health Plan Resources	Role Determination
Transition from MIHP	Transitions of Care

MIHP Care Coordination

- Arranging referrals
- *Communication with all individuals, organizations, institutions involved in accessing care needed*
- Documentation

Communication

- Today's new models of healthcare are focused on maintaining health rather than responding to acute illness
- Success in healthcare requires team-based approaches that are centered on close collaboration among all types of providers from across the care continuum
- Achieving the triple aim, (improving quality, lowering costs, and enhancing the patient experience) can only be done with a deliberate effort in an improved communication strategy

https://medicalreview.columbia.edu/article/communication-healthcare/

Communication Challenges

- Healthcare providers don't talk to each other enough
- Members of the patient's care team don't spend enough time communicating with one another about the patient's needs
- Patients don't get enough time with their care team members to fully understand what's going on with their health
- https://medicalreview.columbia.edu/article/communication-healthcare/

SBAR

S – Situation

B – Background

A – Assessment

R – Recommendation

SBAR is an easy to remember acronym providing a framework for communication between members of the health care team about a patient's condition

History of SBAR

- US Navy Nuclear Submarine Service officers and crew needed a situational briefing tool to communicate clearly, effectively and efficiently
- Michael Leonard, MD, Physician Leader for patient safety, Doug Bonacum and Suzanne Graham at Kaiser Permanente of Colorado adopted this tool for healthcare

SBAR

- *Situation* – What is the concern -- A very clear succinct overview of pertinent issue
- *Background* – What has occurred -- Important brief information relating to event. What got us to this point
- *Assessment/Analysis* – What do you think is going on. Summarize the facts and give your best judgement
- *Recommendation* - What do you recommend – what actions do you want

SBAR In Action

SBAR Ineffective Communication:

https://www.youtube.com/watch?v=CtdNQ-sfKg8

SBAR Effective Communication:

https://www.youtube.com/watch?v=fsazEArBy2g

Planning for the Call

- Gather basic patient info
- Establish the goal of the call
- Fill out SBAR prompts
- Practice/rehearse what you want to say
- Have all information readily available

SBAR – Your Turn!

Scenario: 28yo, pregnant (32 weeks) female recently moved to Ypsilanti MI from Flint to share an apartment with her sister and her 2 children. The patient has not set up OB care yet. She has just run out of her …… to control her blood pressure. She needs an appointment as well as medications to cover her until she can be seen. She has no means of transportation.

- ❑ *Situation* – What is the concern -- A very clear succinct overview of pertinent issue
- ❑ *Background* – What has occurred -- Important brief information relating to event. What got us to this point
- ❑ *Assessment/Analysis* – What do you think is goin on. Summarize the facts and give your best judgement
- ❑ *Recommendation* - What do you recommend – what actions do you want

SBAR – Your Turn!

- ***Scenario:*** *28yo, pregnant (32 weeks) female recently moved to Ypsilanti, MI from Flint to share an apartment with her sister and her 2 children. The patient has not set up OB care yet. She has just run out of her labetalol to control her blood pressure. She needs an appointment as well as medications to cover her until she can be seen. She has no means of transportation.*

- ❑ ***Situation*** – What is the concern? (a very clear succinct overview of pertinent issue)
- ❑ ***Background*** – What has occurred? (important, brief information relating to event. What got us to this point?
- ❑ ***Assessment/Analysis*** **–** What do you think is going on? (summarize the facts and give your best judgement
- ❑ ***Recommendation*** **–** What do you recommend? (what actions do you want?)

MiCMRC Website www.micmrc.org

E Learning Courses

Behavioral Health webinars and resources

Recorded webinars offering CE for Nursing, Social Work and CCMC

References

- Friedman, A. PhD, Howard, J. PhD, Shaw, Eric J.,PhD, Cohen, Deborah J. PhD, Shahidi, Laleh, PhD, Ferrante, Jeanne, M. PhD. (2016). Facilitators and Barriers to Care Coordination in Patient-centered Medical Homes (PCMHs) from Coordinators' Perspectives. *Journal of the American Board of Family Medicine,* 29(1) 90-101.

- Gordan, J. E., MBA, Deland, E. MBA, Kelly, R., E., MD. (2015, May 25). Lets' Talk About Improving Communication in Healthcare. *Col Med Review,* 1(1) 23-27.

- Smith, C.D., C . Balatbat, S. Corbridge, A.L. Dopp, J. Fried, R. Harter, S. Landefeld, C. Martin, F. Opelka, L. Sandy, L. Sato, and C. Sinsky. 2018. Implementing optimal team based care to reduce clinician burnout. *NAM Perspectives*. Discussion Paper, National Academy of Medicine, Washington DC.

Q and A