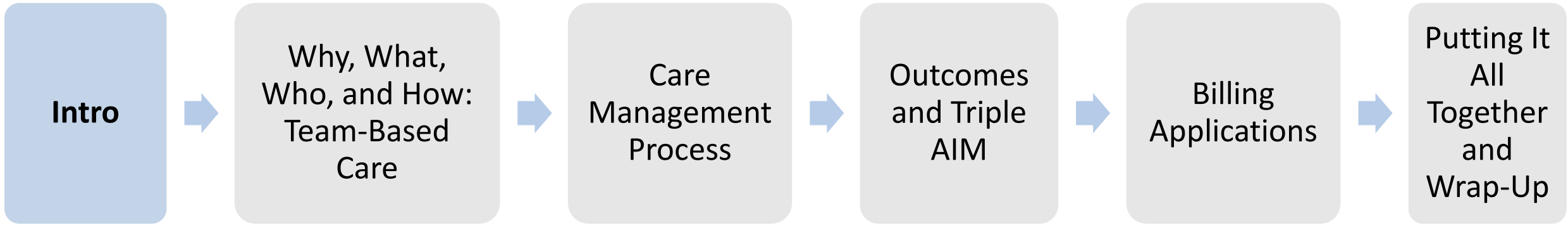
Introduction to Team-Based Care

Agenda


Intro
Why, What, Who, and How: Team-Based Care
Care Management Process
Outcomes and Triple AIM
Billing Applications
Putting It All Together and Wrap-Up

Welcome!

House Keeping

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.

Successful Completion Requirements:

- Attend the entire Introduction to Team-Based Care course, in-person or live virtual
  Attendance criteria:
  - If the Learner misses > 30 minutes; the Learner will not be counted as "attended" and will need to retake the course.
  - If the Learner misses < 30 minutes; the Learner will be counted as "attended". The Learner will need to review the missed course content located here: https://micmt-cares.org/training
  - If course is virtual – must attend by audio and video/internet

- Complete the Michigan Institute for Care Management and Transformation (MICMT) Intro to TBC post-test and evaluation.
  - Achieve a passing score on the post-test of 80% or greater. If needed, you may retake the post-test

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

Please take the post test within 5 days for CE credit!

Disclosures

Nursing:

Social Work:

Reference Guidelines

- Please provide the following as an appropriate reference if you use this material:
  - “Material based off of the Introduction to Team-Based Care course developed through a collaborative effort facilitated by Michigan Institute for Care Management and Transformation and participating Training Organizations.”
- Questions about using or replicating this curriculum should be sent to: micmt-requests@med.umich.edu.
- Please follow this link if you are interested in becoming an approved trainer for this curriculum: www.micmt-cares.org

Introductions

- Your name
- Your discipline
- Your practice location
- How long have you been in your role
- What's most important for you to learn today

Pre-Work (optional slide)

Completion of pre-work material

- Share the Care Document
- Rishi Manchanda on Upstream Health

*If you didn’t not have a chance to view the pre-work, please make sure to review

Learning Outcome

Participants will be able to identify, in the BCBSM Provider Directed Care Management program, the clinical and utilization outcomes measures expected to be impacted by care management.

Learning Objectives

1. Define the team-based model of care.
2. Explain how the team-based care model improves patient outcomes.
3. Identify how to apply these concepts in clinics when acting in the role of a care team member.
4. Define key components of the care management process and the impact on the effectiveness of team-based care.
5. Describe how team-based care can impact outcome measures.
6. Demonstrate the selection of appropriate billing codes for daily care team activities to promote sustainability.
7. Examine opportunities to integrate concepts of team-based care into your own clinical practice.

Agenda

Intro → **Why, What, Who, and How: Team-Based Care** → Care Management Process → Outcomes and Triple AIM → Billing Applications → Putting It All Together and Wrap-Up

Why Do We Need Team-Based Care?

Elizabeth Haberkorn, MSN, FNP-BC
Family Nurse Practitioner at Judson Center Family Health
Associate Medical Director, Medical Network One PC

Think about a loved one or patient…

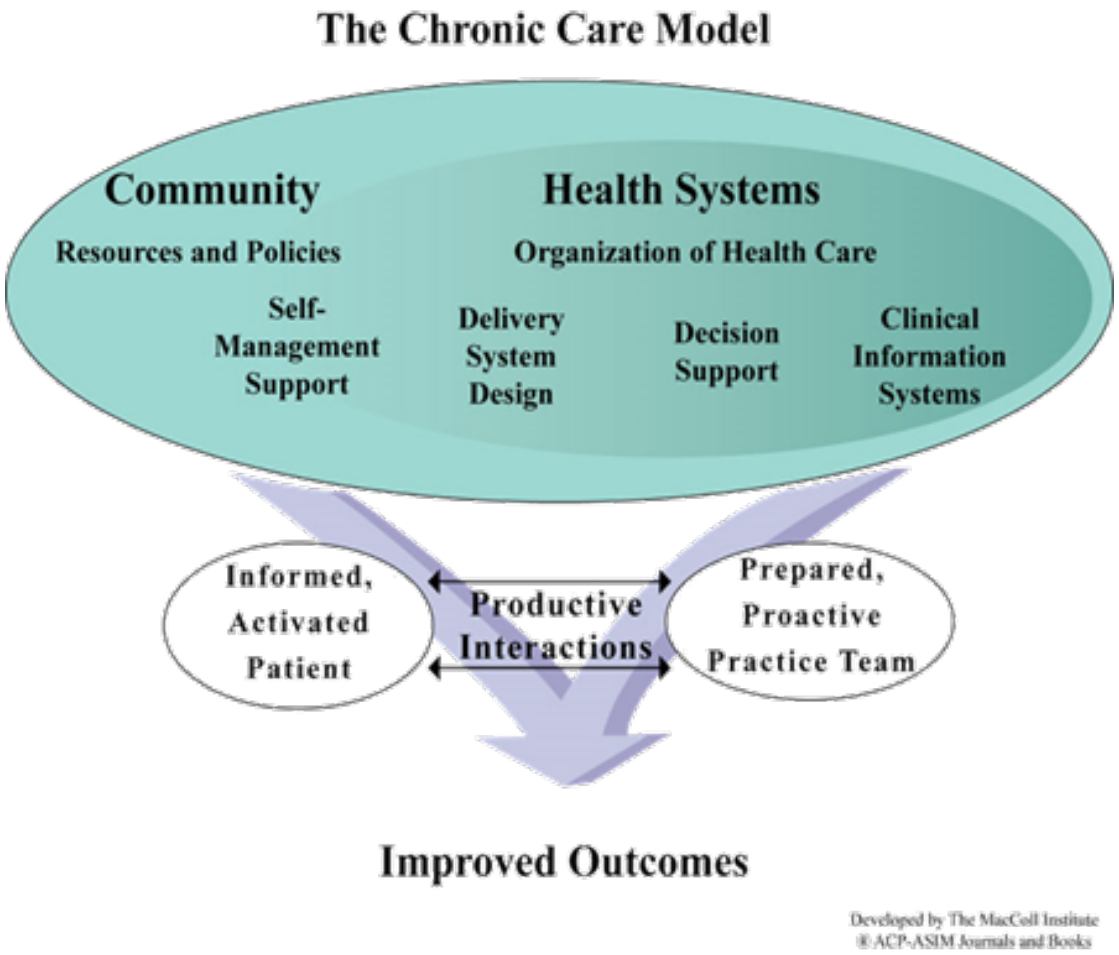
- **Step 1: Individually**
  - Please take about 30 seconds to think about a loved one or patient who had a difficult experience with lots of trips to the ER or hospital.
- **Step 2: Individually**
  - Now, please take 30 seconds to think about how this role could have changed that experience.
- **Step 3: Group sharing**
  - Could at least two (2) people share the patient/loved one experience and how they think this role could have helped them?

What is Team-Based Care?

Dr. Tom Simmer, MD, Retired
Served as Senior Vice President and Chief Medical Officer for BCBSM

