Introduction to Team Based Care

Animation

Animation Complete

Participation from learners

Video

Welcome!

House Keeping

Agenda

Welcome	Care Team Models & Roles • Break	Care Management Process	Outcomes and Triple AIM • Lunch
Group Case Study on Team-based Care Roles – Maria	Breakout – Assessments	Workflows	Team Conference
	Billing, Coding and sustainability	Putting it together and wrap-up	

Virtual Etiquette

Meeting participation:

- We will be using the raise your hand feature by clicking on the little blue hand
- We will be using chat function
- When we are taking breaks be sure not to leave the meeting but rather mute your audio and video

Environment:

- Be aware of your backgrounds to not be distracting.
- Position yourself in the light.

https://www.gend.co/blog/best-practice-tips-for-using-zoom

Michigan Center for Clinical Systems Improvement (Mi-CCSI)

Who We Are

Regional Non-profit Quality Improvement Consortium

What We Do

Mi-CCSI works with stakeholders to:

- Facilitate training and implementation….
- Promote best practice sharing,
- Strengthen measurement and analysis

Mission

Mi-CCSI Partners to Better Care
We do so through…

- Evidence-based Trainings
- Sustainable Training Impact
- Collaborative and Customized Approaches
- Engaging Heart and Mind
- Enhanced Body Mind Spirit Patient Focus

Vision

Mi-CCSI leads healthcare transformation through collaboration

Intro to Team Based Care

Curriculum developed in partnership with:

Ruth Clark, Integrated Health Partners
Scott Johnson, MICMT
Kim Harrison, Priority Health
Lynn Klima, Cure-Michigan
Ewa Matuszewski, MedNetOne/PTI
Lisa Nicolaou, Northern Physicians Organization
Robin Schreur, MiCCSI
Sue Vos, MiCCSI

Successful Completion of Introduction to Team Based Care includes:

- Complete the one day in-person/virtual training.
- Complete the Michigan Institute for Care Management and Transformation (MICMT) post-test and evaluation.
- Achieve a passing score on the post-test of 80% of greater.
  *If needed, you may retake the post-test.

You will have (5) business days to complete the post-test.

MiCCSI Introduction to Team Based Care Disclosures

Nursing:

- There is no conflict of interest for anyone with the ability to control content for this activity.
- Successful completion of the Introduction to Team Based Care course includes:
  - Attendance at the entire course
  - Completion of the course evaluation
- Upon successful completion of the Introduction to Team Based Care Course, the participant will earn 7.0 Nursing CE contact hours
- This nursing continuing professional development activity was approved by the Ohio Nurses Association, an accredited approver by the American Nurses Credentialing Center's Commission on Accreditation. (OBN-001-91)

Social Work:

- Upon successful completion of the Introduction to Team Based Care course, the participant will earn 6.5 Social Work CE Contact Hours

Contact

For post test and materials:
micmt-requests@med.umich.edu

Pre-Work

Completion of pre-work material

- Pre-checklist (orientation elements document)
- Share The Care Document
- SBAR Activity

*If you didn't not have a chance to view the prework please make sure to review

Group Activity: Introductions

Your:

- Discipline
- Practice location
- How long have you been in your role
- What's most important for you to learn today

ZOOM POLL

Team Based Care

The provision of health services to individuals, families, and/or their communities by at least two health care 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://pcmh.ahrq.gov/page/creating-patient-centered-team based-primary-care

The Value of Team Based Care:
A Patient Perspective

Value

- Improved health and outcomes
- Improved engagement and satisfaction
- Decreased unnecessary visits to the emergency department and hospital
- Improved ability to self manage
- Improved ability to engage with the practice team

The Value of Team Based Care: *A Practice Perspective*

Value

- Improved patient care
- Improved engagement of practice teams
- Improved patient outcomes
- Decreased cost
- Decreased burnout and turnover

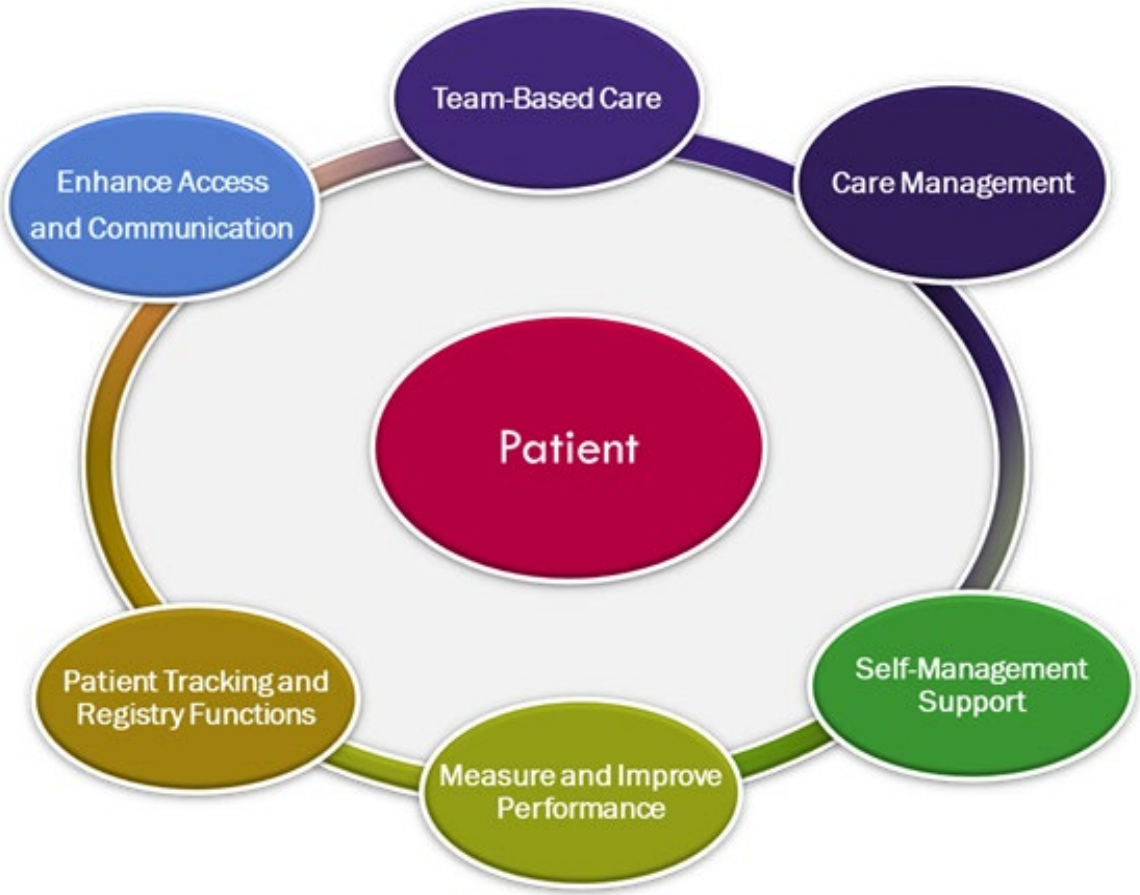
The Value of Team Based Care:
A Payer Perspective

Value

- Payers support programs that demonstrate improved quality and lower overall costs of care.
- Outcomes measures, such as A1c, BP, Inpatient Utilization, and ED Utilization demonstrate improved quality of care resulting in decreased cost of care
- Improved patient care and quality resulting in decreased cost to all equates a successful program

Patient Centered Medical Home (PCMH)

PCMH is a care delivery model in which patient treatment is coordinated through primary care teams to ensure patients receive the necessary care when and where they need it, in a manner they can understand.

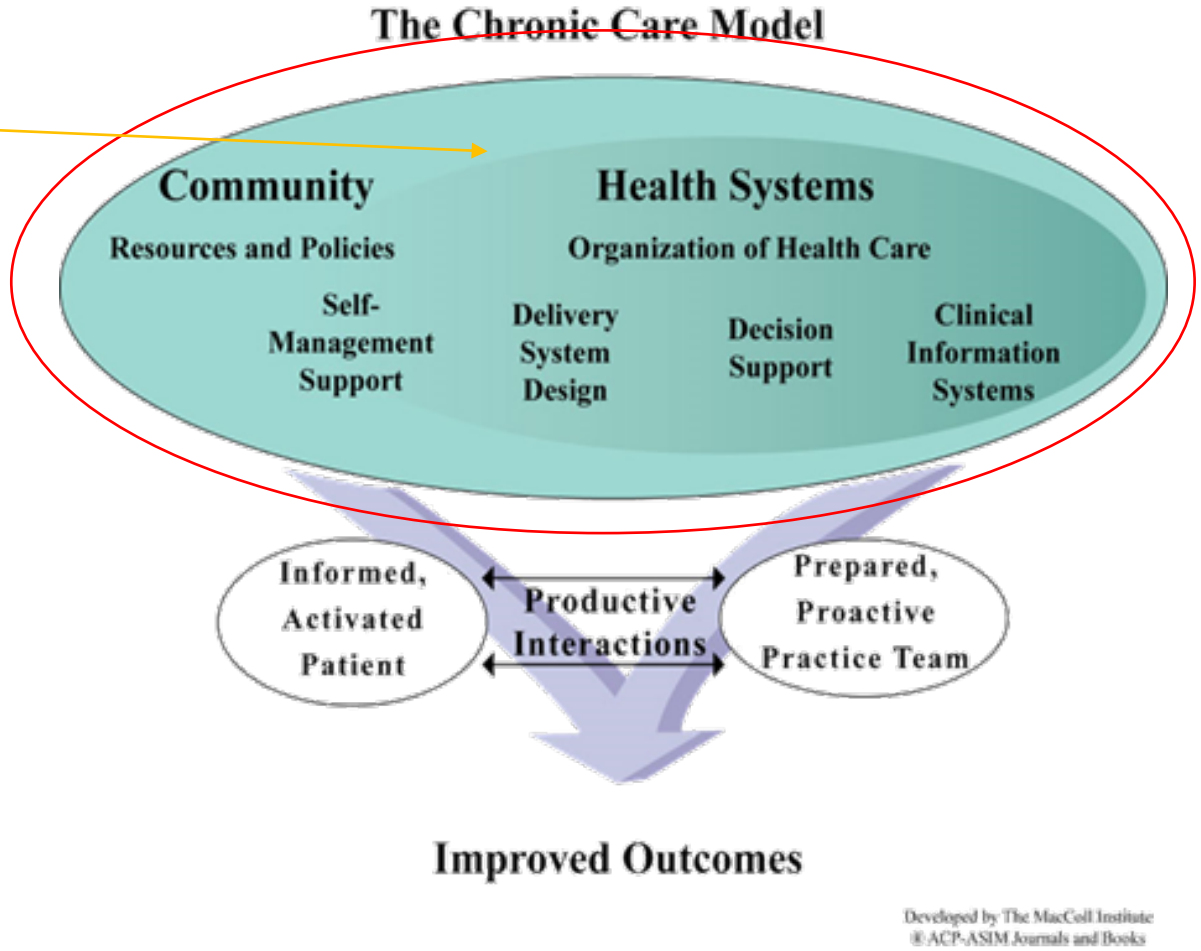


https://www.acponline.org/practice-resources/business-resources/payment/delivery-and-payment-models/patient-centered-medical-home/understanding-the-patient-centered-medical-home/what-is-the-patient-centered-medical-home

The Chronic Care Model

An organized and planned approach to improving patient and population level health:

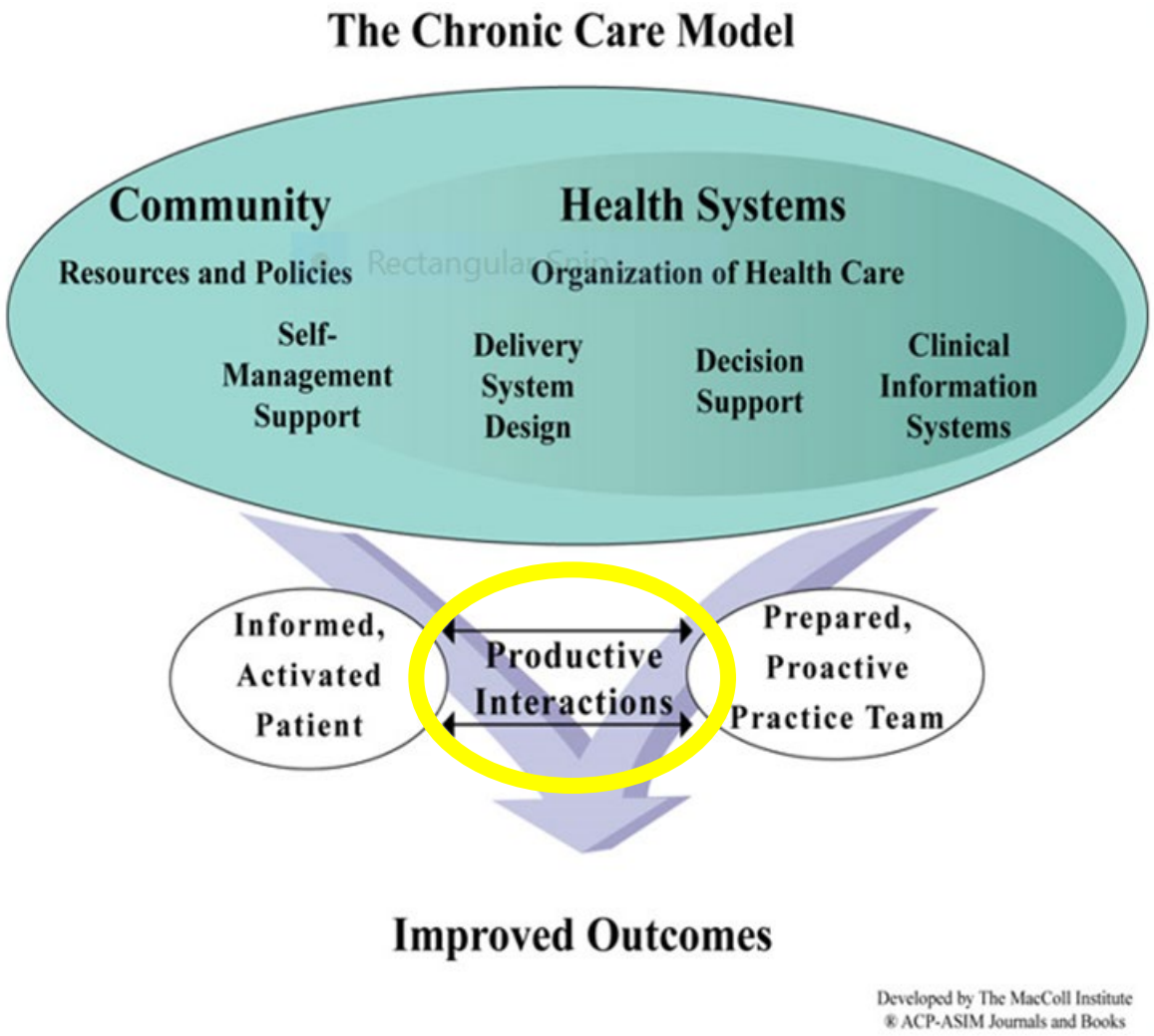
- **Identifies essential elements of a health care system that encourage high-quality chronic disease care.**
- **Formalized change management process fosters productive interactions.**
- **Informed patients take an active part in their care.**
- **Care team has resources, tools and expertise to engage with the patient.**



http://www.improvingchroniccare.org/index.php?p=Model_Elements&s=18

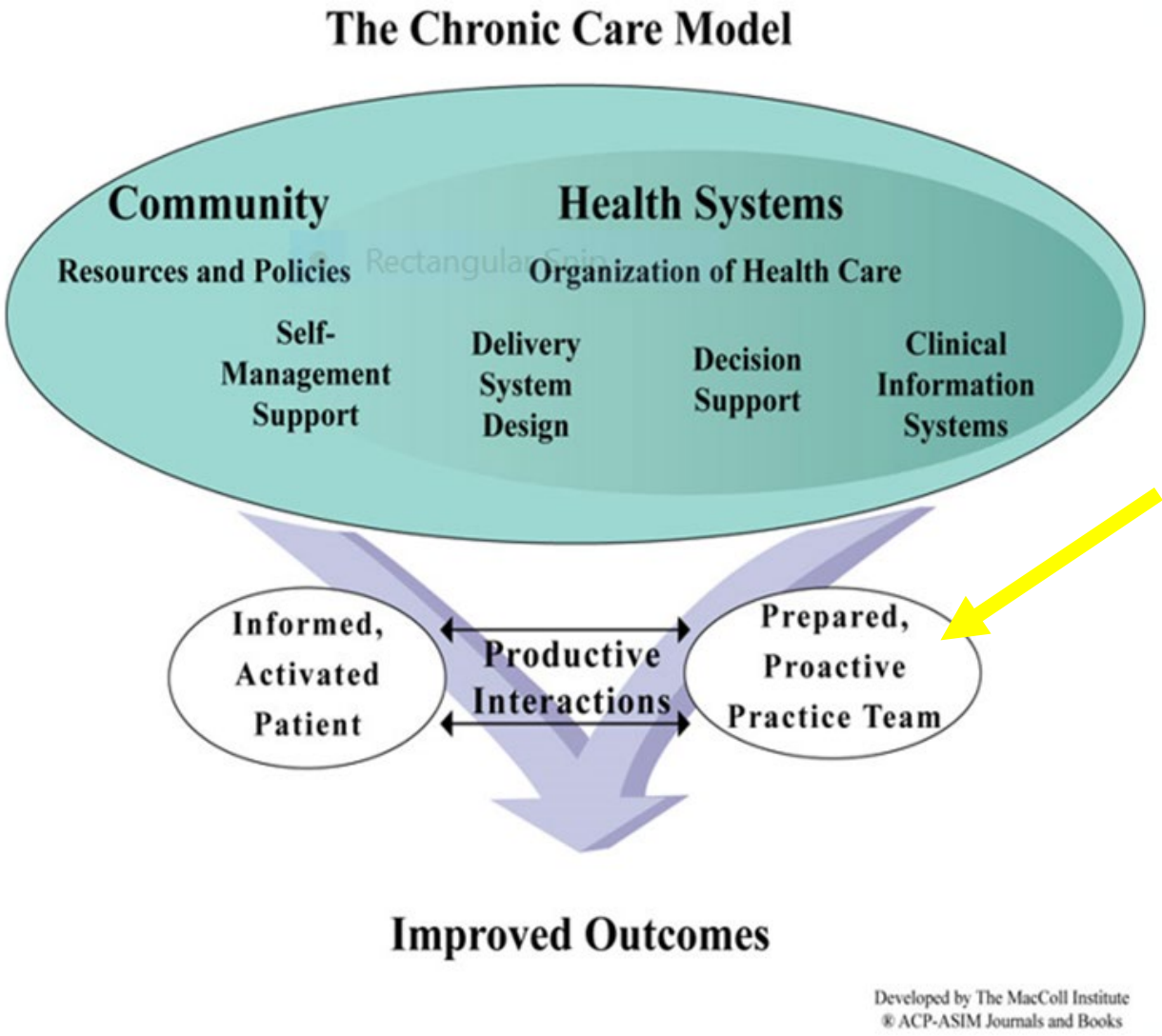
Productive Interaction

- Assess self-management skills and confidence
- Assess clinical status
- Tailor clinical management by stepped protocol
- Collaborative goal setting and problem solving in a shared care plan
- Active, sustained follow-up with patient is scheduled



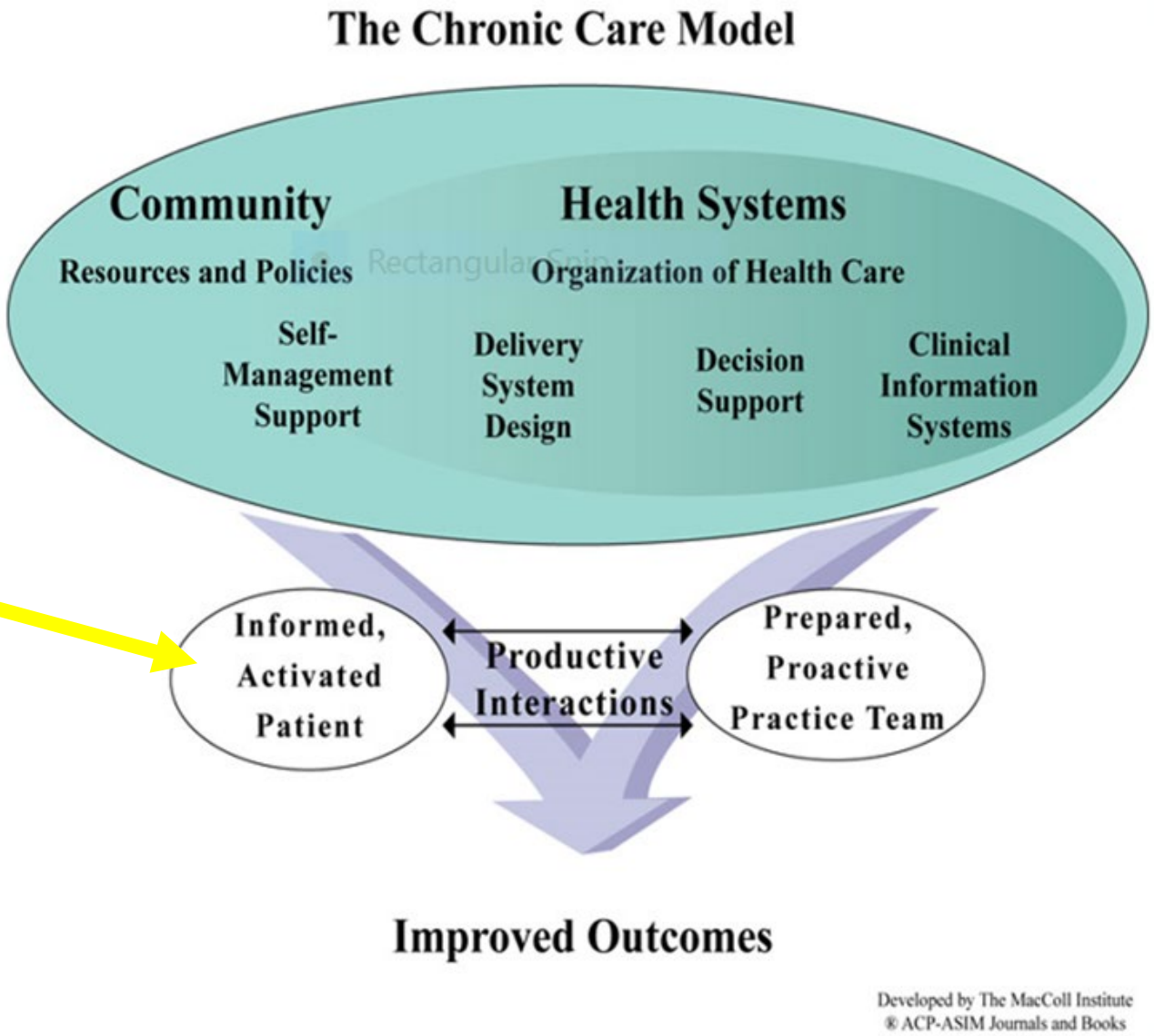
Prepared, Proactive Practice Team

- Patient information at time of visit
- Care team members available for visit
- Necessary equipment available
- Decision support
- Adequate time to provide care
- Care plan v. self-management goal



Informed, Activated Patient

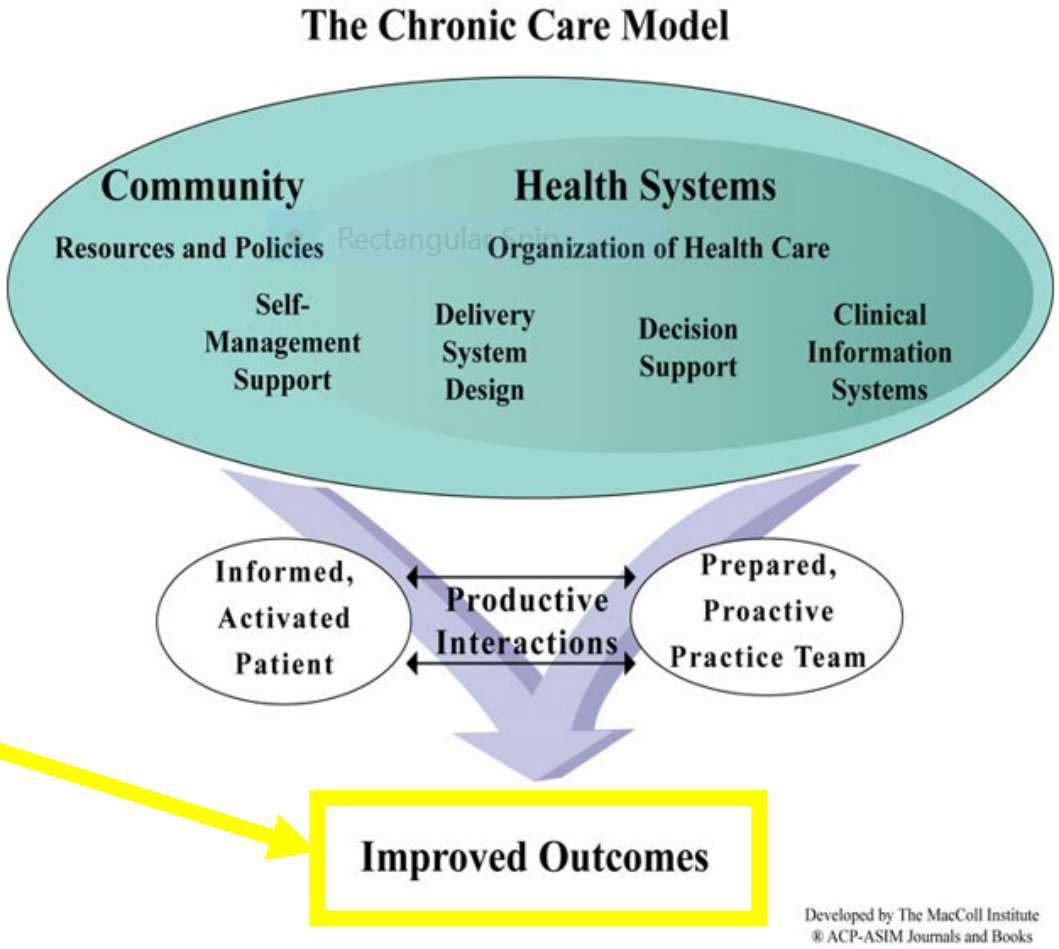
- Understands disease process
- Understands prognosis
- Includes family and caregivers in developing care plans
- Views the provider as a guide
- Manages daily care



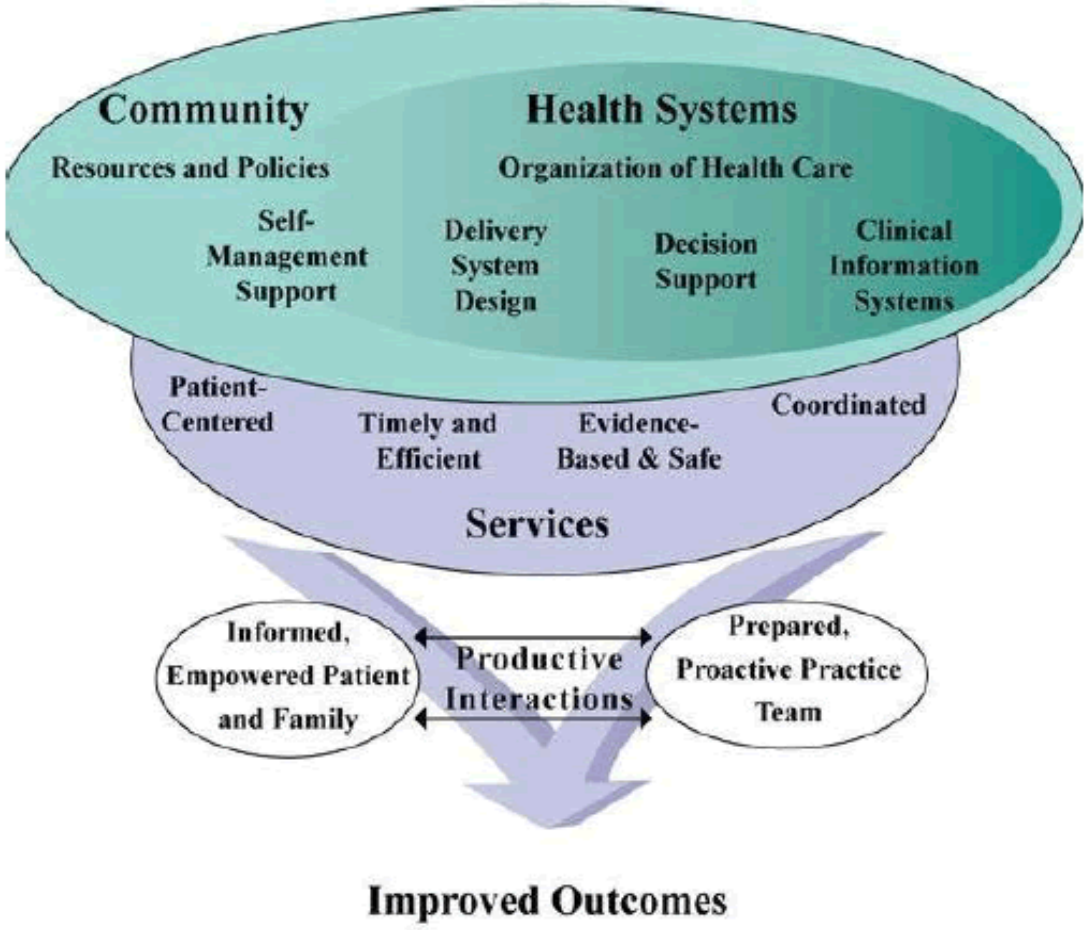
Improved Outcomes

Patient/caregiver is successful with self management of chronic condition(s).

- Improved/stabilized patient quality of life
- Reduced cost of health care
- Patient education: access to Specialty practice, after hours who to call, a tool for decision about ED utilization or not, action plan for chronic condition Medication adherence
- Regular testing and screening
- Healthier lifestyle choices



PCMH and Chronic Care Model Alignment

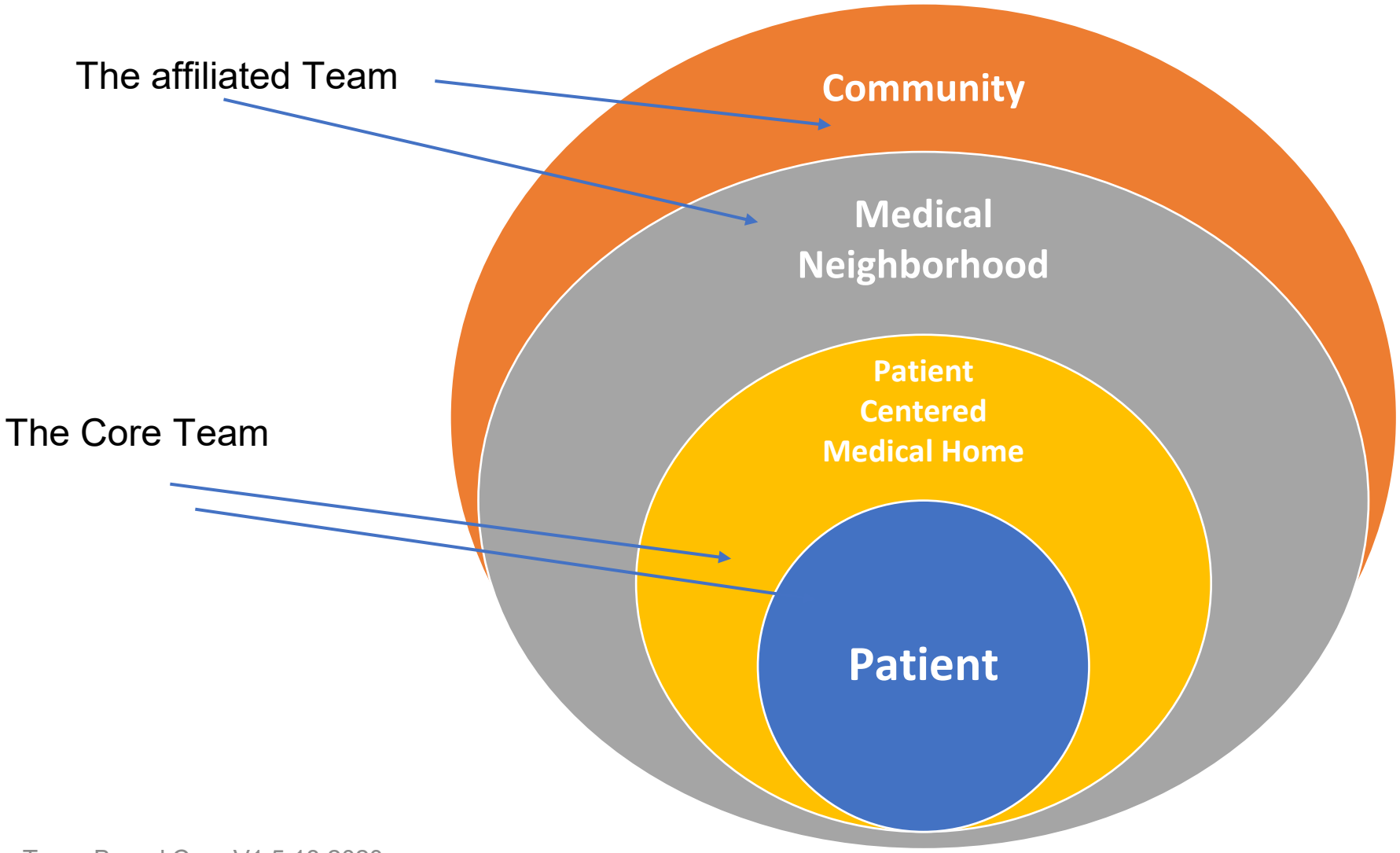


- **Comprehensive Evidence-Based Framework** for improving care delivery and patient-centered chronic condition management across the spectrum of healthcare
- **Recognizes Primary Health Care as the necessary foundation** from which the Community and Health System link to the patient
- **Formal Quality Improvement process**
- **Self Management Support** becomes universally accepted practice to engage patients across the spectrum of care continuum

Polling – what do you see in your practices

https://www.ahrq.gov/ncepcr/tools/pf-handbook/mod16.html

Community Team Members



Review Share the Care

Roles Within Your Setting

Team Expanded Roles Examples

PCP	RN - CM	SW CM – Behavioral Health Specialist	Clinical Pharmacist Medication Management	Community Health Worker	Office clerical Referral Management	MA Panel Management
• Annual Physical • Orders preventive care • Diagnosis, discussion of treatment options and management of acute and chronic conditions • Coordination of care and care team • Referrals to specialists • On call	• Provide care management for high-risk patients • Chronic illness monitoring response to treatment and titrating treatment according to delegated order sets	• Provide behavioral health services in the practice or by referral • Protocol or (service may be in the practice or at another site) • Urgent BH patient need	• Medication review for patents • Review prescribing practices • Assist patients with problems such as non-adherence, side effects, cost of medications, understanding medications, medication management challenges • Titrate medication for selected groups of patient under standing orders • Manages chronic conditions according to Collaborative Practice Agreements	• Provides self-management support • Coordinates care by helping patients navigate the healthcare system and access community services	• Assist with outreach to help patient establish overdue appointments • Assist patients with obtaining referral appointment, having preauthorization orders, and obtaining follow-up reports	• Collaborate with providers in managing a panel • Outreach on preventive services • Provides services to chronically ill patients such as self-management coaching or follow-up phone calls • Scrub chart, provides pre-visit screenings • Reviews medication list
	Quality Improvement Activities Team conducts QI activities to monitor quality measures and improve metrics with involvement of patient and families Team monitors program targets and make changes to improve					

Let's Chat

Teams and Patient Outreach

Typical day

- Scheduled appointments
- Urgent appointments
- Active outreach for follow-up

Types of Outreach:

- Health Coaching Call
- Medication Management Call
- Symptom Management Assessment
- Planned Visit Preparation
- Outreach on Gaps in Care
- Follow up to determine barriers
- Adjustment of the care plan
- ED follow up call
- Transitions of Care Calls

Let's Talk Team Communication

Communication is……..
…a taken-for-granted human activity that is recognized as important only when it has failed."