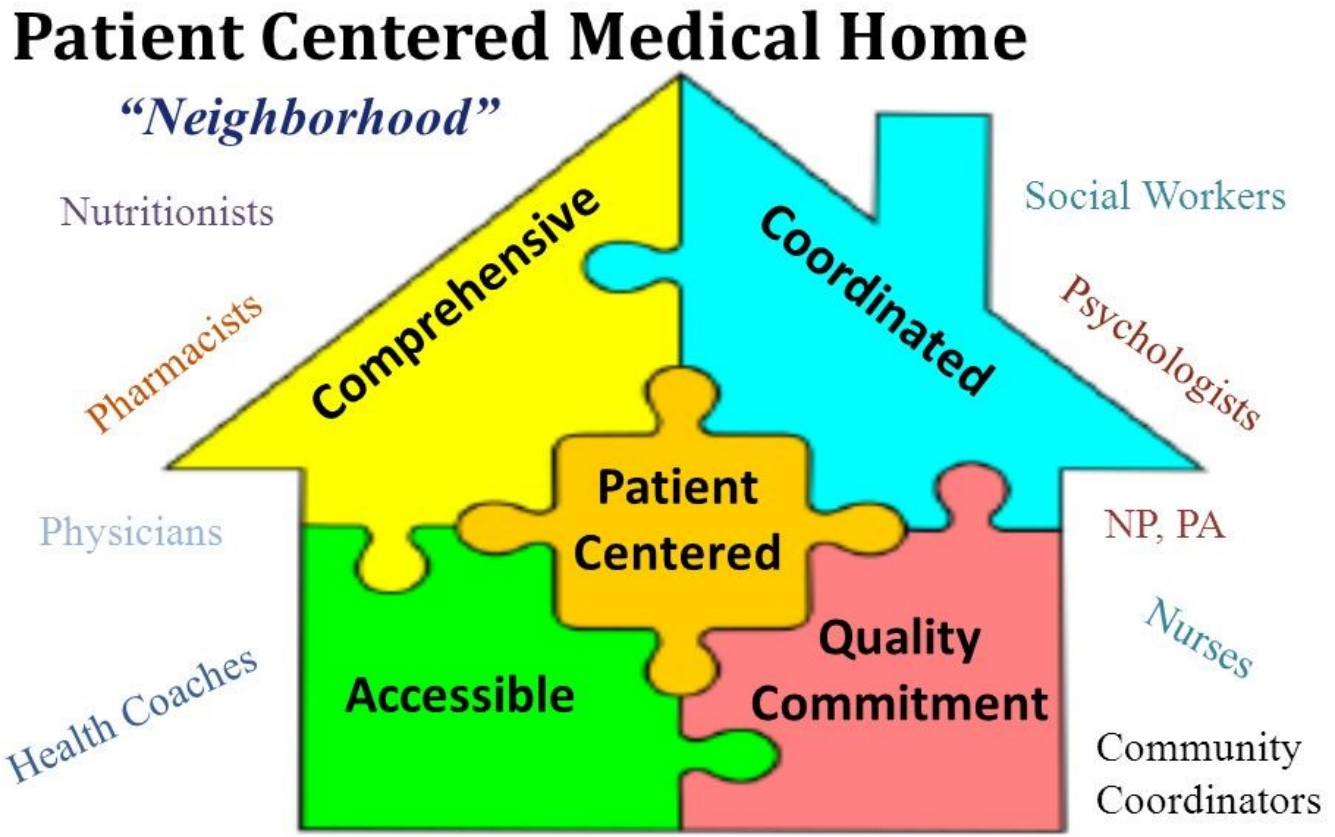
The Chronic Care Model

- An organized and planned approach to improving patient and population level health.
- Focus is on productive interactions to improve healthcare outcomes.



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.



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

Who is on the team? Examples of team roles

Provider	RN - CM	SW CM – Behavioral Health Specialist	Clinical Pharmacist	Community Health Worker	Office clerical	MA
• 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 patients • 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					

Who is on the team?

Review Share the Care

Roles Within Your Setting

(Optional if pre-work is included)

Activity: Review Roles and Responsibilities

	Role				
Responsibility	**Provider**	**Office clerical**	**Clinic MA**	**Care Team Member**	**Patient**
Participate in huddle					
Identify patients for care management					
Call patients after inpatient discharge within 48 hours					
Complete proactive outreach using patient registry lists					
Check-in process					
Complete screenings					
Complete patient assessment for plan of care					
Assist in the development of the patient plan of care					
Assess and reassess patient goals for success					
Assist with navigation of services					
Review/assist with medication management					
Provide self-management support					
Document/communicate the plan of care					
Schedule follow-up visits					
Coordinate case closures					

Discussion: Review Roles and Responsibilities

	Role				
Task	**Provider**	**Office clerical**	**Clinic MA**	**Care Team Member**	**Patient**
Participate in huddle	X	X	X	X	
Identify patients for care management	X	X	X	X	X
Call patients after inpatient discharge within 48 hours			X	X	
Complete proactive outreach using patient registry lists		X	X	X	
Check-in process		X			
Complete screenings	X	X	X	X	
Complete patient assessment for plan of care	X			X	
Assist in the development of the patient plan of care	X			X	X
Assess and reassess patient goals for success	X			X	X
Assist with navigation of services	X	X	X	X	X
Review/assist with medication management	X		X	X	
Provide self-management support	X			X	
Document/communicate the plan of care	X		X	X	
Schedule follow-up visits		X		X	
Coordinate case closures	X			X	

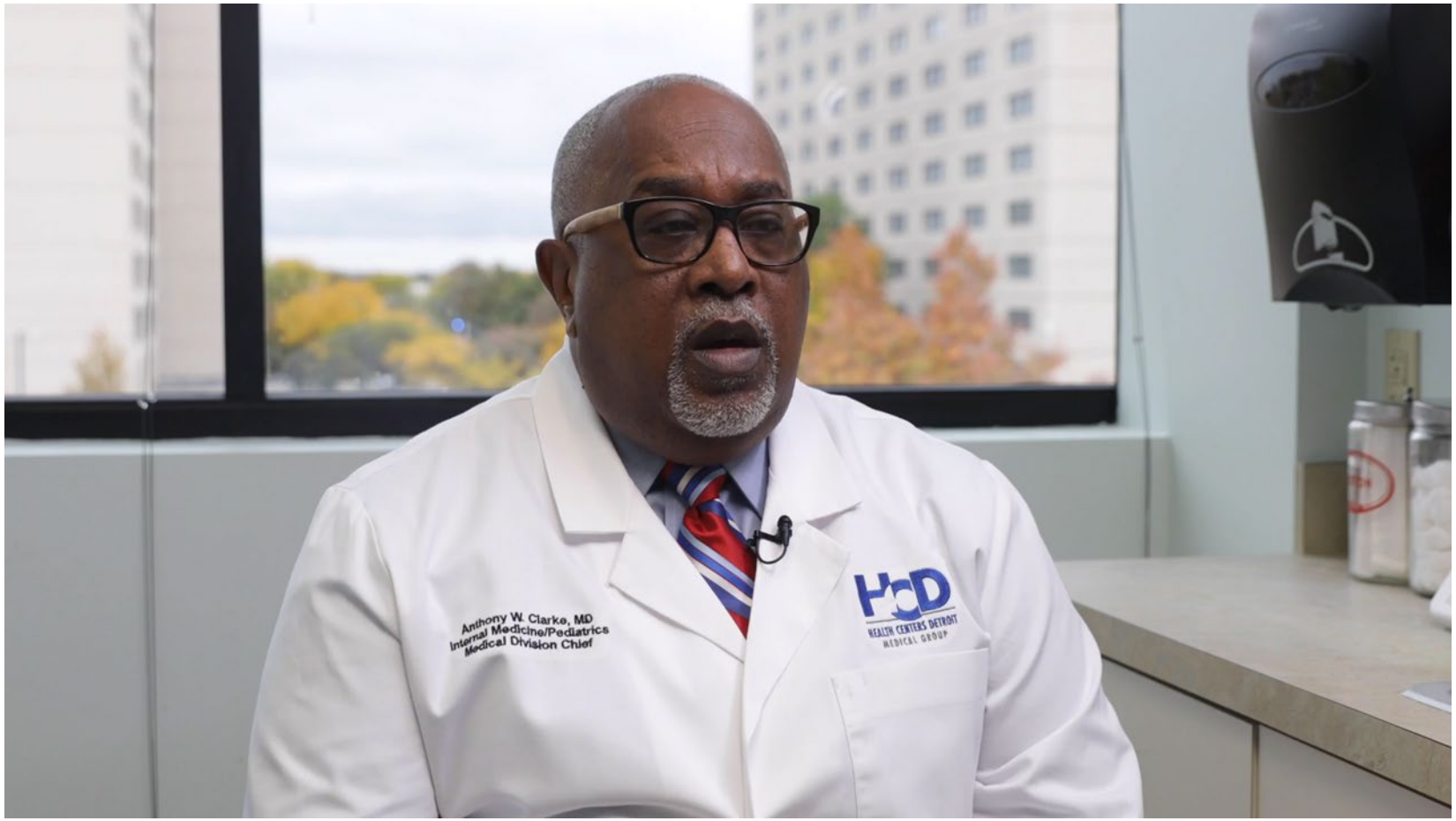
The role of **practice leadership is to support the tasks of the provider, office clerical, clinic MA, and care team members. They are not directly involved in the day-to-day tasks of developing the patient's plan of care.*

Community Team Members

Referral Type	Where to Look
Community Team Members/Schools	• Community Resources (PO and Practice have a list) • School-Based Resources (Psychologist, Social Worker) • Faith-Based Partnerships
Health Department/Public Health	• Maternal/Infant Health (CSHCS: Children's Special Health Care Services) • Adult Resources • Education
Pharmacist	• Local Pharmacy (Walgreens, CVS, Rite Aid for drug specific questions)
Social Worker/Behavioral Health	• Referral from PCP • Local Community Mental Health • DHHS: Department of Health and Human Services • Public Health Services
Dietitian	• Referral from PCP • Online Resources (https://www.eatright.org/find-an-expert)
Other/General Help	• PO/Practice Leadership • MICMT (www.micmt-cares.org)

What is your elevator speech? (Write it down!)

How do Care Teams work together?



Dr. Anthony Clarke, MD
Health Centers Detroit Medical Group

Operating Guidelines: Policies & Procedures

- Collaborative Practice Agreements
- Standing Orders
- Meetings and Huddles

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.

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

Meeting Examples

Huddle	Meeting
Short, patient centered	Has an agenda, operational
Frequent, even daily	Less frequent, but scheduled regularly or ad hoc
Goal is to discuss arising situations that need multi-disciplinary support and are complex enough for a conversation: • High risk patients, complex Plans of Care • ED or IP visits • Requests for different referrals • Concerns for a patient	Goal is to improve the overall program performance: • Review operational opportunities, such as scheduling or standing agreements/orders • Review process for referrals • Review outcomes measures / performance
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

So, now that we've defined the team, we'd like to discuss more about how to use communication tools to really work well as a team!

Team Communication

Barriers to Good Communication

Personal

- Memory limitations
- Stress/anxiety
- Fatigue, physical factors
- Multi-tasking
- Flawed assumptions
- New role/new team

Environmental

- Many modes communication
- Rapid change
- Time pressure
- Distractions
- Interruptions
- Variations in team culture

Feedback Loop for Communication

1. Sender
2. Receiver
3. Message
4. Feedback
    1. Teach-back
    2. Show-back

Example:

- Patient was prescribed a hypertensive medication.
- Patient filled the medication
- At the next visit, BP was still elevated.
- Provider would have prescribed more medication, but the care team member asked how the patient was taking the meds.
- Patient revealed that no meds were taken because of side effects.

Communication Tools

- Clear patient encounter documentation in the EHR
- Messaging (skype)
- Ad hoc conversations
- SBAR (Situation, Background, Assessment, Recommendation)

Different communication tools serve different purposes – all are meant to keep the team informed of patient progress, plan of care changes, and operational changes that support better patient outcomes.