Complex Setting

Complex Patients

TBC Case Study – Focusing on John

John is a 64-year-old male with a diagnosis of COPD. He has had COPD for the last 10 years.

- Current findings:
  - John was recently hospitalized last month due to shortness of breath.
  - John is a smoker even though his physician has educated him on the problems associated with smoking.
  - He also has high blood pressure which at this time is borderline.
  - He currently takes Symbicort and albuterol for management of his COPD.
  - He is currently not on any medication for his blood pressure although when discussed John refuses to be on any medication.
  - John lost his wife one year ago and is on his own.
  - The closest family he has lives out of state.
  - He is on a fixed income and sometimes has difficulty paying his bills or putting food on the table.

Enhancing Team Communication

It’s about Relationship and Engagement with Team members

- Seek out opportunities for interactions
- Shadow and reverse shadow team members
- Be curious
- Recognize common goals and values
- Recognize there may be differences in communication style
- Seek to understand-address proactively
- Assume the best

Team Communication Challenges

These are normal human challenges

Personal	**Environmental**
Memory limitations	Many modes communication
Stress/anxiety	Rapid change
Fatigue, physical factors	Time Pressure
Multi-tasking	Distractions
Flawed assumptions	Interruptions
New role/New Team	Variations in Team Culture

Let's Chat

Care Team Members: Communicating with Providers

- Communication between provider and care team
  - Huddle: Clinical and Operations
  - Team Conference Complex patients, outcomes, ID of cases
  - Patient update: part of both
- Quick and focused

Moving from solo care to TBC requires increased communication between the provider, patient and team. The communication is best when it is efficient and focused

Communication Tools

Spontaneous Communication Tools:

- SBAR (Situation, Background, Assessment, Recommendation)
- Clear patient encounter documentation in the EHR
- Messaging
- Huddles

Communication Tools:

- Collaborative Practice Agreements
- Standing Orders
- Order Sets
- Protocols and workflows

High functioning teams have communication tools and processes that support the team to provide efficient effective care

Examples include:

- SBAR communication
- Team documentation visible to all team members
- Instant messaging between team members
- Huddles.

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:
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?

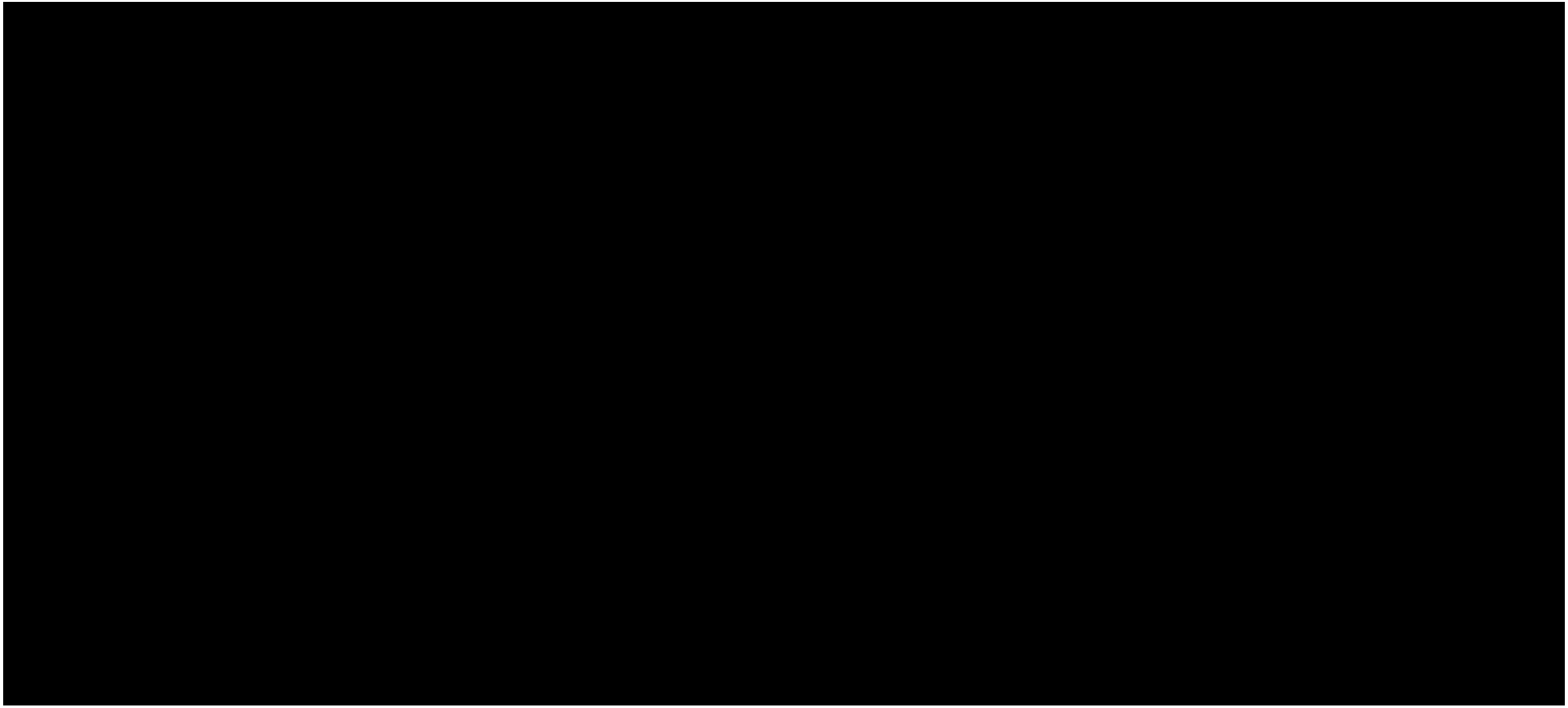
Using SBAR Communications in Efforts to Prevent Patient Rehospitalizations

SBAR Reading & Worksheet

Article titled, Using SBAR Communications in Efforts to Prevent Patient Rehospitalization

SBAR Ineffective Communication

SBAR Effective Communication



What made the difference?

Thoughts on SBAR Videos

SBAR: Example

Kathy is 28 years old and pregnant (32 weeks). She has recently moved to Ypsilanti from Flint to share an apartment with her sister and her 2 children. Kathy has not set up OB care yet. She has just run out of her Toprol to control her blood pressure. She is asking for an appointment and medications to cover her until she can be seen. She has no means of transportation.

- **Situation:** What is the concern? (28 yr old gestation woman recently moved to area – has not been seen in the practice yet)
  A very clear, succinct overview of pertinent issue.
- **Background:** What has occurred? (Has HTN – needs medication refills and is out of medications for her HTN. Unclear on pre-natal care).
  Important, brief information relating to event. What got us to this point?
- **Assessment/Analysis:** What do you think is going on? (Concern with elevated blood pressure with pregnancy. Concern for self and baby).
  Summarize the facts and give your best judgement.
- **Recommendation:** What do you recommend/actions? (Call the previous provider, determine ability to provide medications until her appt here on X date).

Your Turn in Breakouts

- Review the case study – One volunteer to read the case
- One volunteer for each of the SBAR elements
- One volunteer to listen and take on the role of the provider

Team-Based Care Communication Examples

Huddle	Meeting
Short, brief meetings	Has an agenda, operational or clinical
Frequent, even daily	• Less frequent, but scheduled regularly or ad hoc
Operational Focus: Goal is to resolve issues such as the process improvement board/projects, staffing issues, etc… Clinical Focus: Goal is to discuss arising situations that may include accessing the multi-disciplinary support team: • High risk patients, complex care plans • Unnecessary or unplanned ED or IP visits • Requests for different referrals • Concerns for a patient	Goal if operational may be to improve the overall program performance: • Review operational opportunities, such as scheduling or standing agreements/orders • Review process for referrals • Review outcomes measures / performance Goal if clinical may be to: • Monitor patients receiving extended care • Review population reports • Review new patient care policies
Participants include the individuals directly involved with the huddle topics	Participants expanded to include all involved with the process on the agenda: front and back office, billing, PCP, Care Team, MA, Office Manager

Other Communication Modalities

- **Chart Documentation**: Communicate progress
  - Maintain regulatory, practice scope and system requirements
- **Messaging**: Communicates urgent recommendation for action
  - How does the team know what happened, what is needed and planned with follow up?

Standing Orders/Agreements

Standing Orders/Agreements facilitate team-based care by giving blanket agreement for proactive outreach by the care team

- **Standing orders examples**:
  - Transitions of Care phone calls
  - Calling patients for gaps in care / other preventive care
  - Immunizations procedures
  - Enrollment into chronic care management

https://cepc.ucsf.edu/standing-orders; https://www.jabfm.org/content/25/5/594

Collaborative Practice Agreements

- A legal agreement that formally defines the relationship between the physician and care team member (usually used with Pharmacists) that expands the role of the care team member beyond the normal licensure confines.
- For pharmacists, this frequently gives the ability to provide medication management through titration of meds and ordering supplies.

Introduce yourself and your role on the team

Describe how your role differs from others on the team and how the team compliments and assist in providing good care. Who are other team members and their expanded roles?

Identify any tools your practice uses:

- Evidence-based guidelines
- Standing orders, protocols
- Collaborative practice agreements
- Others

Describe your team's communication process

Let's Talk About Teamwork in Your Practice - Homework

Team Communication - High Functioning Teams Impact on Caring for John

John is a 64 year old male with a diagnosis of COPD. He has had COPD for the last 10 years.

- Current findings:
  - John was recently hospitalized last month due to shortness of breath.
  - John is a smoker even though his physician has educated him on the problems associated with smoking.
  - He also has high blood pressure which at this time is borderline.
  - He currently takes Symbicort and albuterol for management of his COPD.
  - He is currently not on any medication for his blood pressure although when discussed John refuses to be on any medication.
  - John lost his wife one year ago and is on his own.
  - The closest family he has lives out of state.
  - He is on a fixed income and sometimes has difficulty paying his bills or putting food on the table.

Key Takeaways

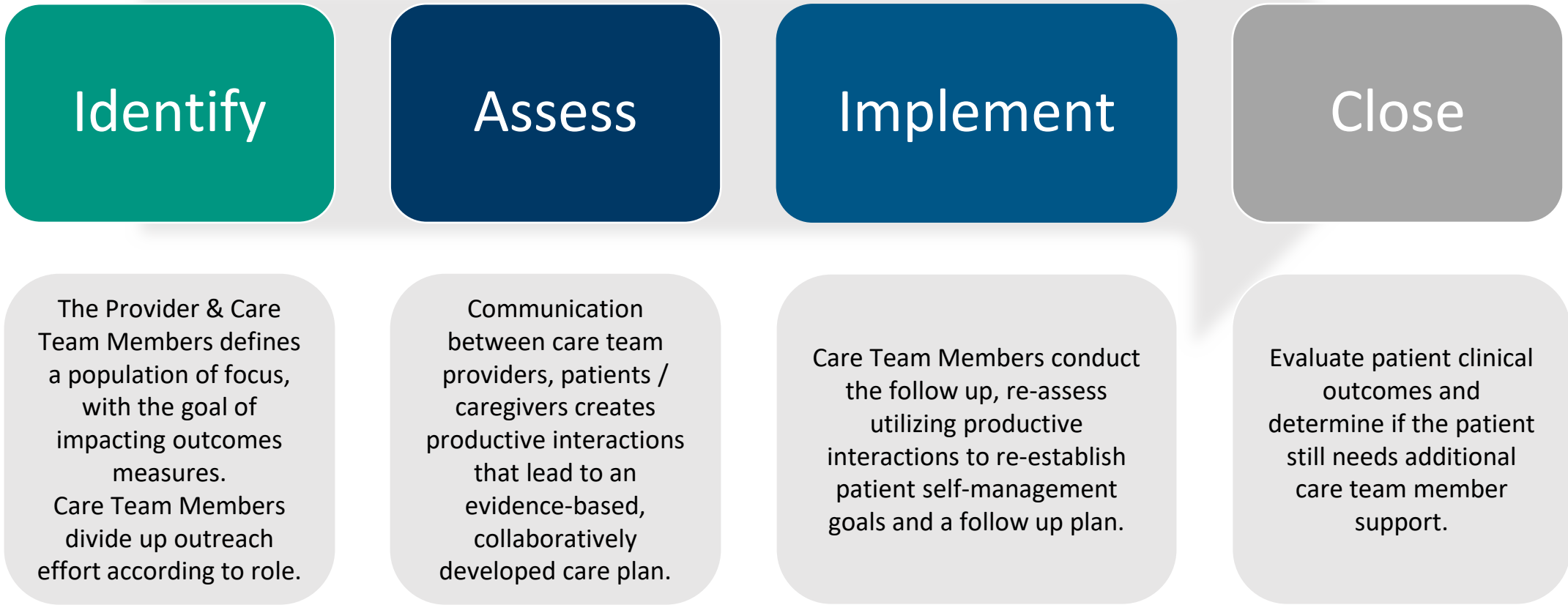
- Discussed the value of team-based care from the practice, patient and payer perspective
- The Care Model visualizes an organized and planned approach to improving patient health
- Team Communication

Break Time

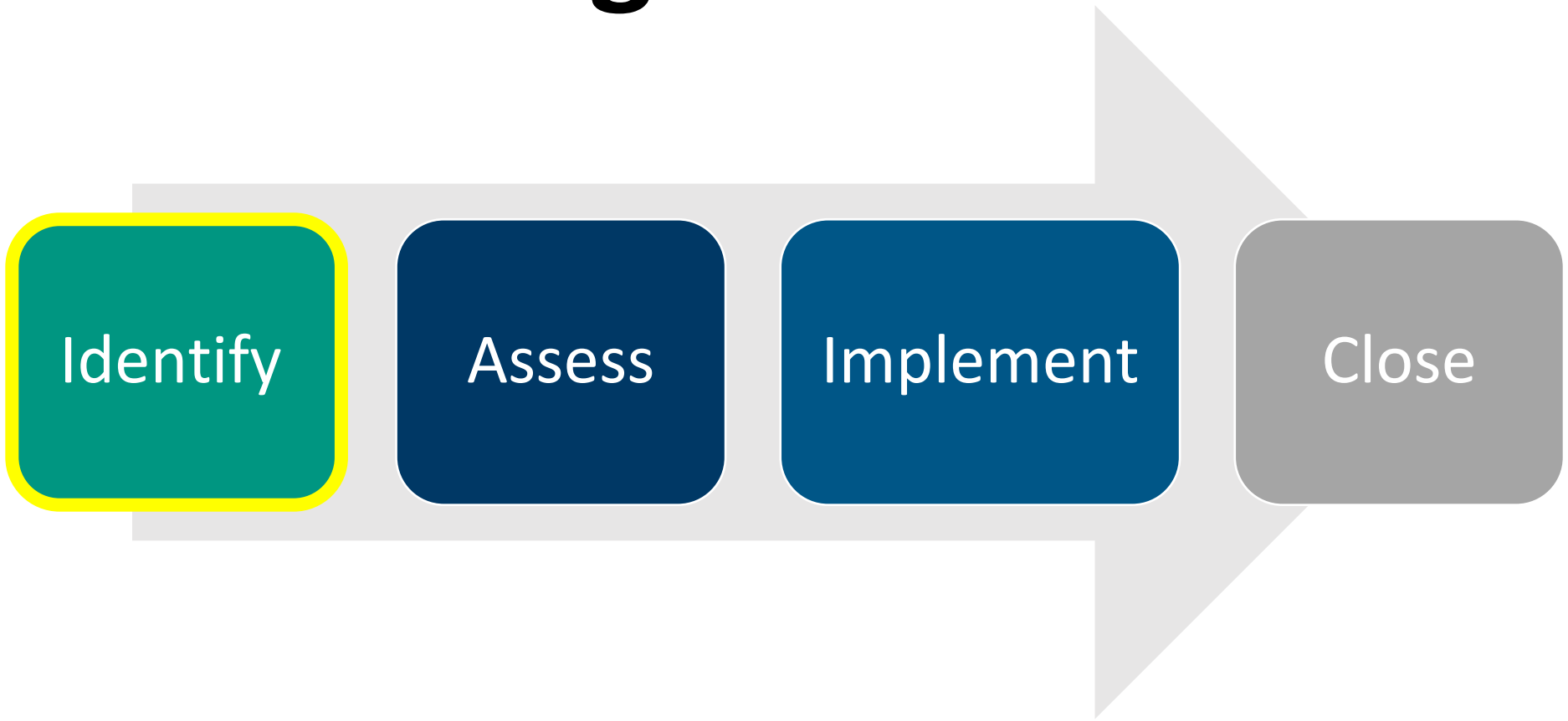
10 minute break!

Care Management Process

Care team members improve outcomes by using evidence-based care within the framework of the Care Management Process and through productive interactions with the patient.



Care Management Process



Patient Identification

Who does your practice focus on for quality improvement?

- Patients with a high level of social needs
- Vulnerable patients, aging/elderly, frail, compromised immune system
- Patients with out of scope measures such as A1c, uncontrolled blood pressure
- Patients with high utilization such as emergency use or unnecessary inpatient use

Aligning services with the strategic plan of the organization/practice

- Seek information on your Physician Organization (PO)/ clinic / health system's:
  - strategic plan
  - populations served
  - Team structure and decision-making process

Identifying Patients for Care Management and other Extended Services

Work with your practice team and providers to identify patients who will benefit from added support to impact key outcomes measures.

Evidence-based Guidelines

Top Outcome Measures:

- Lower ED Utilization
- Lower Inpatient Utilization
- A1c in Control
- BP in Control

"It is not the number of diagnoses that determines the need for care coordination, but the complexity of health problems, complexity of social situations and complexity manifested by frequent use of healthcare services."

Predicting use of nurse care coordination by older adults with chronic conditions. (2017). Western Journal of Nursing Research. https://doi.org/10.1186/s12913-019-2016-5

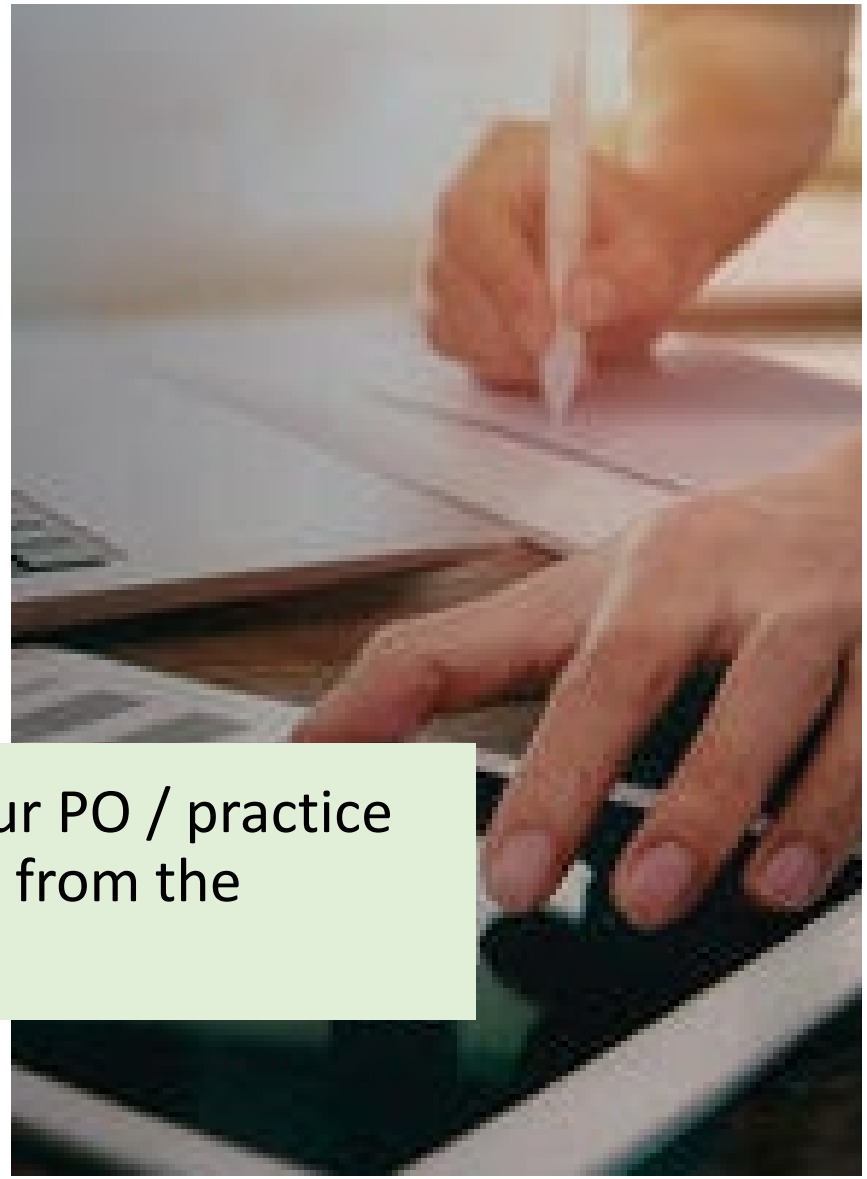
Proactive Identification: A Critical Step!

- It will take considerable time to build caseloads and impact outcomes if we wait for patients to seek care and for members of the team to make a referral
- Patients that may need your service may not seek care or come into the practice
- Without protocols or workflows team members may not remember to refer

Patient Identification Tools

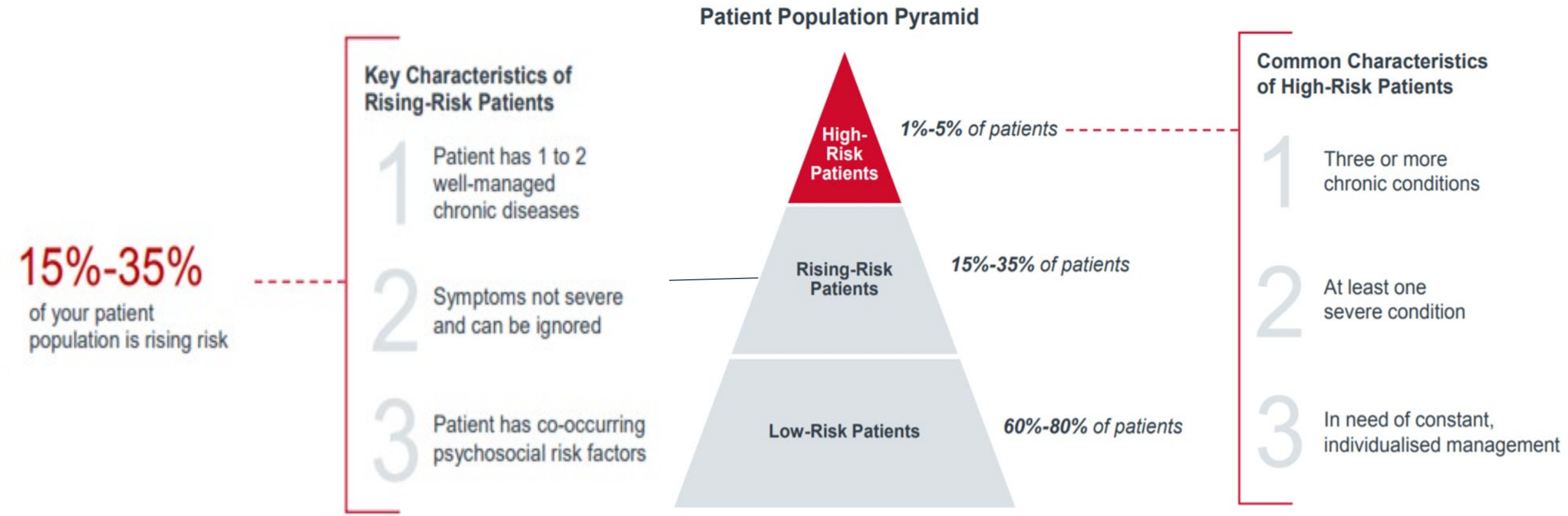
Registry: Practices, POs and Payers have lists of patients who have 'out of scope' measures or gaps such as an elevated A1c or BP.

These can be great target lists!



Admission / Discharge / Transfer (ADT) Notifications: Your PO / practice will have a way of knowing when somebody is discharged from the hospital / ED; usually on a daily basis, if not in real time!

Understanding a patient's risk level will help in the identification of potential patients



SOURCE: "Mind the Gap", The Advisory Board Company.
https://www.advisory.com/-/media/Advisory-com/Research/PHA/Research-Study/2017/Mind-the-Gap-Managing-the-Rising-Risk-Patient-Population.pdf

Passive Attrition vs Proactive Outreach Patient Identification

Passive: receiving patients into your panel because somebody else wants you to support the patient.

Main Process:

- Physician or care team referrals

Proactive: finding patients who would have better outcomes if you were involved and helping the patient self-manage. Reaching out to patients who have not been into the office.

Main Process:

- Identify 'lost to follow up' patients:
  - Have an 'out of control' quality metric - such as high A1c or BP
  - TOC - Calling patients after an ED or IP admission.
  - High risk/ rising risk patient list

Engage With Providers

Providers are an important part of the care team. They direct the patient-level plan of care. Engage the provider and team in every step of the process.

Input:

Provider often has knowledge of patient's circumstances:

- psychosocial
- readiness for change
- Previous actions and responses

Outreach:

Providers should be engaged in defining proactive outreach attempts

Care team members should have agreement from providers before engaging in proactive outreach based on specific patient parameters.

Provider input saves time - builds team relationships - builds trust!

Transitions of Care (TOC)

- **A set of actions** designed to ensure the coordination and continuity of health care as patients transfer from hospital to the next place of service

- TOC services are valuable when provided after a patient is discharged from any one of these inpatient settings:

Inpatient acute care hospital

Hospital outpatient observation

Skilled nursing facility (SNF)

Other inpatient settings

https://apps.who.int/iris/bitstream/handle/10665/252272/9789241511599-eng.pdf;jsessionid=15B79538FFD509D36F09E059C4CD6BB2?sequence=1

“Why are Transitions of Care Important?”

20% of patients experience an adverse event (66% drug related).

“US health care spending **increased 4.6%** to reach $3.6 trillion in 2018, a faster growth rate than the rate of 4.2% in 2017 but the same rate as in 2016.” (Health Affairs, January 2019)

20% of Medicare patients are readmitted within 30 days of discharge.

Helps to mitigate risk and to improve patient care.

Analysis conducted by the Medicare Payment Advisory Committee (MedPAC) US data
Reference: Schall M, Coleman E, Rutherford P, Taylor J. How-to Guide: Improving Transitions from the Hospital to the Clinical Office Practice to Reduce Avoidable Re-hospitalizations. Cambridge, MA: Institute for Healthcare Improvement; June 2013. Available at www.IHI.org.
https://healthinsight.org/outpatient-clinicians/strengthening-primary-care/transitional-care-management
National Health Care Spending In 2017,” *Healt Affairs,* January 2019

Goals for a Positive Transition of Care

- Patient receives the continuity of care they need to stay safe, keep condition stable or recognize warning signs and actions to take
- Health outcomes are consistent with patient's wishes
- Avoid hospital readmission
- Patient and family's experience and satisfaction with care received
- Providers have the information they need to understand and bridge care

Nielsen GA, Bartely A, Coleman E, Resar R, Rutherford P, Souw D, Taylor J. *Transforming Care at the Bedside How-to Guide: Creating an Ideal Transition Home for Patients with Heart Failure.* Cambridge, MA: Institute for Healthcare Improvement; 2008. Available at http://www.ihi.org

Transition of Care : Poll

Key Elements of the Transitions of Care Call

** Reference the MiCCSI post-discharge call template on our website under the training documents

The patient doesn't meet criteria or doesn't have coverage – then what? What are some options?

If you can't support the patient because of insurance, they don't meet the qualifications of high risk, or any other reason, the best option for the patient is a referral to a community resource that *can* support them. Often, payers have centralized care teams that can also provide support.

For **Blue Cross Health and Wellness**: call 800-775-2583

For Coordinated Care Program **Blue Cross and BCN:** call 1-800-845-5982
For Coordinated Care Program **Blue Cross Complete:** call 888-288-1722

Priority Health Outpatient Care Management Contacts

LOB	Name	Role	Phone #	Email
ACA Individual	Bethany Swartz	Manager	616-575-7338	Bethany.Swartz@priorityhealth.com
	Julie Reynolds	CM/Referral Lead	616-464-0438	Julie.R@priorityhealth.com
Commercial	Debbie Collins	Manager	616-464-8132	Deb.C@priorityhealth.com
	Maria Knoppers	Supervisor	616-464-8415	Maria.K@priorityhealth.com
Medicaid	Bethany Swartz	Manager	616-575-7338	Bethany.Swartz@priorityhealth.com
	Nichol Scholten	Supervisor	616-355-3261	Nichol.S@priorityhealth.com
	April Sydow	Supervisor	616-464-8186	April.S@priorityhealth.com
Medicare	Stacey Ottaway	Supervisor	616-575-5833	Stacey.O@priorityhealth.com
	Susan Molenaar	Supervisor	616-355-3247	Susan.M@priorityhealth.org
Behavioral Health	For urgent/emergent concerns related to Behavioral Health, contact the PH Behavioral Health Dept. at 1-800-673-8043			
Home Health	For questions about Home Health Care call the Home Health Care Management Line at 616-464-9437			

Engaging the patient!

Introducing team-based care management and other services to the patient/caregiver: Elevator speech

Asking patient/caregiver: What are your concerns? What is important to you and what would you like to work on?

Meet the Patient Where They are At

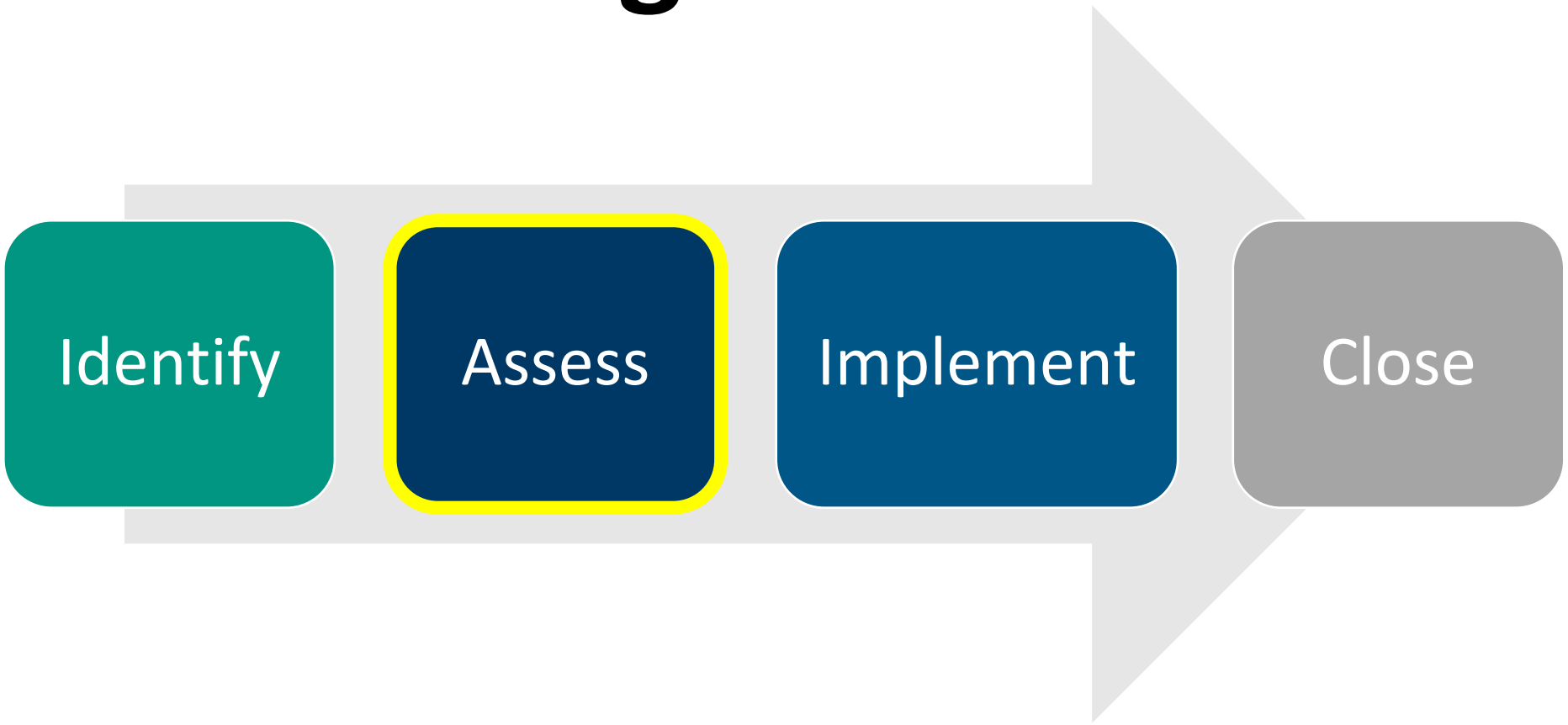
Key Components of the Introduction

- Relationship of your role to others on the team to include the provider and patient
- Timeline – how long
- What can the patient expect
- The patient's role
- Value to the patient

Key Takeaways

- Transitions of care can help to identify patients that would benefit from CM
- Having patient identification criteria improves efficiency in the practice
- TOC follow up can Mitigate risk and improve patient care
- Meeting the patient where they are is patient-centered, and engaging

Care Management Process



Assessment and Care Planning

Assessment provides patient context and supports development of the Patient Self-Management Plan, which may include use of Action plans for symptom management.