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?

SBAR Ineffective Communication

SBAR Effective Communication

Thoughts on SBAR Videos

What made the difference?

SBAR: Your Turn!

Can someone share an experience that might have benefited from an SBAR communication?

- **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?

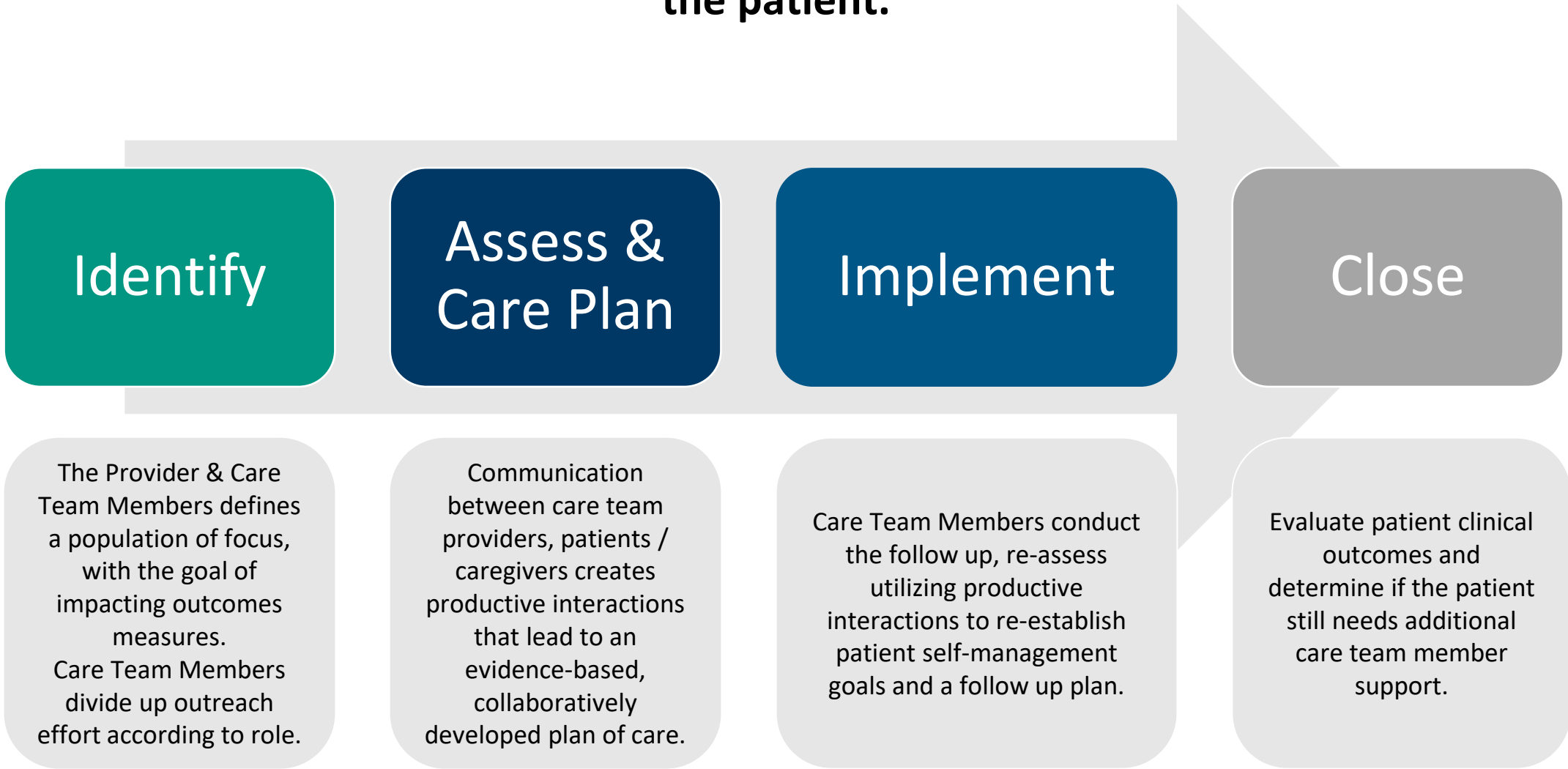
Key Takeaways

- Team-based care is derived from the chronic care model and patient-centered medical home.
- Team structure and roles help define how the team can work together.
- Communication tools help improve the team's ability to provide patient-centered care.
- Feedback loops help assure that the sender's message has been understood by the receiver.

Agenda

Intro → Why, What, Who, and How: Team-Based Care → **Care Management Process** → Outcomes and Triple AIM → Billing Applications → Putting It All Together and Wrap-Up

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

Build a panel of patients that is related to the outcomes measures that indicate program success

Align Outreach with Outcomes

Work with your practice team and physician to identify patients who need support to improve the key outcomes measures.

Evidence-based Guidelines

Top Adult Outcome Measures

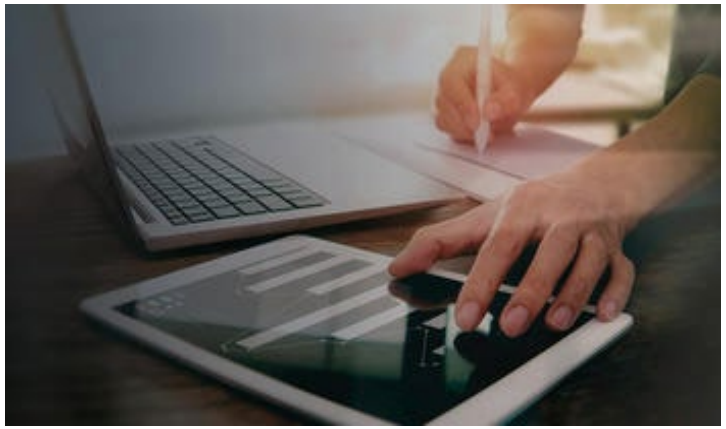
- Lower ED Utilization
- Lower Inpatient Utilization
- A1c in Control
- BP in Control

Top Pediatric Outcome Measures

- Lower ED Utilization
- Lower Inpatient Utilization
- ED Visit Follow-Up for Mental Illness
- ADHD Medication Management
- Asthma Medication Management

Build a Targeted Patient Panel

- **Referrals:** Physicians and other care team members can identify patients - often through screenings - who would be appropriate and refer them to you for support.
- **Registry:** Proactive outreach using lists of patients from a registry can be an easy way to find patients with the diagnoses or gaps of focus.
- **Transitions of Care and 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!
- **PO or Practice Risk Stratification Processes:** Your PO / practice may have a way to identify high risk and rising risk patients.



Referral Process

- Developing a simple referral process for providers and care team members to send you patients is one of the ways that you can build your team.
- If your providers are open to the idea, set up regular short huddles to review the patients who are coming in for the day or for the week to see if there are appropriate people for care management.
- This keeps the provider engaged in the care and provides an opportunity for the care team member to learn more about the patient from the provider.

Provider input saves time - builds team relationships - builds trust!
(Plus, it's billable: G9007)

Proactive Identification: A Critical Step Using Your Registry

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 who may need your service may not seek care or come into the practice.
- Proactive outreach for gaps in care can help re-engage patients with evidence-based preventive care.

Admission / Discharge / Transfer (ADT) Notifications

- ADT notifications are the process by which your Physician Organization (PO) or office knows when patients are admitted to the hospital or present to the Emergency Department (ED).
- It's important to find out how your office receives ADT notifications so that you can support the patient.

Resource: Improving Care Coordination Through Health Information Exchange, Oakland Southfield Physicians

Transitions of Care (TOC)

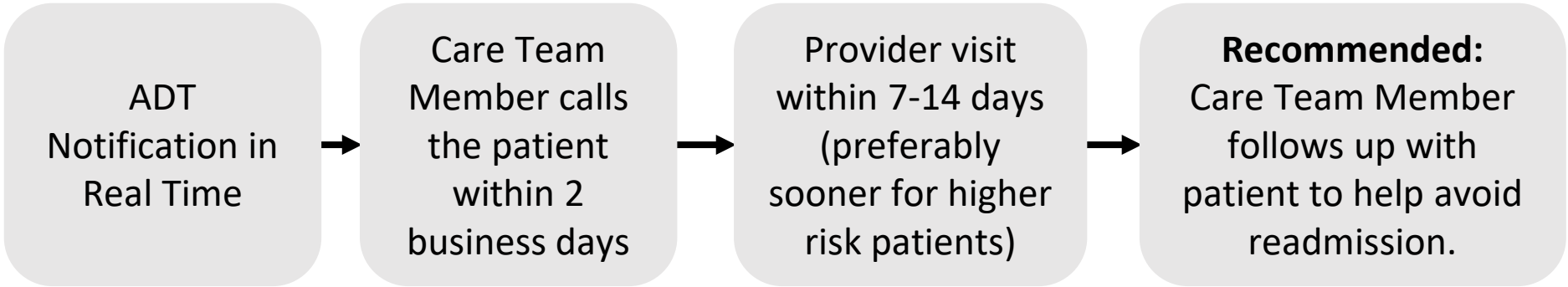
- A set of actions designed to ensure the coordination and continuity of health care as patients transfer from hospital to home.
- TOC services are provided after a patient is discharged from one of these inpatient settings, with the goal of preventing a readmission:

Inpatient acute care hospital	Hospital outpatient observation	Skilled nursing facility (SNF)	Other inpatient settings

Resource: Transitions of Care eLearning

Transitional Care Management (TCM) Requirements

- TCM requirements are the steps needed for your provider to bill a higher level code (99495 and 99496) after a patient is discharged home from the inpatient setting.
- TCM requirements are also shown to reduce readmissions. Win/Win!