- Performed by licensed care team professionals, in compliance with payer and licensure scopes of practice.
- Supported by non-licensed professionals through provision of screenings, documentation, and other information gathering processes.

Getting started:
Preparing and Starting the Visit

Key Area of Focus	Screening tools / methods
Engage the patient • **Desire and Ability** • **Active role within the team**	• Review with the patient the visit activities and reasons • Determine the patient's readiness to set goals • Confidence in achieving goals • Evaluate patient's understanding of his/her health
Medical	• Chronic conditions • Functional status • Utilization • Who else is on the care team? Is there a PCP care manager? • Patient's risk score
Behavioral	• PHQ-9 • GAD-7 • Cognitive status
Social	• Social Needs Assessment • Nutritional Status • What is the support level? Does the patient have a caregiver?

Identify Metric Targets

- Informed by patient identification criteria
  - A1C
  - PHQ
  - Medication interactions
  - Utilization of ER/Inpatient
  - B.P.
  - Positive screening for Social Needs

An Effective Comprehensive Assessment

**Familiarize yourself with your organization's tool/assessment

Behavioral

Medical

Social

- Assessing each and incorporating barriers from these 3 areas results in a comprehensive assessment.
- With this, incorporate the patient desire and ability.
- Combined, results in an effective care plan.
- One without the others is incomplete.

Conducting the Assessment with a Focus on Patient-Centeredness

- Use of open-ended questions
- Demonstrating interest in the patient
- Active listening

Group Activity: Create an open-ended question for one of the Key Areas of Focus

<u>Key Areas of Focus</u>

- Linguistic and Cultural Needs
- Health Status
- Psychosocial Status/Needs
- Patient Knowledge/Awareness/Ability

Medical Concerns and Interventions Identified

- Symptom Management
- Medication Management
- Education and coaching to self-manage condition/health
- Planned interventions: tests, procedures
- Follow up schedule: planned visits, phone calls
- Coordination of care across settings: specialists, community

Psychosocial: Cultural and Linguistic Needs

Agency for Health Research and Quality

Linguistic Competence: Providing readily available, culturally appropriate **oral and written language services to limited English proficiency**

Examples

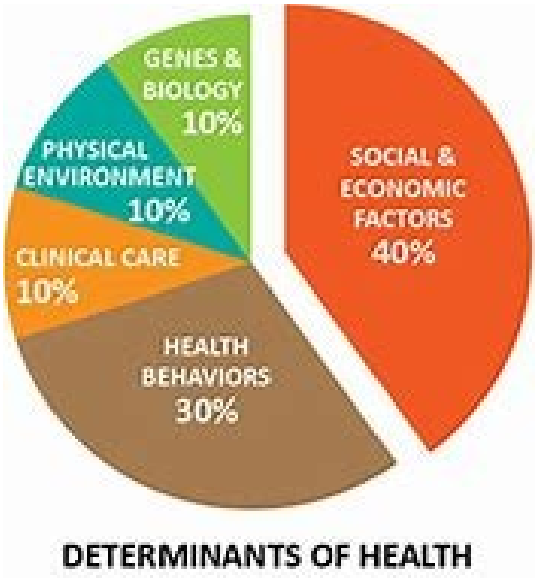
- Bilingual/bicultural staff
- Trained medical interpreters
- Qualified translators

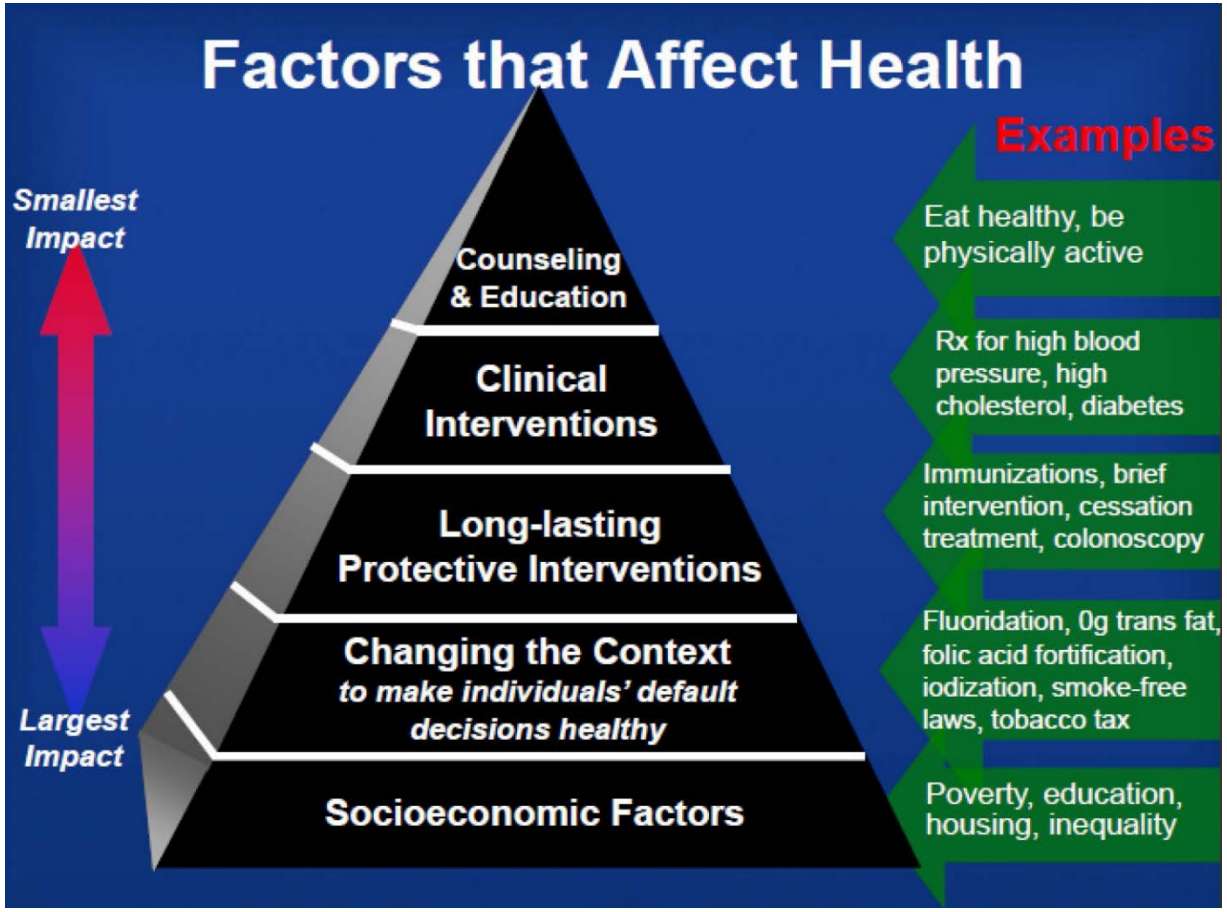
Cultural Competence: A set of **congruent behaviors**, **attitudes**, and **policies** that come together in a system or agency or among professionals that **enables effective interactions in a cross-cultural framework.**

Cultural and Linguistic Competence: The **ability** of health **care providers** and health care organizations to **understand** and **respond effectively** to the **cultural and linguistic needs** brought **by the patient** to the health care encounter.

Note where the responsibility and accountability are in this statement

According to the Center for Disease Control





Social Needs Video

Social Determinants of Health

https://www.youtube.com/watch?v=I7iSYi3ziTI

Behavioral Needs

Screenings conducted to identify patients with risk

- Depression Screening (PHQ-9)
- Anxiety Screening (GAD-7)

Workflows

- Documentation
- Confirm diagnosis
- Treatment plan

Patient Self-Management Plan

- Developed by the **patient** with **support from the care team** to set mutual goals and **actions** for the patient care plan. Ideally this will align with the medical plan set forth by the physician.
- It is derived from the assessment and plan:
  - **Identified barriers** (medical, behavioral, social);
  - Patient abilities and desired goals

Something you'd like to improve in the next 2 weeks?

Use SMART Goals

- Specific
- Measurable
- Attainable
- Realistic
- Timebound

Examples
Instructional Based Action Plan

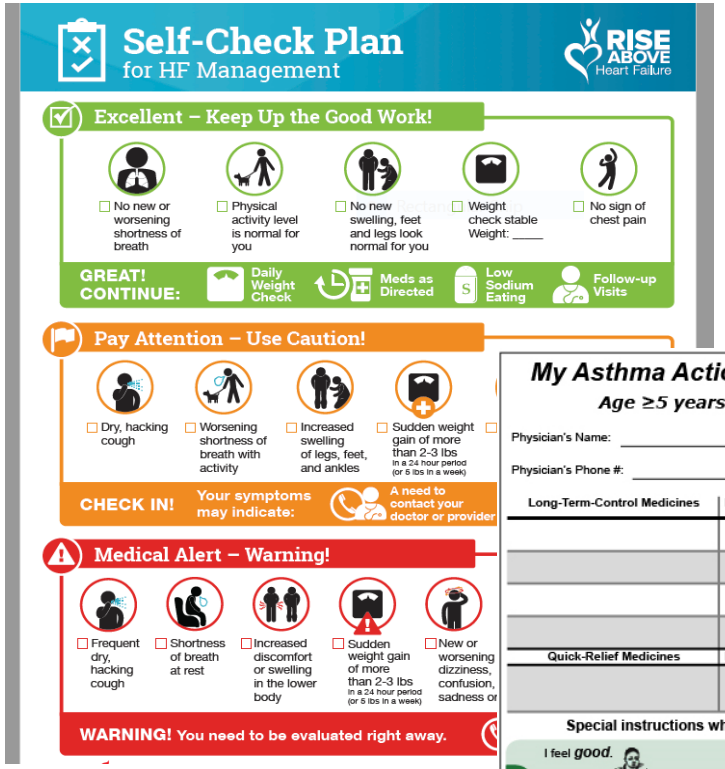
Provided by the clinician and used by patients to recognize and monitor their symptoms. Providers share these tools to:

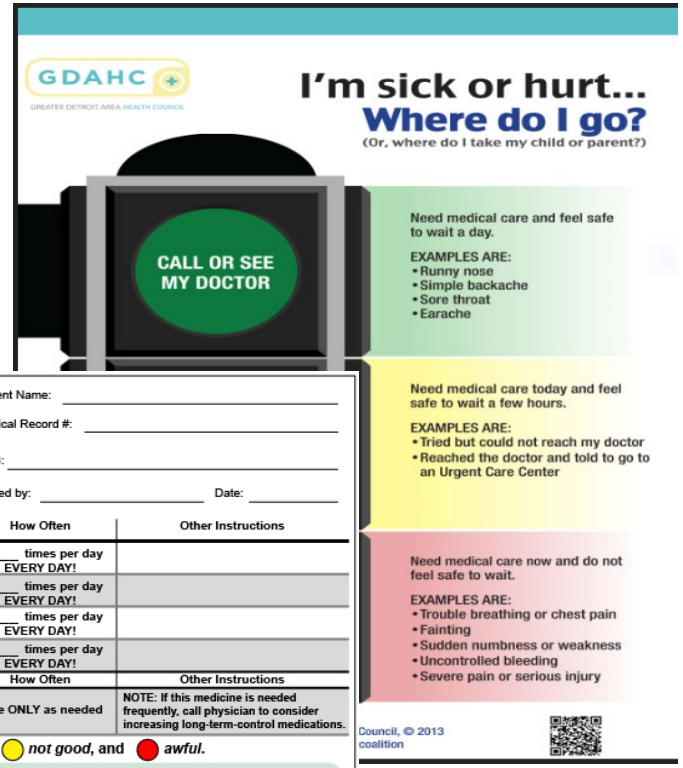
- Assist patients in recognizing early symptoms with the goal of avoiding risk
- To be better informed and prepared to manage the condition
- To prevent unnecessary emergent situations and risk and hospitalizations
- Symptom to be aware of and actions to take at each level

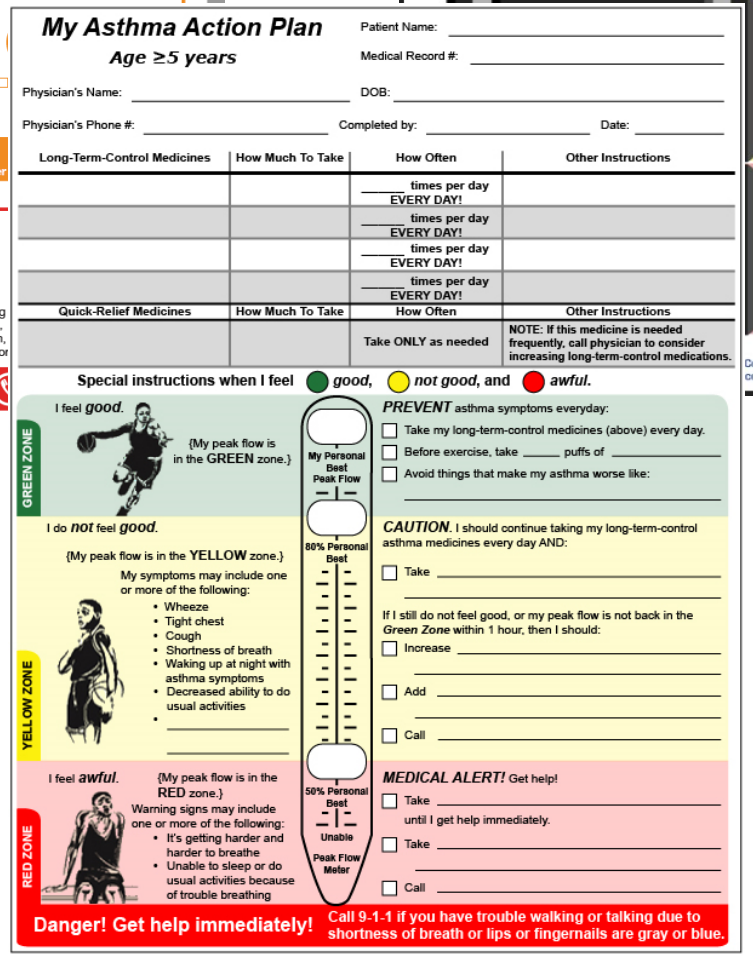
Green: Maintaining Goal(s)
Yellow: Warning when to call provider/office
Red: Emergency symptoms

Action Plan Examples

Polling Your Experience







Episodic vs Longitudinal

Episodic

- **Otherwise stable patients going through Transitions of Care (TOC)**
- **New or unstable chronic condition**
- **Short-term, goal oriented**

Longitudinal

- Combination of multiple comorbidities
- Complex treatment regimens
- Behavioral and social risks
- Ongoing relationship

The Plan of Care

Starts with the Assessment –

- Identification of barriers and strengths
- Patient risk/safety
- Patient desire, need, and ability

Care plan –

- Actions to overcome barriers (medical, social, behavioral)
- Based on patient desire, need, and ability
- Use of evidence-based approaches
- Personalized
- Considers the provider treatment plan

Case Study: Mary

Let's Chat

Mary is a 65 year old African American female with diagnoses of Heart Failure, Congestive Obstructive Pulmonary Disease, Diabetes Type II, and Hypertension. In the past 6 months, Mary had 3 ER visits and 2 Hospital admissions. Yesterday Mary was discharged from the hospital with a diagnosis of ketoacidosis. Mary is a widow and lives alone; her daughter lives nearby.