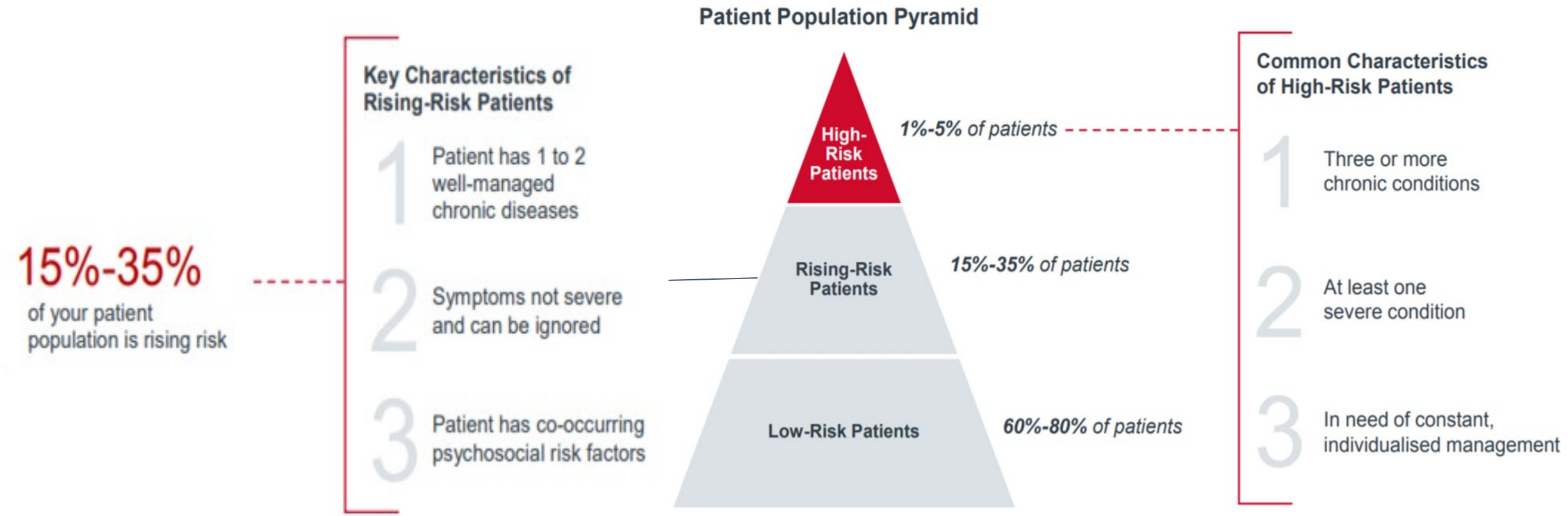
*Note: The 98966-68 phone call codes should not be billed when calling the patient as part of the TCM codes.

Resource: CMS TCM Services

The Transition of Care Experience

Erika Perpich, PharmD, BCACP
Director of Clinical Services, Ambulatory Care Clinical Pharmacist
Olympia Medical LLC

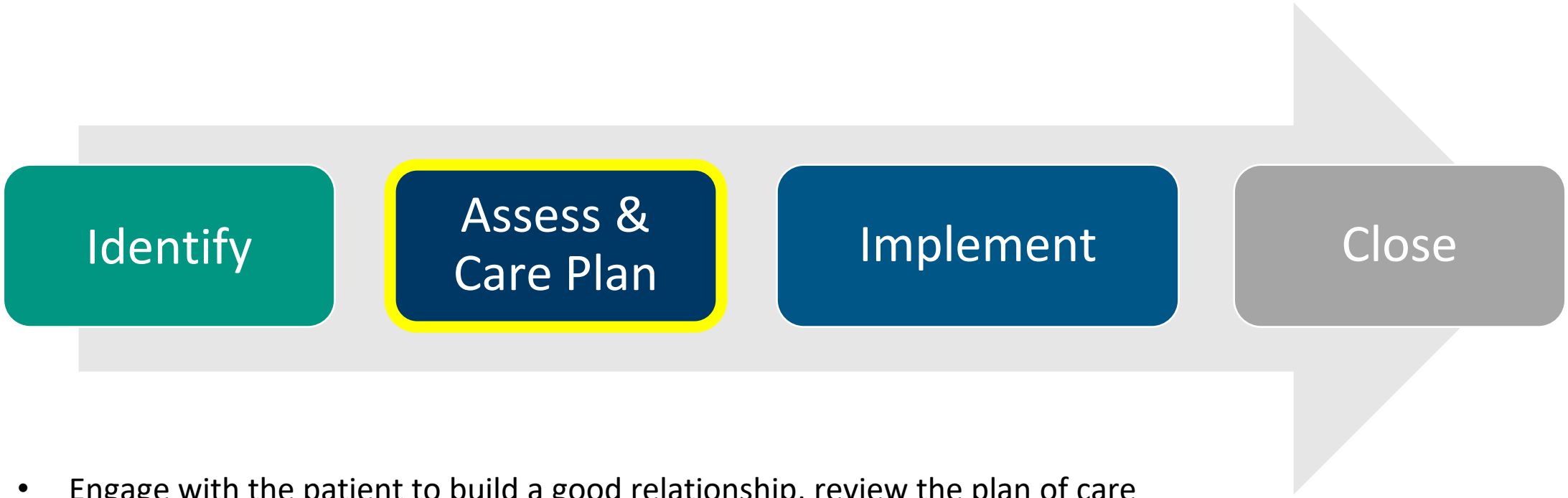
Risk Stratification



Key Takeaways

- Build a panel of patients that is related to the outcomes measures that indicate program success through:
  - Referrals
  - Proactive outreach through registry lists
  - ADT notifications to support transitions of care

Care Management Process



- Engage with the patient to build a good relationship, review the plan of care
- Review the Physical, Behavioral, Social characteristics of the patient, as well as the patient's desire to change
- Co-develop a plan of care that might include a Symptom Management plan
- Co-develop a Self-Management Action Plan with patient
- Determine the follow up plan

Engage the Patient for a Successful Assessment

- Use open-ended questions
- Demonstrate interest in the patient
- Active listening

Key Areas of Focus

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

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

Optional video: Dr. Lisa on the Streets

Patient Engagement

To learn more about Patient Engagement, sign up for the 1-day training
Other Resources/Webinars: MI Skill Building; MI Advanced Skill Building; MI in Team-Based Care: The Secret Weapon of Behavioral Change

Patient Assessment

The assessment provides patient context and supports co-development of the Plans of Care.

Review historical screenings, gather information from the provider or other care team members as possible, and talk with the patient to understand the patient's understanding of and situation with regards to their:

- Physical diagnoses
- Behavioral diagnoses or symptoms
- Social needs (Social Determinants of Health)
- Desire for change

Licensed Care Team Members can bill a G9001 for a Comprehensive Assessment.

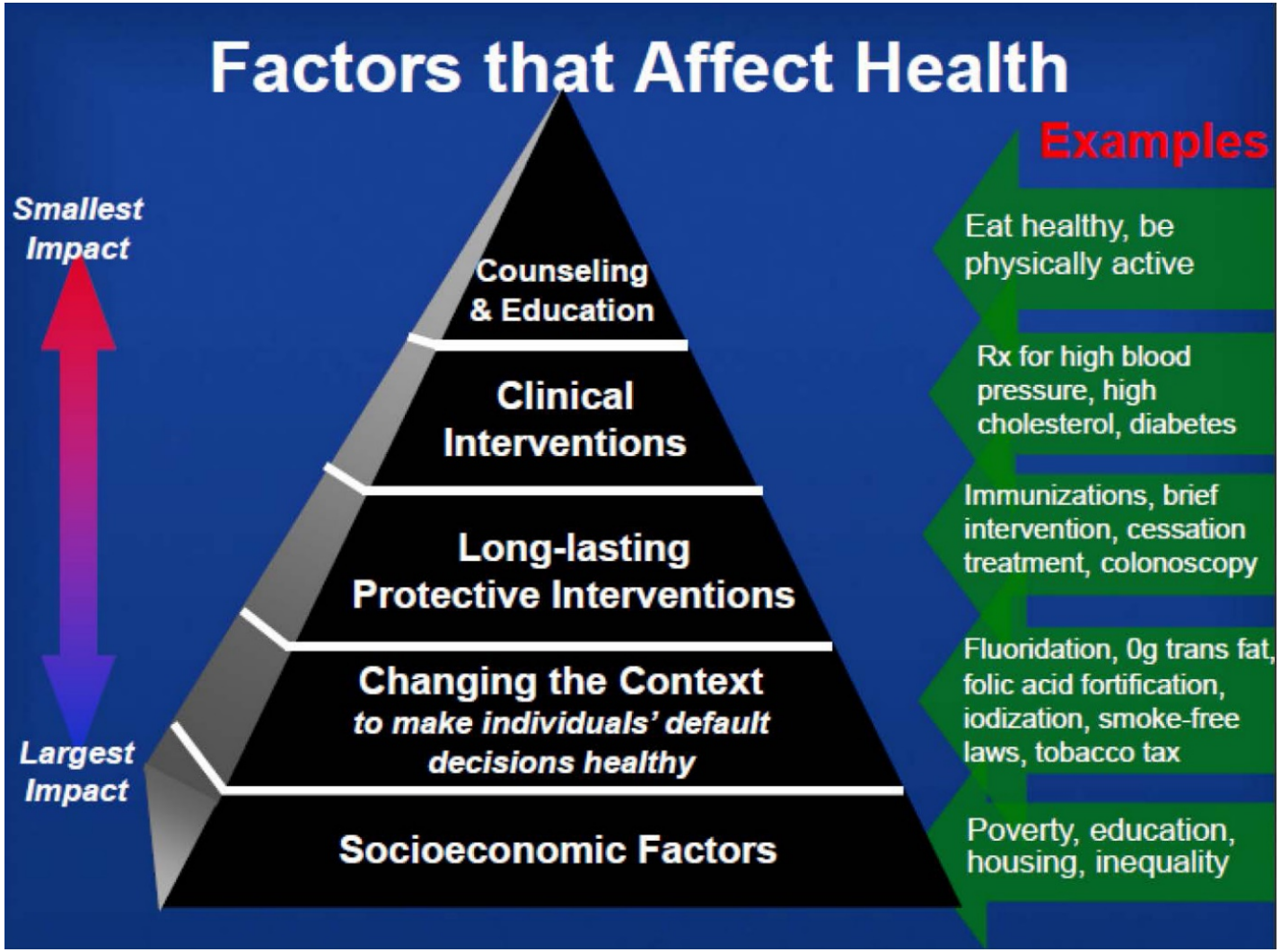
Assessment Elements for Plans of Care

Key Area of Focus	Screening tools/Methods
Physical • Clinical diagnoses, medications	• Identify the extended care team (specialists, PCP, etc) • Chronic conditions • Functional status • Utilization • Patient's risk score • Evaluate patient's understanding of his/her health • Medication Review
Behavioral • Behavioral health symptoms and/or diagnoses	• Behavioral health diagnoses and if the patient is working with a Behavioral Health Specialist • Substance Use (smoking, alcohol, controlled substances) • PHQ-9 • GAD-7 • Cognitive status
Social • Social Determinants of Health (SDoH), health literacy, family / community support	• Social Needs Assessment • Nutritional Status • What is the support level? Does the patient have a caregiver?
Patient or Caregiver's Ability / Desire • Desire and Ability • Active role within the team • Patient/Caregiver concerns, importance, priority, hope	• Discussion about ideal state / goals • Confidence in achieving goals • Review with the patient the visit activities and reasons for the visit • Determine the patient's readiness to set self-management action plan goals