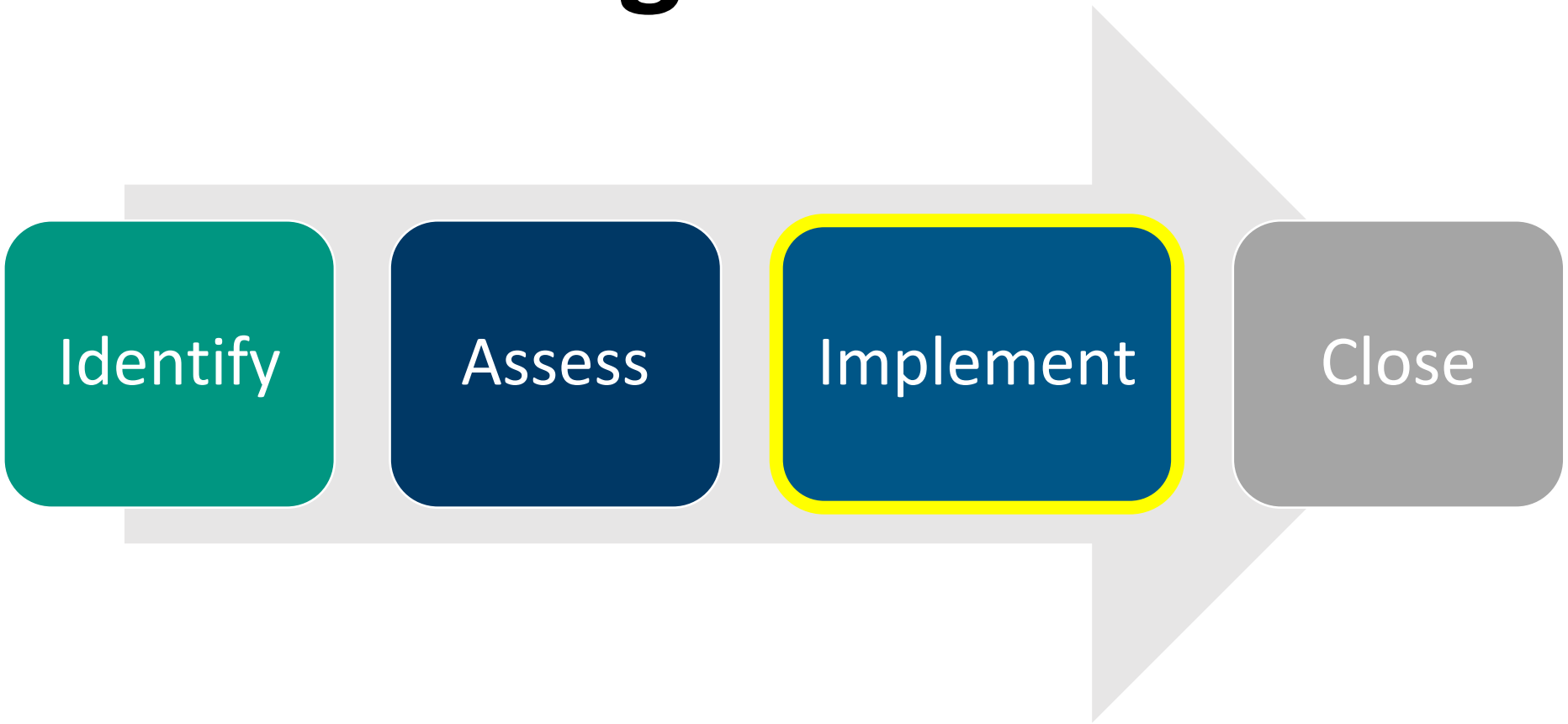
After speaking with Mary and her daughter you gather:

- Daughter notices her mom is more and more isolated and has observed a decline in her mom's memory
- Mary shares she is having difficulty affording medication and food.
- Most days Mary has anxiety.
  - Takes 8 prescription medications daily
  - Meals consist of canned and prepared food
  - Understanding of self management for her chronic conditions is limited

Key Takeaways

- Assessment leads to the development of the patient's self management plan
- Action plans are designed to help patients identify what plan to carry out when faced with a change in their health, i.e. an exacerbation of their COPD
- Episodic versus longitudinal care

Care Management Process



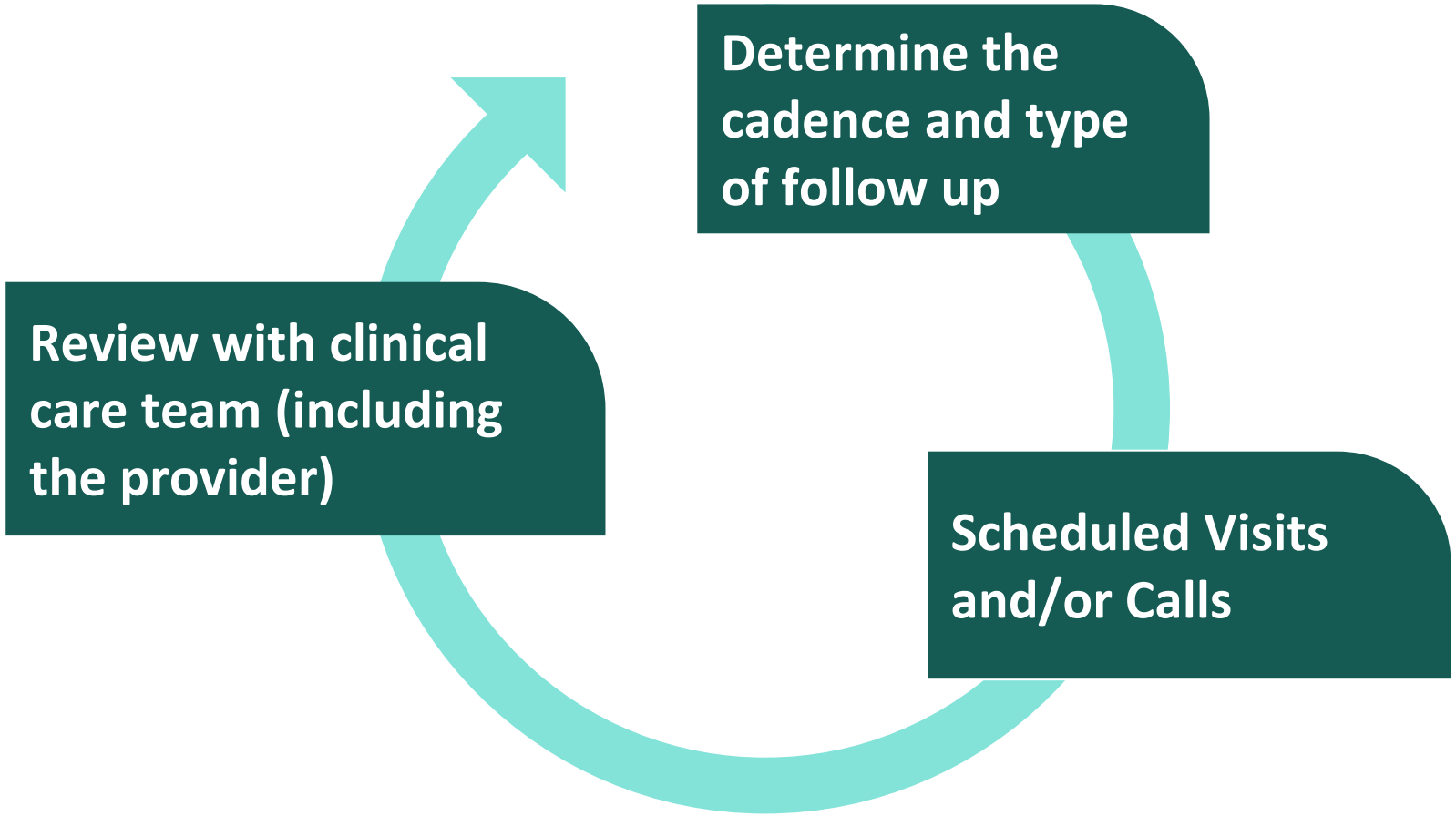
Confirm the Follow Up Plan & Schedule the next visit!

The follow up plan is based on patient level of:

- ✔ Risk & Safety issues
- ✔ Agenda setting - We have 15 minutes……

  - ✔ Changes in condition or care: new diagnosis or medication
  - ✔ Treatment to target goals/trend
  - ✔ Self-management abilities
  - ✔ Support needed to accomplish their goals

Implementation: Follow Up and Monitoring



http://www.cmbodyofknowledge.com/content/case-management-knowledge-2

Follow up and Monitoring Guidance

COMPASS

Care Management Phases & Follow-up Guide

This tool provides recommended guidance for the COMPASS team assisting a patient through the phases of care. Each system has to determine the tailoring needed within their own processes to operationalize this guide to its fullest. Above all, remember the patient is fluid and not a referral to be "handed off" to any one team member and then "given back". Communication leading up to and following each transition is critical to ensure all members of the team including the patient are aligned with the same goals. Stages of change and readiness are parallel aspects of this flow and may resonate with some users in applicability.

Active Engagement Phase *1st & 2nd contacts*	**Active Management Phase** *Weekly contacts in the first month* *Every other week over the next 2-3 months*	**Active Transition Phase** *Frequency gradually extended* *Average duration 5-18 weeks*	**Maintenance Phase** *Monthly to every 3 mo* *Average duration 6-12 months*
• Determine eligibility & appropriateness • Introduce COMPASS & set the roadmap for care • Start building relationship with patient to identify preferences, strengths and challenges • Establish primary care team communication strategy, engagement plans, caseload impact & understanding of patient care needs	• Clinical prioritization, assessment of red flag risks and identify patient preferences • Establish care plan including both short & long term goals for optimal improvement • Purposeful care management using Motivational Interviewing, Behavioral Activation & goal setting that links treat-to-target clinical plan including med intensification with personal health goals by developing strategies for self-monitoring, treatment (including medications) adherence and problem solving skills • Shared understanding of working toward optimal maintenance of the chronic conditions and the organic but intentional process of outcome oriented care management	• Based on pt's progress with clinical and personal goals and agreement that significant improvement has been made. • Less frequent contacts as an opportunity for pt to practice identifying triggers, problem solve and self-monitor. • Duration may need to be variable based on pt readiness, unanticipated pitfalls and ongoing coaching needs but overall becomes longer periods of self-management success. • Starting to build maintenance plan using pts own words for what has contributed to improvement & problem solve obstacles	• Patient has been practicing and more consistently demonstrating self-management including ability to identify triggers, setbacks and opportunities • Maintenance Plan has been developing along the way and patient can now articulate and complete own written plan for sustainment (example: own personal "yellow zone" and when to contact clinic when things come up and assistance is needed) • Schedule established for PCP follow-up and lab/clinical monitoring intervals • Primary care team understanding of maintenance plan including support role and and routine follow up expectations

Intake completed, care plan established, first SCR completed → Parameters progressing toward target goals → Demonstrated goal attainment and progress toward sustainability

Reassessing when patients don't meet goals…

Treat to target and Treatment Intensification

Not right goals, refocus

Not engaging

Not progressing, identify barriers

Transition to another level of care

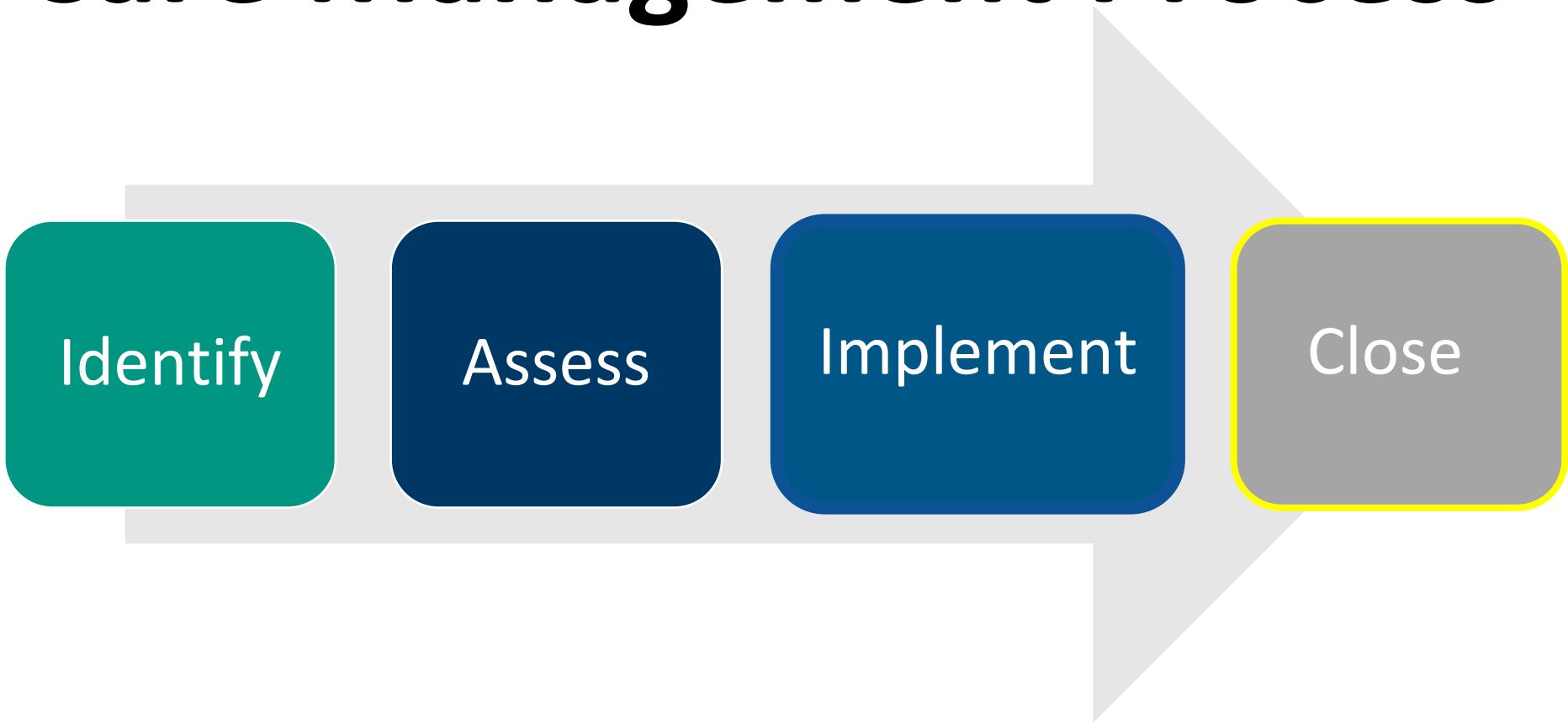
Different service or specialty

Relapse Prevention

Key Takeaways

- Follow up and monitoring are key to help prevent the patient from relapsing
- Following up and monitoring is a continuous flow to ensure that patients are staying on track with their self management.
- Determining progress of treat-to-target and need for treatment intensification
- The implementation phase is cyclic
  - Assess
  - Develop the Care Plan
  - Monitor
  - Re-assess
  - Adjust the Care Plan
  - Monitor…….

Care Management Process



Case Closed and Evaluation

Reasons for case closure and discharged from care management services:

- Patient has met their goals
- Patient moves out of region/state
- Patient is admitted to hospice care
- Patient declines further services
- Patient expires

What are other reasons: Let's Chat

Case Closure for “Extra” Care Team Support:

- Evaluation of the impact:
  - Did the patient get to target?
  - Lessons learned, process improvement opportunities.
  - Internal self-assessment for patient engagement skills.
- Notify the provider - ideally with a discussion that outlines reasons for closure.
  - Notify the patient verbally whenever possible and follow up as needed with a letter that identifies how to get back in touch as needed.
  - Document within the record.

Always keep the door open! The patient may need your services again.

Patient “Return to Usual Care”

Transition

- Transition to care within the Patient-Centered Medical Home.

Continuous Monitoring

- Monitoring to assure that the patient is receiving evidence-based care and determining if the patient would benefit from care management in the future.

Key Takeaways

- Many reasons a patient may discontinue care management services
- The need for a returning to care as usual for the patient for monitoring
- Keeping the door open

Outcomes Measures

- In healthcare, we are always striving to help patients. It's what we do.
- Improving patient care that improves outcomes is why we want to practice in a team-based care model.
- Outcomes measures tell us if we have truly made a difference in patient care.

Why: Connecting Heart

Common Outcomes Goals

Quality

Controlled HbA1c
Controlled Blood Pressure

Utilization

Decreased emergency department visits
Decreased hospital admissions

Homework for you!

Outcomes Goals:
Be Part of the Strategy

Care Team:

- **Learn** their PO's strategy and core measures focus.
- **Develop** a plan for how they will also impact the selected goals.
- **Monitor** impact of strategies they implement and continuously improve.

BCBSM 2020 Targets

Metric	Performance Threshold	Performance Source	Improvement
ED Encounters (per 1000 members per year)	175 encounters (per 1000 members per year)	Milliman Loosely Managed Benchmark (2018)	10%
IP Encounters (per 1000 members per year)	45 encounters (per 1000 members per year)	Milliman Loosely Managed Benchmark (2018)	8%
HbA1c Control < 8%	70%	NCQA 75th percentile (2018)	10%
High Blood Pressure	70%	NCQA 50th percentile (2018)	10%

- VBR = Value-Based Reimbursement; it's essentially an increase in payment on every office visit and PDCM code paid in a primary care office.
- These are subject to change every year – **so keep in touch with your PO for updates!**

Quality Metrics: A1c <8%

- Patients aged 18-75
- Have a diagnosis of diabetes
- The last A1c measure of the year must be less than or equal to 8
- Your goal should be to help your practice have at least 70% of your diabetic population with an A1c<8

There is a significant patient impact when these outcomes measures are not being met.

Activity: What is the impact of outcome measures being “out of control”?

Share an example

Review of Evidence Based Care Guidelines

Evidence-based care guidelines are a set of interventions that have been proven to improve patient outcomes.

Outcomes measures are derived from evidence-based guidelines as a way of measuring whether or not a program is actually improving population health.

Evidence-based Guidelines: MQIC can be an easy tool

Homework:

Michigan Quality Improvement Consortium Guideline June 2015

Management of Diabetes Mellitus

The following guideline applies to patients with type 1 and type 2 diabetes mellitus. It recommends specific interventions for periodic medical assessment, laboratory tests and education to guide effective patient self-management.

Eligible Population	Key Components	Recommendation and Level of Evidence	Frequency
Patients 18-75 years of age with type 1 or type 2 diabetes mellitus	Periodic assessment	Assessment should include: Height, weight, BMI, blood pressure **[A]** Assess cardiovascular risks (tobacco use, hypertension, dyslipidemia, sedentary lifestyle, obesity, stress, family history, age > 40) Comprehensive foot exam (visual, monofilament, and pulses) **[B]** Screen for depression **[D]** Dilated eye exam by ophthalmologist or optometrist **[B]**, or if no prior retinopathy, may screen with fundal photography **[B]**	• Perform periodic assessment at least annually • Record BP at every visit • In the absence of retinopathy repeat retinal eye exam in 2 years
	Laboratory tests	Tests should include: A1C **[D]** Urine microalbumin measurement **[B]** (unless already on ACE or ARB) Serum creatinine and calculated GFR **[D]** Lipid profile **[B]**, preferably fasting Consider TSH and LFTs **[D]**	• A1C every 3-6 months based on individual therapeutic goal; other tests annually
	Education, counseling and risk factor modification	Comprehensive diabetes self-management education and support (DSME and DSMS) from a collaborative team or diabetic educator if available Education should be individualized, based on the National Standards for DSME[1] **[B]** and include: - Importance of regular physical activity including interrupting sedentary periods at least every 90 minutes with physical activity, and a healthy diet **[A]**, and working towards an appropriate BMI - Assessment of patient knowledge, attitudes, self-management skills and health status; strategies for making health behavior changes and addressing psychosocial concerns **[C]** - Description of diabetes disease process and treatment; safe and effective use of medications; prevention, detection and treatment of acute and chronic complications, including prevention and recognition of hypoglycemia - Role of self-monitoring of blood glucose in glycemic control **[A]** - Cardiovascular risk reduction - Tobacco cessation intervention[2] **[B]** and secondhand smoke avoidance **[C]** - Self-care of feet including nail and skin care and appropriate footwear **[B]**; preconception counseling **[D]**; encourage patients to receive dental care **[D]**	At diagnosis and as needed
	Medical recommendations	**Care should focus on tobacco cessation, hypertension, lipids and glycemic control:** - Medications for tobacco dependence unless contraindicated - Treatment of hypertension using up to 3-4 anti-hypertensive medications to achieve adult target of 140/90 mmHg **[A]** (see *MQIC hypertension guideline)*. Mortality increases if diastolic is < 70. - Prescription of ACE inhibitor or angiotensin receptor blocker in patients with chronic kidney disease or albuminuria **[A]**[3] - Moderate intensity statin[4,5] therapy for primary prevention against macrovascular complications (e.g. simvastatin 20-40 mg, atorvastatin 10-20 mg) - For patients with overt CVD, high intensity statin (e.g. atorvastatin 40-80 mg) - Anti-platelet therapy **[A]**: low dose aspirin for adults with cardiovascular disease unless contraindicated. - Individualize the A1C goal[6]. Goal for most patients is 7-8%. Mortality increases when A1C is > 9% **[B]**. - Assurance of appropriate immunization status [Tdap or Td, influenza, pneumococcal vaccine (PCV13 and PPSV23), Hep B] **[C]**	At each visit until therapeutic goals are achieved

[1] National Standards for Diabetes Self-Management Education and Support

[2] There is no evidence that e-cigarettes are a healthier alternative to smoking or that e-cigarettes can facilitate smoking cessation

[3] Consider referral of patients with serum creatinine value > 2.0 mg/dl (adult value) or persistent albuminuria to nephrologist for evaluation

[4] Diabetes Care. January 2015; Cardiovascular Disease and Risk Management

[5] 2013 ACC/AHA Blood Cholesterol Guideline Table 5. High-, Moderate-, and Low-Intensity Statin Therapy

[6] Diabetes Care, Volume 38, Supplement 1, January 2015, S37, Table 6.2

Levels of evidence for the most significant recommendations: A = randomized controlled trials; B = controlled trials, no randomization; C = observational studies; D = opinion of expert panel

This guideline lists core management steps. It is based on the American Diabetes Association Standards of Medical Care in Diabetes - 2015; Volume 38, Supplement 1, Pages S1-S93 (http://care.diabetesjournals.org). Individual patient considerations and advances in medical science may supersede or modify these recommendations.

Approved by MQIC Medical Directors June 2008, 2010, 2012, 2013, 2014, 2015 MQIC.ORG

http://www.mqic.org/guidelines.htm

Quality Metrics: Blood Pressure < 140/90

- "In control" means that it's less than 140 / 90 in both categories.
- We're measured by the last blood pressure taken in a calendar year.
- Your goal should be to help your practice have at least 70% of your hypertension population with a blood pressure either at or below 140/90.

Blood Pressure Categories

American Heart Association | American Stroke Association

BLOOD PRESSURE CATEGORY	SYSTOLIC mm Hg (upper number)		DIASTOLIC mm Hg (lower number)
NORMAL	LESS THAN 120	and	LESS THAN 80
ELEVATED	120 – 129	and	LESS THAN 80
HIGH BLOOD PRESSURE (HYPERTENSION) STAGE 1	130 – 139	or	80 – 89
HIGH BLOOD PRESSURE (HYPERTENSION) STAGE 2	140 OR HIGHER	or	90 OR HIGHER
HYPERTENSIVE CRISIS (consult your doctor immediately)	HIGHER THAN 180	and/or	HIGHER THAN 120

https://www.health.harvard.edu/heart-health/reading-the-new-blood-pressure-guidelines

Hypertension is often called the "silent killer"

Impacting Outcomes

While A1c, BP, ED and IP utilization are **outcomes measures**, lots of different factors play into whether or not your patient population meets targets:

- Medication Adherence
- Multiple diagnoses
- Clinical guidelines
- Symptom Management
- Treating to target
- Quality Metrics
- Health Literacy
- Social Needs
- Review internal processes for opportunities to improve

Impacting Outcomes: Productive Interactions

Seeing patients is the way to impact your outcomes! Having enough productive interactions can be the difference between meeting outcomes goals and falling short.

We suggest at **least 4 productive interactions with patients** in a half day in order to see an outcomes impact.

Productive interactions are those that support the patient to take actions between visits that accomplish their self-management goals, with the overall end goal of accomplishing the Care Plan that was designed by the team, especially the patient.

Tracking Quality: Identifying Success

- **Metrics resources:**
  - **EHR** can provide a report on practice level performance.
  - **Registry** can provide a report on metrics.
    - List by payer or practice.
    - List of patients who are not in control or who are missing evidence-based care.
- **Payer reports and websites** will additionally show your performance and the list of patients with a ‘gap’ in their care.

Activity: How is your practice doing?

Tracking Utilization

- Admission/Discharge/Transfer notifications can be tracked over time.
- Payer Reports can be used both as a way to identify patients and to follow performance over time.

BCBSM: Consolidated Dashboard, a PO level report, twice a year.

BCN: HealtheBlue (HeB), provides a utilization report

Priority Health: File Mart on the Priority Health website

Activity

Step 1: Individually
Please take about 30 seconds to think about a loved one or patient who had a difficult experience with lots of trips to the ER or hospital.

Step 2: Individually
Now, please take 30 seconds to think about how this role could have changed that experience.

Step 3: Group sharing
Could 1 or 2 of you share the patient/loved one experience and how they think this role could have helped them?

Key Takeaways

- How care teams can impact outcomes by using evidence-based care, productive interactions with patients and the care management process.
- Review of evidence-based guidelines
- Common outcome goals include A1C, BP, ED utilization and inpatient utilization
- Impacting outcomes requires productive interactions

Breakout Sessions

Documents We Will Use

PHQ results

Assessment tools

Factsheets

Maria Case Study

Lunch

Case Study Application Maria

Workflow

- How did we get here
  - Starting with outbound patient gap in care to team conference
- Value of workflows
- Use for quality monitoring
- Who should be involved in creating a workflow in the clinic

2 Breakouts for Assessment (45 minutes)

- Psychosocial needs assessment
  - Social workers
  - Medical assistant
  - Community Health Workers

- Biomedical needs assessment
  - Nurses/NP’s/PA’s
  - Pharmacist

Team Care Conference on Judy

Participant Worksheet for Team Conference Simulation Activity

Use the SBAR Format to report out to others on the team

We did all this work

Financial Opportunities

Billing importance

- Billing for services and being paid for services places value on the patient care that you provide.
- Billing, along with care management incentive programs, is how team based care can be sustainable.
- Sustainability comes from:
  - Seeing enough patients in a day → a minimum of 4 on average per half day, which could telephone, initial comprehensive assessments, or other virtual/face to face follow ups.
  - Billing consistently for all billable services.

Incentive Programs

BCBSM

Value Based Reimbursement
(i.e. increase on every E&M code and PDCM code)
In 2020:

- 5% of this is VBR for billing codes: 2 touches on 4% of the population.
- Up to 8% is for Quality and Outcomes, focusing on A1c (2%), BP (2%), IP utilization (2%), and ED utilization (2%).
- PCMH Designation: 15%
- Fee For Service on all codes billed.
- No patient co-pay/provider liability.

Priority Health

- Annual PMPM incentive payment if outreach achieved for 2- 5% of the patient population. 5% available for CPC+ Track 2 practices only.
- 2 billed codes on different dates of service.
- Fee For Service on all codes billed.
- No patient co-pay.

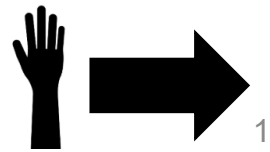
CPC+ isn't specific in its funding.

8-10 Interactions with Patients per Day is a Minimum for

Week-Long Review	
Pre-Work Start of Week	Review schedule and identify patients based on payer, risk, diagnoses. Review patients with provider.
Target (15) minutes with Provider after enrollment.	Review complex patients and face to face patients from that week (12 patients; 12 G9007 codes).
Target interacting with (1-4) new patients per week.	(1-4) G9001 or G9002 codes
Target interacting with (3-4) existing patients in face to face visits per week.	(3-4) G9002 codes
Target follow up phone calls at least (4-6) phone calls per day with the patient.	(20-30) patient phone calls a week (98966-98968)
Target follow up phone calls for coordination of care – accumulated time billed monthly	

That sums to **36 - 50 codes** per week!

- Look at a month, as a day/week is too variable.
- Review the example it shows how you might get up to 10 billable type activities per day or 50 per week.



Telehealth and Virtual Visits

- Due to COVID, there has been a shift in the modality of care management visits to telehealth, and this has some early indications of improved ability to connect with patients.
- While this isn't universally true, there is significant opportunity with telehealth and virtual visits:
  - One Michigan organization saw a decrease in no show rates from 34% to 11% on average.
  - Another Michigan organization saw an increase of up to 39% increased use of virtual face to face codes.

Activity: Billing Progress Reports

- Each payer program sets benchmarks for number of patients receiving care management services at the practice level.
- Each payer also sends a progress report to the PO:
  - BCBSM sends through the EDDI mailbox on approximately a quarterly basis.
  - Priority Health sends through Filemart to PO Representatives on a monthly basis.
- Work with your PO to devise a best strategy for tracking progress towards program goals.

Different payers, Different rules!

BCBSM

- **BCBSM removed the distinction between lead care managers and qualified health professionals – now they simply have "physicians" and "care team members," and those care team members are either licensed (e.g., social workers, nurses) or unlicensed (e.g., MAs, CHWs).**
- **The care team can be comprised of any health care or behavioral health professional the provider believes is qualified to serve on the care team.**

https://micmt-cares.org/billing-resources

Priority Health

- QHPs include: RNs, certified NPs, PA-Cs, licensed Master social workers (LMSWs), psychologists, certified diabetes educators (CDEs), certified asthma educator (CAE), Registered Dieticians, clinical pharmacists.

PH:
https://www.priorityhealth.com/provider/manual/services/medical/care-management

Codes for Care Team Members:

BCBSM		Priority	
Licensed	X	QHP	X
Unlicensed MA, CHW			

Face to Face w/ patient

G9001 - Initiation of Care Management (Comprehensive Assessment)
G9002 - Individual Face-to-Face or face to face telephonic

Group Visits w/ patient

98961 - Education and training for patient self-management for 2–4 patients; 30 minutes
98962 - Education and training for patient self-management for 5–8 patients; 30 minutes

End of Life Counseling Advanced Directive

S0257 - Counseling and discussion regarding advance directives or end of life care planning and decisions

BCBSM provider liability if patient does not have the Care Management Benefit.

BCBSM		Priority	
Licensed	X	QHP	X
Unlicensed MA, CHW			

G9001 Comprehensive Assessment Code

- **BCBSM**
  - Individual, face to face (or video for commercial)
  - One per patient per day
- **Priority Health**
  - Individual, face to face
  - May be billed once annually for patients with on-going care management.

G9001 Comprehensive Assessment Code

BCBSM		Priority	
Licensed	X	QHP	X
Unlicensed MA, CHW			

The **Comprehensive Assessment** (G9001) is a face to face meeting that results in a care plan that the care team and the patient can follow.

The Care Plan consists of 2 things:

Patient Driven Goals

Follow Up and Support Plan

G9002 Face-to-Face Visit Code

BCBSM		Priority	
Licensed	X	QHP	X
Unlicensed MA, CHW			

BCBSM (Commercial and Medicare Advantage):
Quantity Billing

- Individual, face to face or video
- If the total cumulative time with the patient adds up to:
  - 1 to 45 minutes, report a quantity of one; 46 to 75 minutes, report a quantity of two; 76 to 105 minutes, report a quantity of three; 106 to 135 minutes, report a quantity of four.

Priority Health (Commercial, Medicare Advantage, Medicaid):
No Quantity Billing

- In person visit with patient, may include caregiver involvement.
- Used for treatment plan, self management education, medication therapy, risk factors, unmet care, physical status, emotional status, community resources, readiness to change.
- Priority Health allows a virtual visit with POS 02

BCBSM: 2P Modifier for G 9002- Payable when contact is made with patient to discuss the program and patient does not enroll in care management

Face to Face/Video Codes

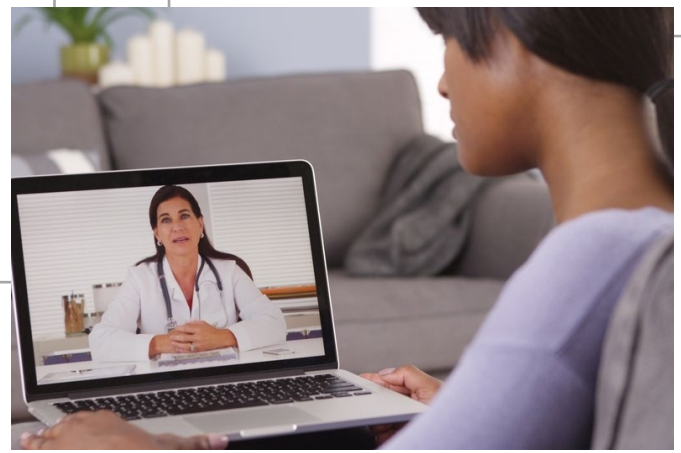
BCBSM		Priority	
Licensed	X	QHP	X
Unlicensed MA, CHW			

G9001 Comprehensive Assessment

- A face to face or video meeting, duration at least 30 minutes, that results in a care management plan that all care management team members and the patient will follow.
- This is a holistic, encompassing type of patient visit that helps define a significant change in how the patient approaches managing their health: new diagnosis, transition of care, addressing a symptom that requires a significant change to the previous care plan.