Dr. Lisa on the Streets

https://www.youtube.com/watch?v=ThIKurq1oZg

Social Determinants of Health



Plans of Care

Care Plan Type	Definition	Example
Plan of Care	Clinical care plan that identifies the outcomes goals recommended by the care team. It includes the symptom management plan and the self-management action plan. A follow up plan with the care team is part of the Plan of Care.	Mrs. Brown comes into the office with shortness of breath. Peak flow is evaluated; respiratory assessment is done. Provider team develops a plan of care that includes follow up visits and care management visit on a weekly basis for a month. The patient is given an asthma action plan showing symptom management progression and appropriate actions to take if her asthma exacerbates. The patient discussed self-management goals with the care manager. Mrs. Brown's desire is to go walking again with a group of friends without discomfort from shortness of breath. She committed to using her medication regularly as a first step to being able to walk regularly again.
Symptom Management Plan	Identifies the appropriate next steps based on symptoms –i.e. when to use the emergency department, call the office, self-care.	From the above example: The Asthma Action Plan is the symptom management plan. It shows Mrs. Brown when to go to the ED, when to call the office, and when the symptom is something she can handle on her own with an inhaler.
Self-Management Action Plan	Small, usually life-style goals driven by the patient's desired outcomes. Can also include elements of the symptom management plan.	From the Plan of Care: Mrs. Brown committed to using her medication regularly.

Symptom Management Plan

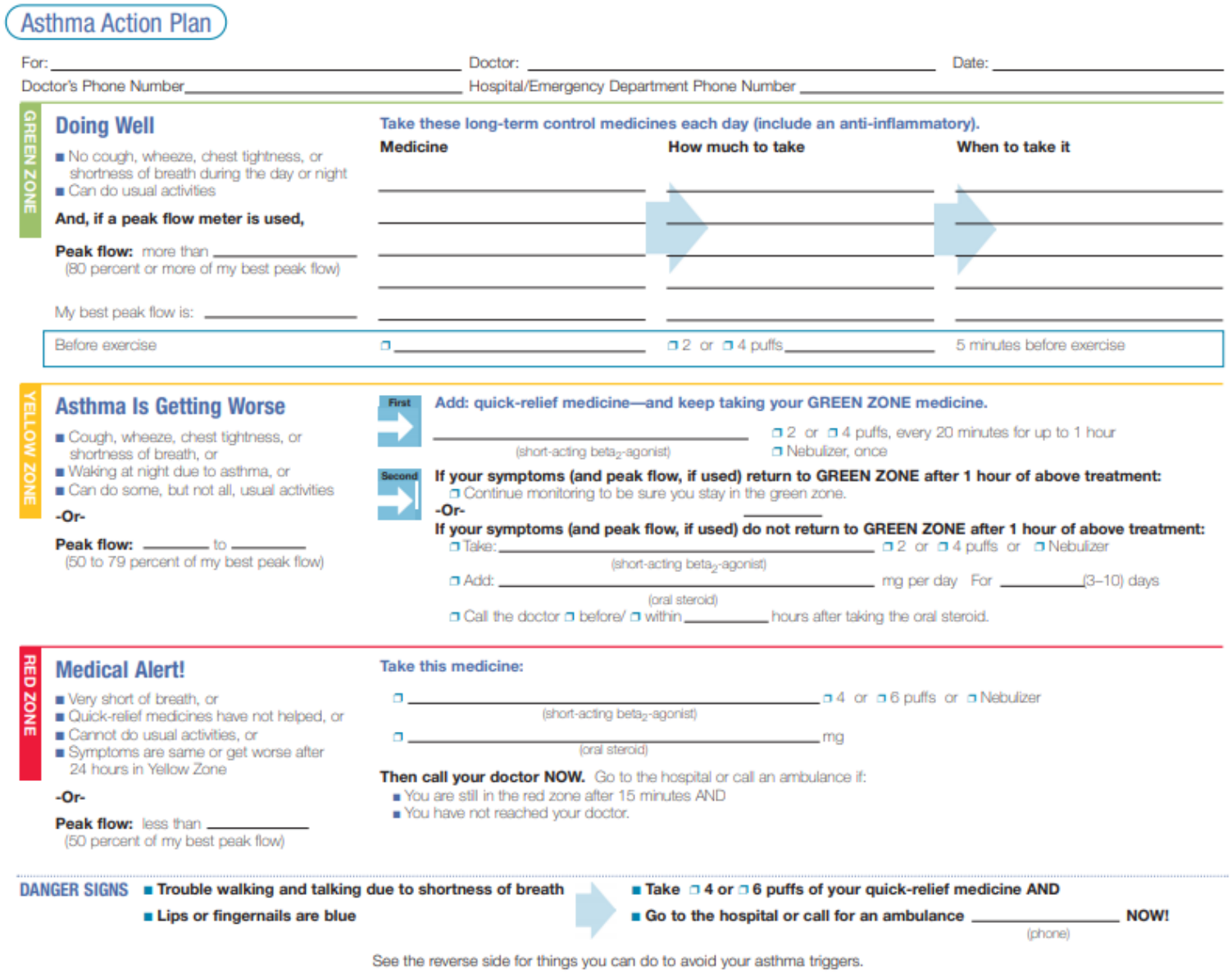
Helps patients recognize and monitor their symptoms:

- Assist patients in recognizing early symptoms with the goal of avoiding unnecessary utilization.
- Identifies the symptoms to be aware of and appropriate corresponding actions.

Frequently follows the ‘stoplight’ model:

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

Asthma Action Plan Example



Asthma Action Plan

For: _____ Doctor: _____ Date: _____

Doctor's Phone Number _____ Hospital/Emergency Department Phone Number _____

GREEN ZONE

Doing Well

- No cough, wheeze, chest tightness, or shortness of breath during the day or night
- Can do usual activities

And, if a peak flow meter is used,

Peak flow: more than _____
(80 percent or more of my best peak flow)

My best peak flow is: _____

Take these long-term control medicines each day (include an anti-inflammatory).

Medicine	How much to take	When to take it
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
Before exercise ❒ _____	❒ 2 or ❒ 4 puffs _____	5 minutes before exercise

YELLOW ZONE

Asthma Is Getting Worse

- Cough, wheeze, chest tightness, or shortness of breath, or
- Waking at night due to asthma, or
- Can do some, but not all, usual activities

-Or-

Peak flow: _____ to _____
(50 to 79 percent of my best peak flow)

First

Add: quick-relief medicine—and keep taking your GREEN ZONE medicine.

_____ (short-acting beta$_2$-agonist)
❒ 2 or ❒ 4 puffs, every 20 minutes for up to 1 hour
❒ Nebulizer, once

Second

If your symptoms (and peak flow, if used) return to GREEN ZONE after 1 hour of above treatment:
❒ Continue monitoring to be sure you stay in the green zone.

-Or-

If your symptoms (and peak flow, if used) do not return to GREEN ZONE after 1 hour of above treatment:
❒ Take: _____ (short-acting beta$_2$-agonist) ❒ 2 or ❒ 4 puffs or ❒ Nebulizer
❒ Add: _____ (oral steroid) mg per day For _____ (3–10) days
❒ Call the doctor ❒ before/ ❒ within _____ hours after taking the oral steroid.

RED ZONE

Medical Alert!

- Very short of breath, or
- Quick-relief medicines have not helped, or
- Cannot do usual activities, or
- Symptoms are same or get worse after 24 hours in Yellow Zone

-Or-

Peak flow: less than _____
(50 percent of my best peak flow)

Take this medicine:

❒ _____ (short-acting beta$_2$-agonist) ❒ 4 or ❒ 6 puffs or ❒ Nebulizer
❒ _____ (oral steroid) mg

Then call your doctor NOW. Go to the hospital or call an ambulance if:
- You are still in the red zone after 15 minutes AND
- You have not reached your doctor.

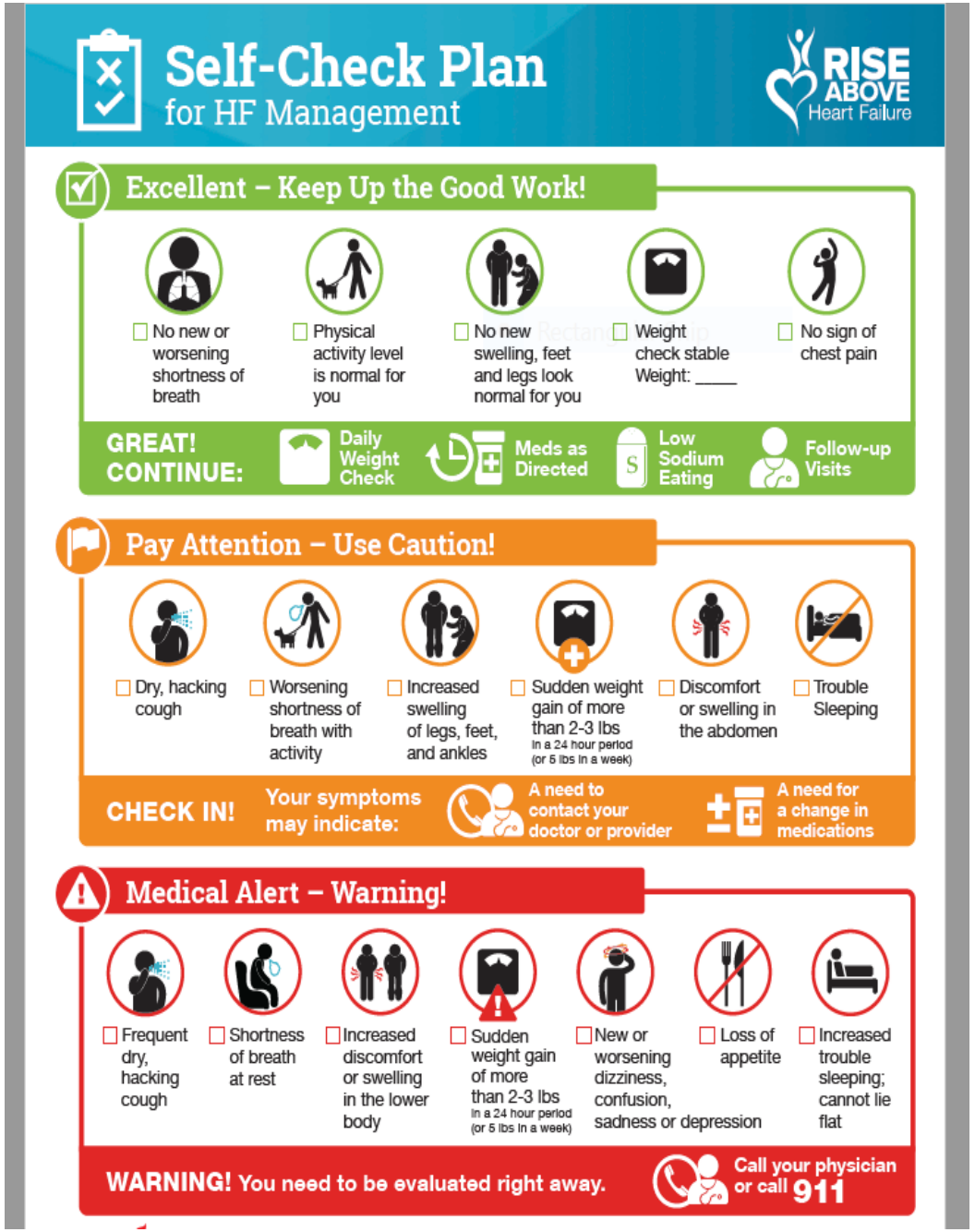
DANGER SIGNS
- **Trouble walking and talking due to shortness of breath**
- **Lips or fingernails are blue**

- **Take ❒ 4 or ❒ 6 puffs of your quick-relief medicine AND**
- **Go to the hospital or call for an ambulance _____ (phone) NOW!**

See the reverse side for things you can do to avoid your asthma triggers.

Emergency Room Utilization Symptom Management Plan

Heart Failure Symptom Management Plan

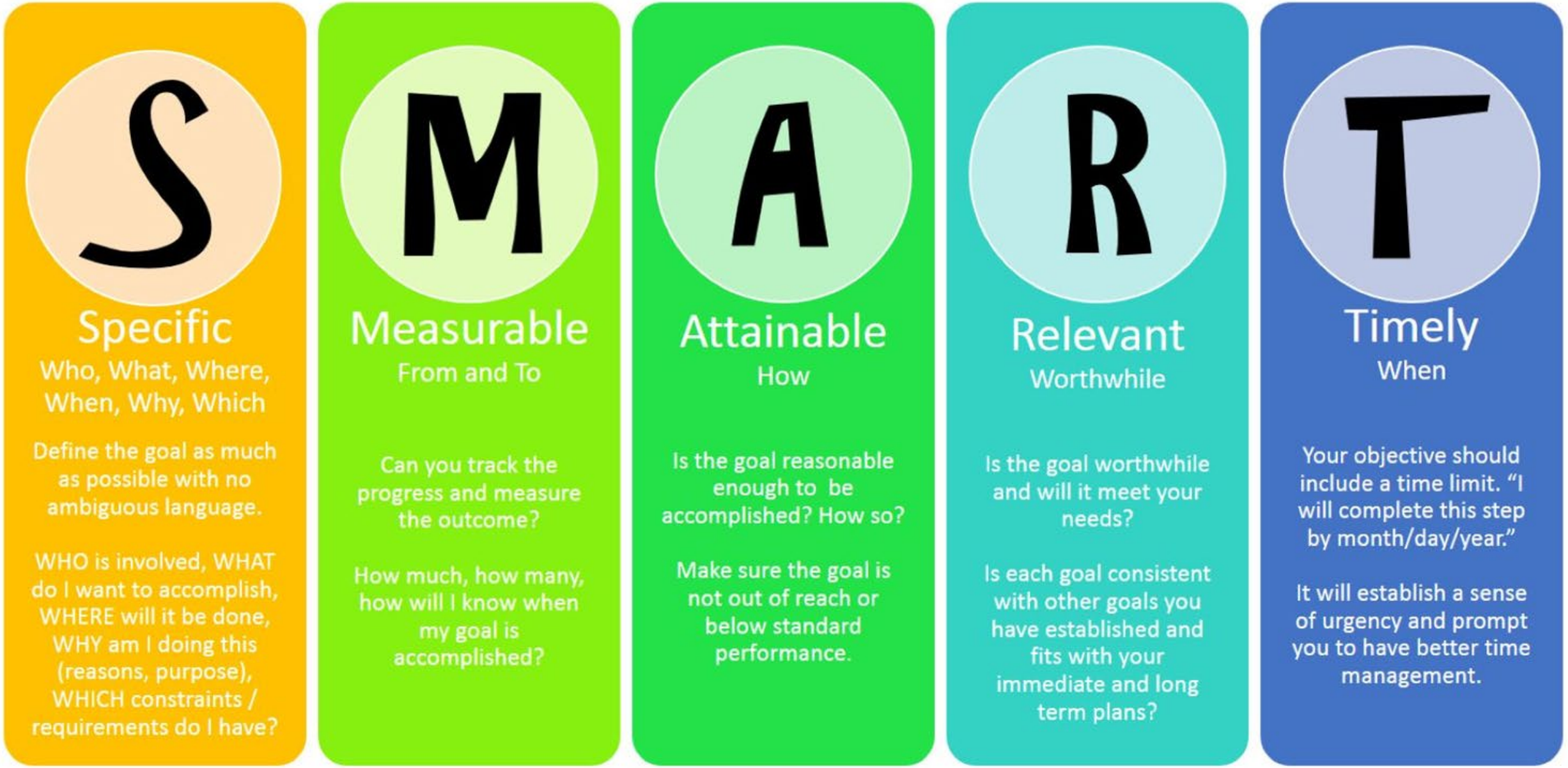


Self-Management Action Plan

- Supports the team-developed Care Plan
- Developed by the patient with support from the care team to set mutual goals and actions to support improved health outcomes.
- Should be reviewed and potentially revised at every visit.

Components can include

- SMART goals (developed with patient)
- Lifestyle changes
- Symptom Management Plan
- Medication Management
- Education and coaching to self-manage condition/health
- Planned interventions: tests, procedures
- Follow up plan (both planned visits with the provider and in-between visits with the care team)
- Coordination of care across settings: specialists, community


S
Specific
Who, What, Where, When, Why, Which
Define the goal as much as possible with no ambiguous language.
WHO is involved, WHAT do I want to accomplish, WHERE will it be done, WHY am I doing this (reasons, purpose), WHICH constraints / requirements do I have?
M
Measurable
From and To
Can you track the progress and measure the outcome?
How much, how many, how will I know when my goal is accomplished?
A
Attainable
How
Is the goal reasonable enough to be accomplished? How so?
Make sure the goal is not out of reach or below standard performance.
R
Relevant
Worthwhile
Is the goal worthwhile and will it meet your needs?
Is each goal consistent with other goals you have established and fits with your immediate and long term plans?
T
Timely
When
Your objective should include a time limit. "I will complete this step by month/day/year."
It will establish a sense of urgency and prompt you to have better time management.

Follow-Up and Next Interaction

The follow up plan is based on patient level of:

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

<u>Schedule the next interaction, whenever possible!</u>

Plans of Care: Communication Needs

- Plans of Care should be documented and shared in the EHR/patient record.
- Communication of the Plans of Care are also important across locations of care:
  - Verbally at huddles or with the provider in the office
  - Between PCPs and Specialists
  - With the patient and his/her caregivers (there may be multiple caregivers!)

Key Takeaways

- Assessment includes the following components:
  - Physical
  - Behavioral
  - Social
  - The patient's desire to change
- The assessment informs the patient's Plans of Care, which outline overall health goals, what the patient believes he/she can do to improve health outcomes and the follow up plan between the care team and the patient.

Care Management Process

- Implement the Plans of Care through scheduling follow up interactions, continuously re-assessing the patient's progress.

Reassessing when patients don’t meet goals… The patient’s needs drive the approach.