G9002 Patient Visit

- A face to face or video meeting that is focused on addressing a piece of the care management plan.
- This type of visit should additionally address patient goals and a follow up plan.



98961, 98962 Group Education Code

- **98961 Group Education**
  - 2-4 patients for 30 minutes
  - Face to Face with patient or caregiver guardian, parent, etc
  - Quantity bill per 30 minutes
- **98962 Group Education**
  - 5-8 patients for 30 minutes
  - Face to Face with patient or caregiver guardian, parent, etc
  - Quantity bill per 30 minutes

S0257 End of Life Counseling Advanced Directive Discussion Code

BCBSM		Priority	
Licensed	X	QHP	X
Unlicensed MA, CHW			

Individual face to face, video or telephone

- **BCBSM:** one per day
- **Priority:** no quantity limits

Note that physicians can also bill this code. It differs from the 99497 and 99498 codes, which are for physicians and require that the forms for ACP be completed.

Phone Codes for Care Team Members

BCBSM		Priority	
Licensed	X	QHP	X
Unlicensed MA, CHW	X		

Telephone with patient

98966: Telephone assessment 5-10 minutes of medical discussion
98967: Telephone assessment 11-20 minutes of medical discussion
98968: Telephone assessment 21-30 minutes of medical discussion

Telephone on behalf of patient Care Coordination **(not with patient or provider)**

99487: First 31 to 75 minutes of clinical staff time directed by a physician or other qualified healthcare professional with no face-to-face visit, per calendar month

99489: Each additional 30 minutes after initial 75 minutes of clinical staff time directed by a physician or other qualified healthcare professional, per calendar month. (An add-on code that should be reported in conjunction with 99487)

BCBSM provider liability if patient does not have the Care Management Benefit.

98966, 98967, 98968 Phone Service Codes

BCBSM		Priority	
Licensed	X	QHP	X
Unlicensed MA, CHW	X		

Call with patient or caregiver to discuss care issues and progress towards goals.

98966 for 5-10 minutes

98967 for 11-20 minutes

98968 for 21-30 minutes

BCBSM: 2P Modifier for 98966, 98967, 99868 - Payable when contact is made with patient to discuss the program and patient does not enroll in care management

99487, 99489
Phone Service Codes

BCBSM		Priority	
Licensed	X	QHP	X
Unlicensed MA, CHW	X		

Call on behalf of the Patient to coordinate care.

- **99487** for first 31 to 75 minutes of clinical staff time working on behalf of the patient with someone other than the patient or provider.
  - Examples: coordinating DME for a patient; reaching out to a resource to help support a SDOH need.
- **99489** for each additional 30 minutes after 75 minutes per calendar month.

Codes for Providers/Physicians

Care Team Member and Provider Discussion	**G9007:** Coordinated care fee, scheduled team conference
Physician discussion with patient, other physicians, extended care team members not part of the care team.	**G9008:** Physician Coordinated Care Oversight Services (Enrollment Fee)
End of Life Counseling Advanced Directive	**S0257:** Counseling and discussion regarding advance directives or end of life care planning and decisions

BCBSM provider liability if patient does not have the Care Management Benefit.

Provider Code:
G9007 Team Conference Code

- PCP and a care team member formally discuss a patient's care plan.
- Can be billed once per day per patient regardless of time spent.
- May be billed by a physician or APP.

Physician Code:
G9008 Physician Coordinated Care Oversight Services (Enrollment Fee)

BCBSM

- Once per day, but no quantity limit.
- May be conducted face to face, via video, or by telephone. This does not include email exchange or EMR messaging.
- Communication with paramedic, patient, other health care professionals not part of the care team when consulting about patient who is engaged in care management.

Priority Health

- One time per practice.
- Only be conducted face to face. May be done virtually
- Can only be billed when the physician has discussed the care plan with the patient and if the licensed care team member has had a face to face with the patient on or before the day of the physician's discussion with the patient.

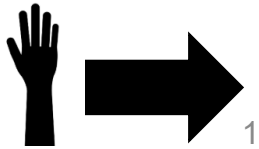
Break Time

10 minute break!

High Risk Patient

Identify the codes:
G9007, G9001

- Patient is flagged as high risk by a payer list.
- Care manager discusses overall care plan goals with provider, and it is determined the patient is appropriate for care management.
- Care manager reviews the chart, recent screenings (SDOH, PHQ-9), problem list, medications, and utilization history.
- Care manager sees the patient in a face to face visit, patient agrees to care management. CM evaluates the patient's current ability to steward completing the comprehensive assessment.
- Patient develops a SMART goal, and the care manager connects the patient with various resources that address identified barriers.
- Care manager discusses care plan with the provider. Provider agrees with the care plan.
- Patient and care manager agree on a follow up plan.
- Care manager documents in the chart and adds the appropriate billing codes.

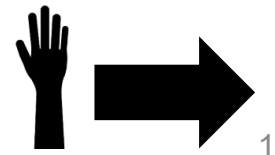


Face to Face Visit and Follow Up Plan

Identify the codes:
G9002, G9008 BCBSM
G9007 PH

- A patient comes into the office to be evaluated by their PCP. After the evaluation the PCP introduces the patient to the care manager (CM).
- During the conversation with the patient the CM assesses that there is not a clear understanding about asthma management.
- CM conducts a medication review, teaches how to use peak flow and keep a log, provides an asthma action plan.
- CM and patient agree to follow up in one week via a phone visit.
- This initial visit with the patient was 60 minutes.
- PCP and patient discuss and agree with the action plan.

Note how this is different from the **G9001!**



Identify the code:
99487

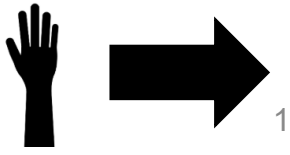
Coordination of Care

- Care manager contacts the home health agency to schedule in-home visits and conduct a safety assessment.
- In addition, a call was made to the DME provider to arrange for delivery of home O2.
- Time spent coordinating care was over 30 minutes.

Gaps in Care

Identify the code:
98968 BCBSM

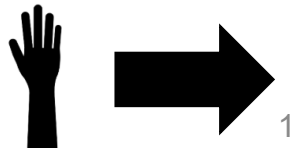
- RN notices during chart review that several of the patients who are enrolled in care management have not received their cancer screenings, even though the RN and provider reminded them.
- RN shows the list to the Medical Assistant.
- Per the Standing Agreement that has been put in place with the physician, the Medical Assistant calls the patient enrolled in care management to discuss gaps in care and facilitate closing the gaps. Time more than 31 mins.



Identify the codes:
G9007, G9001, G9002

Multidisciplinary Team

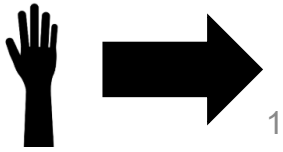
- Patient with diagnosis of diabetes, COPD and HTN has a comprehensive assessment completed by the pharmacists and SW CM.
- Patient screens positive for SDOH – food insecurity, struggling to afford medications, lacks caregiver support during face-to-face visit with SW.
- An multidisciplinary team conference was held with the Clinical Pharmacist, SW CM and PCP to discuss the initial plan of care with the team, which includes:
  - The SW CM to schedule a virtual face to face visit with the patient regarding the lack of caregiver support and social isolation, which is linked with admissions.
  - The Clinical Pharmacist to follow up with the patient on the ability to afford medications and the chronic diseases management also linked to frequent ED visits.
  - Both SW CM and Clinical Pharmacist follow up with the team at their regular huddle.



Advance Directives End of Life

Identify the code: **S0257**
*Note: this code allows for phone visit and meeting may be with the patient, care giver, or family member.

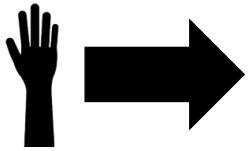
- CM conducts a 20 minute in person meeting with a patient regarding their advance directives.
- During the discussion, information is given to the patient to review regarding advance directives.
- Discussion includes:
  - How the patient prefers to be treated.
  - What the patient wishes others to know.
- CM and patient agree to follow up via a phone call in 2 weeks.



Reducing ED visits

Identify the code:
98966 BCBSM

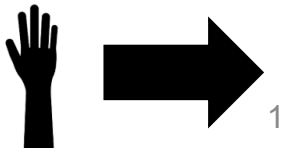
- Proactive patient education to consider the PCMH practice first for acute healthcare needs, suggesting nearby urgent care, or ED for true emergency.
- Follow up each ED visit with a call to identify issues, coordinate follow up care, and encourage seeking care through the practice rather than the ED when appropriate. Often, this can be performed by a medical assistant.
- Medical assistants, operating under a protocol, may call patients, ask if the ED physician recommended follow up care, coordinate the needed care, transfer to clinician for issues requiring immediate medical assessment or guidance, and encourage the patient to bring in all medications. Call takes 10 minutes.



Phone Service

Identify the code:
98967

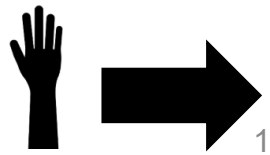
- CM speaks with a patient via the telephone.
- CM reviews the patient's asthma action plan and reviews the symptoms that indicate worsening symptoms and asthma exacerbation.
- This is also reinforced when to call the office.
- In addition, CM asks the patient about interest in attending an asthma group visit. Patient indicates interest and CM provides the information regarding the asthma group visit.
- CM and patient agree on follow up in one week via in person visit at the office.
- This meeting takes 20 minutes.



Identify the code:
G9002

Patient Visit Face to Face

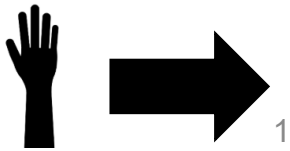
- The patient returns to the office one week later to meet with CM.
- During the visit, CM and patient discuss symptoms, medications, and SMART goals.
- Patient states he/she has not needed to use the rescue inhaler and feels they now have a better understanding of how to care for his/her self. You again review the action plan and state you will follow up in one month.



Identify the codes:
3 patients 98961
6 patients 98962

Group Education Visit

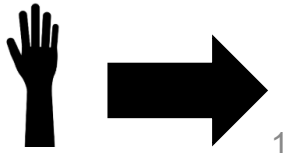
- Patient and caregiver indicate interest in Asthma Education class.
- Patient attends with caregiver with 3 other patients for 30 minutes.
- Patient attends a second class with 6 other patients for 30 minutes.



Identify the code:
G9008 BCBSM

Medical Community

- Physician calls a Pulmonologist to discuss a joint treatment plan for patient's asthma.



Summary

In this module we:

- Demonstrated how to use the billing codes to create a sustainability program and earn available incentive dollars.
- Reviewed definitions of billing codes and scenarios of when the codes might used in daily care team activities.

What have we discussed?

- The chronic care model framework and how to use it successfully in a team based care practice model so that we can improve patient outcomes.
- The care management process and how to identify, assess and collaboratively create a self-management plan, and how to implement that plan.
- How to know whether or not our efforts are making a difference in the health of the whole population of patients supported by the office by watching the outcomes measures that we've targeted: A1c, BP, ED utilization, and IP utilization.
- How to bill and keep the program sustainable in the long term

What will you start using in your role as a care team member tomorrow?

Refining the elevator speech - making it your own!

Homework: Questions to take back to your practice

- Virtual and telehealth visits
- What screening tools does your practice use
- What clinical evidence-based guidelines is the practice following
- What outcome measures are being focused on
- What role do I play in ensuring the metrics are being met
- Shadow your team members
- Prepare an elevator speech to member of the team and patient
- Determine the organizations expectations on caseload size, number of contacts per day and use of billing codes

Successful Completion of Introduction to Team Based Care includes:

- Completion of the one day in-person/virtual training.
- Completion of the Michigan Institute for Care Management and Transformation (MICMT) post-test and evaluation.
- Achieve a passing score on the post-test of 80% of greater.
  *If needed, you may retake the post-test.

You will have (5) business days to complete the post-test.

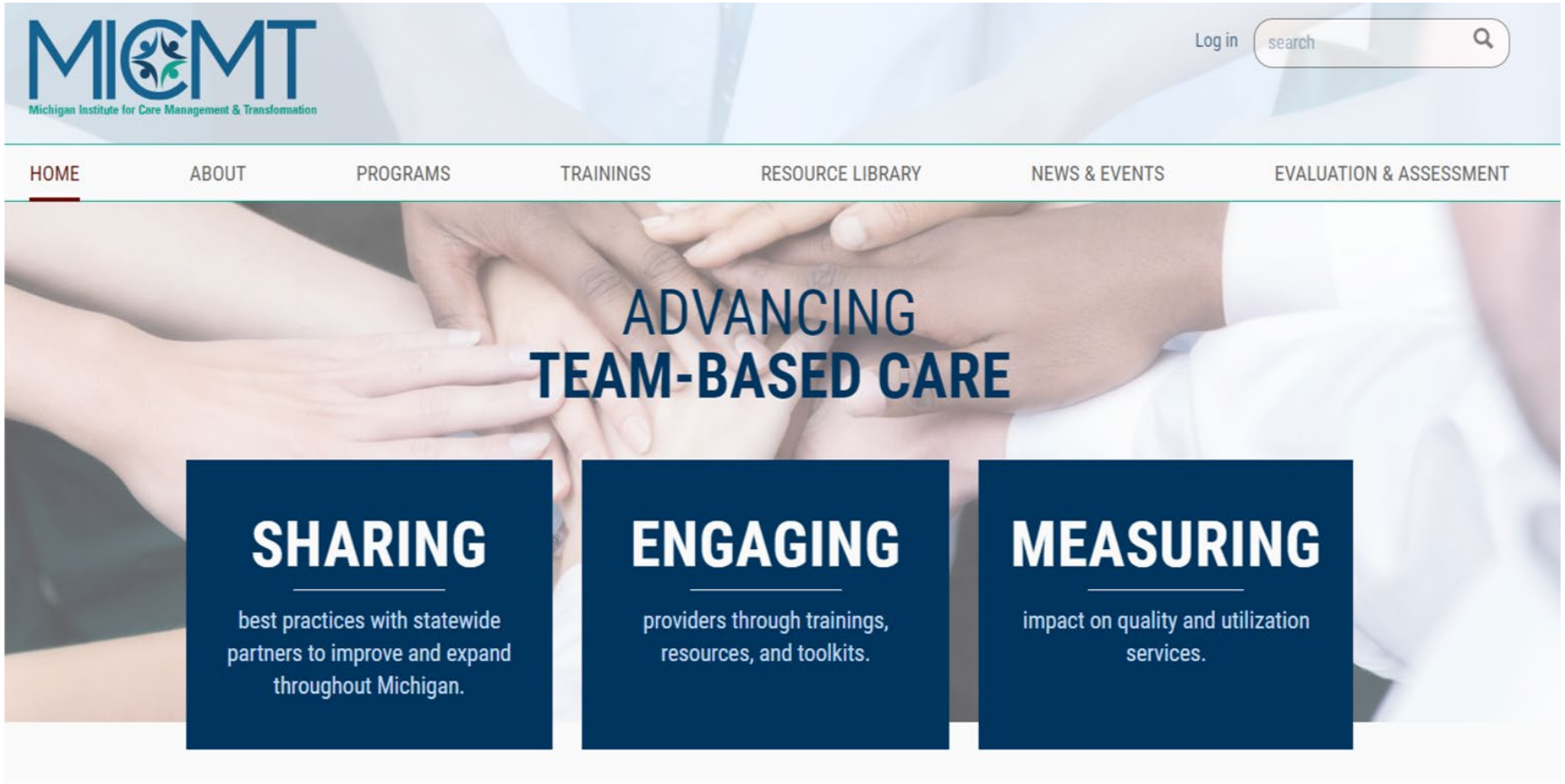
Contact Us

micmt-requests@med.umich.edu

Resources

MICMT Resources

https://micmt-cares.org/



Additional Resources on Huddles and Meetings

Creating Patient-centered team based Primary Care
https://pcmh.ahrq.gov/sites/default/files/attachments/creating-patient-centered-team based-primary-care-white-paper.pdf

UCSF Center for Excellence in Primary Care- Healthy Huddles
https://cepc.ucsf.edu/healthy-huddles

Huddles: Improve Office Efficiency in Mere Minutes
https://www.aafp.org/fpm/2007/0600/p27.html

IHI Optimize the Care Team Communication
http://www.ihi.org/IHI/Topics/OfficePractices/Access/Changes/IndividualChanges/UseRegularHuddlesandStaffMeetingstoPlanProductionandtoOptimizeTeamCommunication.htm

MICMT Website Online Resources

- Care Manager Introduction Phone Script
- Care Management Explanation Flyer
- Share the care: Assessment of Team Roles and Task Distribution
- Michigan Community Resources
- MDHHS Community Mental Health Services Programs
- Michigan 2-1-1 Informational Guide

Resources: Care Management Services

- Michigan Institute for Care Management and Transformation
- BCBSM
  - PDCM Billing online course
  - PDCM Billing Guidelines for Commercial
  - Medicare Advantage
- Priority Health
- Centers for Medicare & Medicaid
  - Transitional Care Management
  - Chronic Care Management
  - Behavioral Health Integration