- Achieving targeted goals in the Plans of Care
- Not the right goals; refocus
- Not engaging
- Not progressing; identify barriers
- Transition to another level of care
- Different service or specialty

Assessing and Reassessing Goals for Success: When the patient's goals are not yet aligned with the clinical goals

Jon Broek, RD
Clinical Consultant for Medical Advantage TBC Group

“Guidance of the team reflects the needs of the patient”

- While the care team may have goals for the patient, it’s really the *patient* who decides the goals that they can and want to work on.
  - This frequently means the focus is on behavioral, not outcomes goals.
- Use a scale from 1-10 to measure the patients’ confidence in achieving the goal. Higher confidence = more likely to succeed!

Other Training Options and Strategies for Patient Engagement

Trainings / Courses

- Patient Engagement Course

Webinars

- Care Management Fundamentals: Motivational Interviewing Skill-Building
- Care Management Fundamentals: Motivational Interviewing Advanced Skill-Building
- Motivational Interviewing in Team-Based Care: The Secret Weapon of Behavioral Change

Resources

- Readiness Ruler
- Taking Care of my Health Action Plan

Key Takeaways

- Implementation of the Plans of Care involve:
  - A clearly outlined, hopefully pre-scheduled set of visits
  - Goal re-assessment at every visit
  - “Guidance of the team reflects the needs of the patient”

Care Management Process

- Close care management support when the patient seems able to maintain and is consistently achieving goals.
- Patients can re-enroll as necessary.

Reasons for Case Closure

Reasons for case closure and discharge from care management support:

- Patient can be managed by the clinic
- Patient can self-manage
- Patient has met his/her goals
- Patient can maintain a good current state
- Patient moves out of region/state
- Patient is admitted to hospice care
- Patient declines further services
- Patient expires

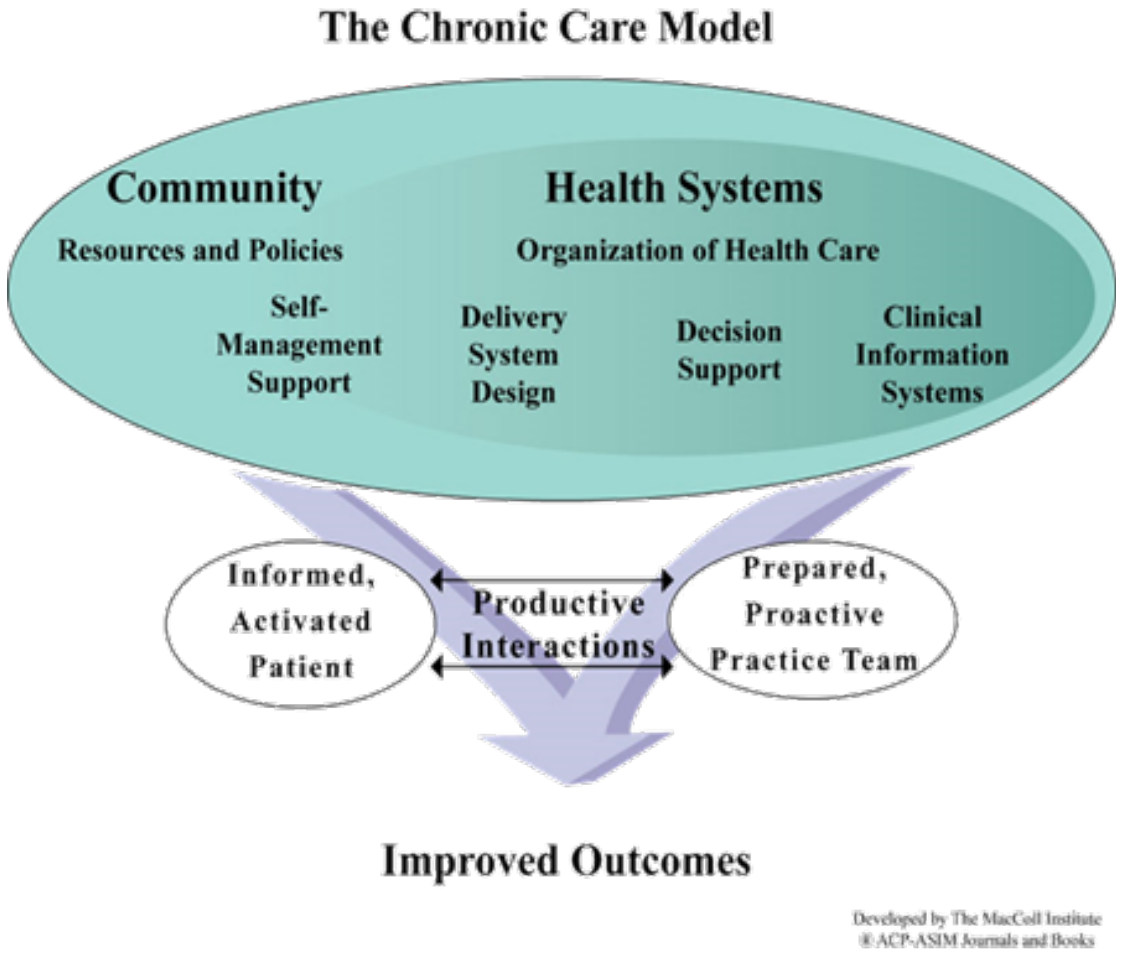
Discussion: What are other reasons?

Patient Can Self-Manage

"Informed and Activated Patient" was identified earlier in this course and is a critical component of the Chronic Care Model.

Practically, this means that the patient:

- Has the resources, knowledge to consistently manage his/her own care.
  - This might not mean perfection, but it does mean that the patient understands and has sufficient motivation to take care of themselves.
- Can problem-solve around their health care symptoms without needing additional guidance.
- Knows how to reach their care team for support as needed.



Communicating Case Closure

- Discuss case closure with provider and other members of the care team (both internal and external).
- Discuss with the patient.
  - Review the patient's journey: Lessons learned, goals achieved, symptom management plan.
  - Follow up 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.
- Review the ongoing support structure within the clinic and how the team will continue to support the patient, even if they're not specifically receiving care management support.

Post Case Closure

- Evaluate the impact of care management:
  - Did the patient get to target?
  - Lessons learned
  - Process improvement opportunities
  - Internal self-assessment for patient engagement skills

- How would patients be identified if they needed to be re-enrolled? (Keep the door open!)

Key Takeaways

- Close care management support when the patient seems able to self-manage and is consistently achieving goals.
- Evaluate performance for opportunities.
- Patients can re-enroll as necessary.

Care Management Process
Case Study: Mary

Case Study: Mary

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 has had 3 ER visits and 2 inpatient admissions. Yesterday, Mary was discharged from the hospital with a diagnosis of ketoacidosis. Mary is a widow and lives alone; her daughter lives nearby.

Additional background gleaned from conversations with Mary and her daughter:

- 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 her chronic conditions is limited; she doesn't understand appropriate symptom management or key behaviors to manage her health.

Case Study: Mary

Step 1: Identify

- What ways might you have received Mary as a referral to CM?
- Identify the team – who can help support Mary and how?

Case Study: Mary

Step 2: Assess & Care Plan

- Assess:
  - What are the pertinent Physical, Behavioral, Social characteristics of Mary's situation that would inform the Plans of Care?
  - What is Mary's desire for and ability to engage in change?
- Plans of Care:
  - Symptom Management Plan
  - Self-Management Action Plan Goals
  - Follow Up Plan

Case Study: Mary

Step 3: Implement

- Re-evaluate the Plans of Care:
  - Goals
  - Symptom management plan

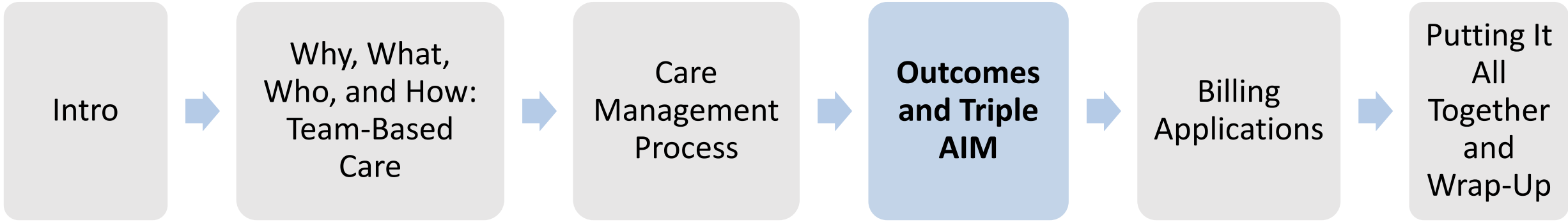
- Follow Up Visits
  - Is the patient engaging in follow up visits? Are they scheduled or ad hoc?

Case Study: Mary

Step 4: Close

- How do you evaluate whether or not Mary is able to self-manage?

Agenda


Intro
Why, What, Who, and How: Team-Based Care
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Outcomes Measures

- Better outcomes is part of the “Quadruple Aim”.
- Our primary objective is to help patients.
- Improving patient outcomes is why we practice in a team-based care model.
- Outcomes measures tell us if we have truly made a difference in patient care.

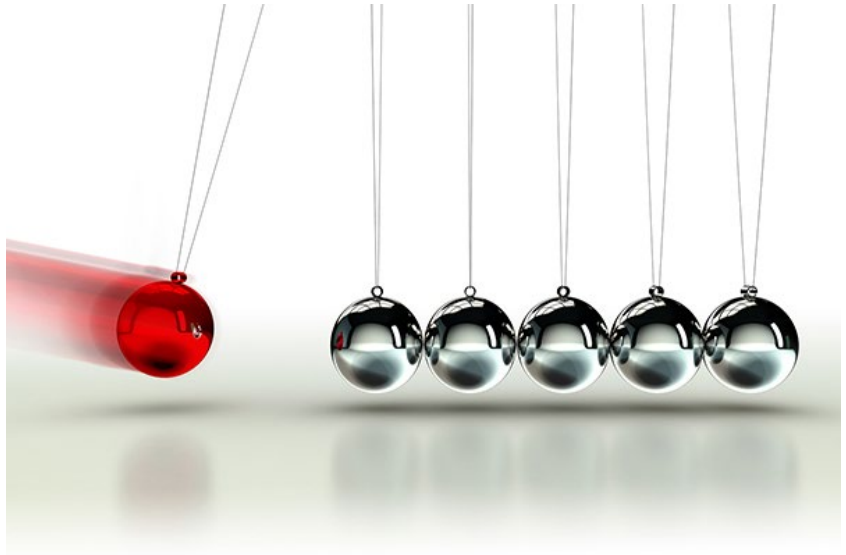
Quadruple Aim

Why: Connecting Heart

https://youtu.be/1ytFB8TrkTo

Impact of Unmet Outcomes

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



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: Michigan Quality Improvement Consortium (MQIC)

- The Michigan Quality Improvement Consortium (MQIC) is a diverse group of physicians, payers, researchers, quality improvement experts, and specialty societies.
- MQIC was formed to establish and implement consistent, evidence-based clinical practice guidelines and performance measures with a focus on improvement and positive health outcomes.

MQIC Guideline: Example

Michigan Quality Improvement Consortium Guideline
Management of Diabetes Mellitus

June 2015

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

Incentive Programs

BCBSM

Value Based Reimbursement (increase on every E&M code and PDCM code)

PDCM Touches – Tiered Model (measured at practice level) for attributed population:

- 4% with 2 touches = 5% VBR

Adult Outcomes VBR (measured at subPO level):

- HbA1c control
- Blood pressure control
- ED encounters
- Inpatient encounters

Pediatric Outcomes VBR (measured at subPO level):

- ED encounters
- Inpatient encounters
- Pediatric quality composite

- To be eligible to earn outcomes VBR, practices must meet 1% outreach with 2 touches
- 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!

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.

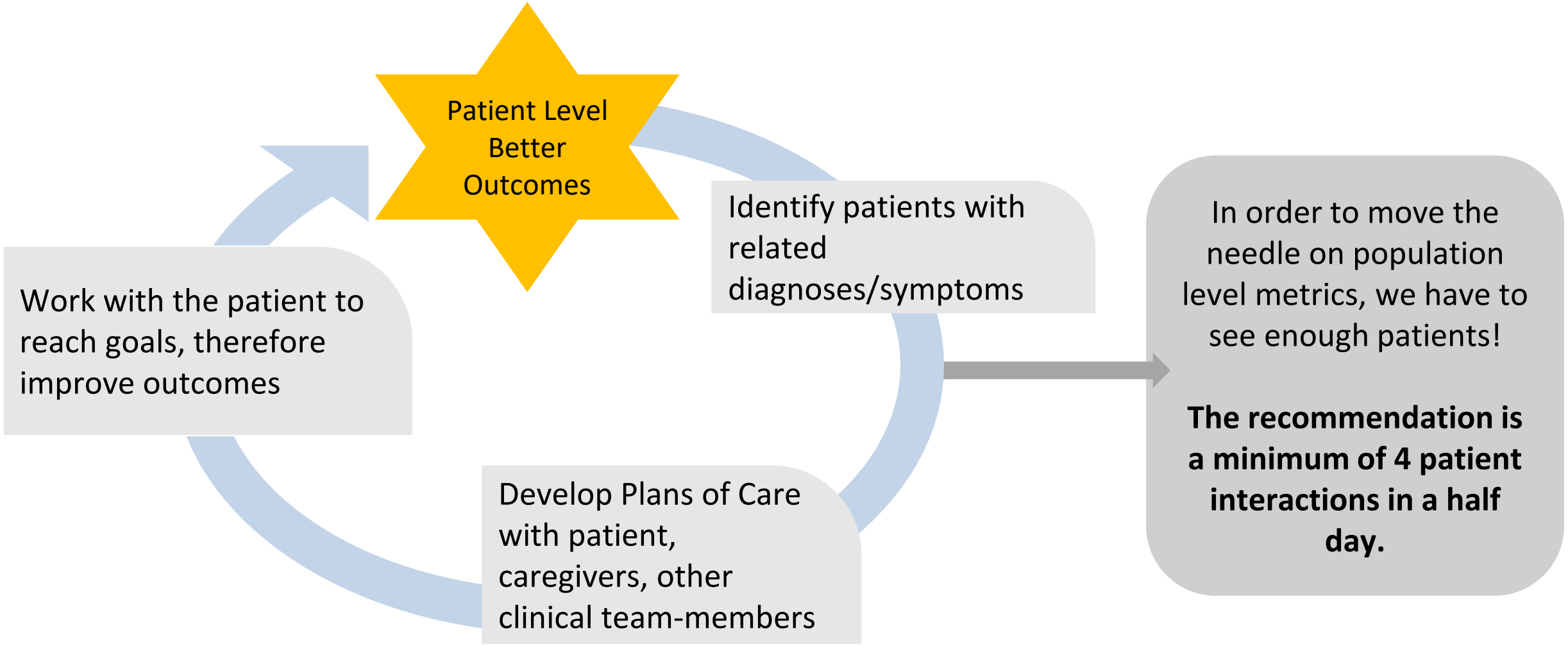
2021 BCBSM PDCM Outcomes VBR - Adult

Measure	Performance Threshold	Improvement Percent
ED Visits (per 1000 members per year)	171	10%
IP Discharges (per 1000 members per year)	35	10%
Comprehensive Diabetes Control: HbA1c < 8%	0.720	10%
High Blood Pressure **(<140/90 mm Hg for all adults age 18–64 with hypertension)**	0.771	10%

2021 BCBSM PDCM Outcomes VBR - Pediatric

Measure	Composite Measure	Performance Threshold	Improvement Percent
ED Visits (per 1000 members per year)	N/A	161	10%
IP Discharges (per 1000 members per year)	N/A	13	9%
Follow-Up After Emergency Department Visit for Mental Illness	PEDCOMP1	0.660	N/A
Follow-Up Care for Children Prescribed ADHD Medication - Continuation and Maintenance Phase	PEDCOMP1	0.570	N/A
Asthma Medication Ratio - 5 to 11 Ratio > 50%	PEDCOMP1	0.955	N/A
Asthma Medication Ratio - 12 to 17 Ratio > 50%	PEDCOMP1	0.930	N/A

Impacting Outcomes: It Takes Quality & Quantity



How can Care Team Members impact outcomes goals?

1. Know your outcomes and where the team is in achieving their goals.
2. Proactively engage with patients who would contribute to improvement in the measure.
3. Design a patient-centered process that supports timely and evidence-based care.

Tracking Quality to Evaluate 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 does your clinic track quality metrics?

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

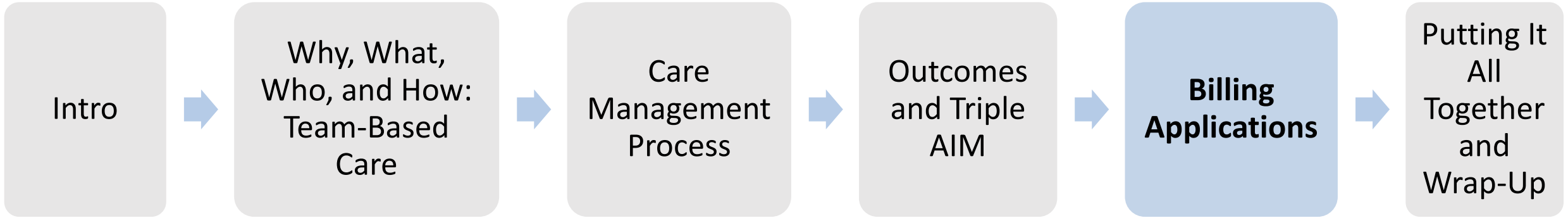
Patient-Centered, Evidence-Based Processes

- In all models of care, it's important to take an active interest in *how* we things to make sure we're providing consistent and effective care.
- The "PDSA" or Plan, Do, Study, Act model is a simple method of process improvement.

Key Takeaways

- Care teams can impact outcomes by using evidence-based care, productive interactions with patients and implementing the care management process.
- Adult and Pediatric populations have specific metrics that look at overall performance and improvement.
- Impacting outcomes requires sufficient numbers of productive interactions.

Agenda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Why is billing important?

- 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
    - Minimum of 4 on average per half day
    - Could include telephone, initial comprehensive assessments, or other virtual/face to face follow ups
  - Billing consistently for all billable services.

PDCM Procedure Codes

- G9001* - Coordinated Care Fee – Initial Assessment
- G9002* - Coordinated Care Fee – Maintenance or follow up (quantity billed >45 minutes)
- 98961* - Group Education 2–4 patients for 30 minutes (quantity billed)
- 98962* - Group Education 5–8 patients for 30 minutes (quantity billed)
- 98966* - Phone Services 5-10 minutes
- 98967* - Phone Services 11-20 minutes
- 98968* - Phone Services 21-30 minutes
- 99487* - Care Management Services 31-75 minutes per month (care coordination in the medical neighborhood)
- 99489* - Care Management Services, every additional 30 minutes per month (care coordination in the medical neighborhood)
- G9007* - Team Conference
- G9008* - Physician Coordinated Care Oversight Services (physician only service and can only be billed by the physician)
- S0257* - End of Life Counseling

Major Differences between Payers

BCBSM

- BCBSM removed the distinction between lead care managers and qualified health professionals – now they simply have “physicians” and “care team members”
  - 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.

Priority Health

- QHPs include:
  - RN
  - RD
  - MSW
  - LMSW
  - CDE
  - CAE
  - PA
  - NP
  - AE-C
  - Respiratory Therapist
  - Registered Dietitian Nutritionist
  - Master’s Level in Nutrition
  - Clinical Pharmacist

Major Differences between Payers (cont.)

G9001 (*NOT BILLIABLE BY PHYSICIAN)*
BCBSM: Billed per practice/per patient/per qualified licensed care team member
PH: Billed Annually only per qualified licensed care team member

G9008 (*BILLABLE BY PHYSICIAN ONLY)*
BCBSM: No quantity limit. Coordinated care delivered by physician and another care team member which can include but not limited to Paramedic, care-team member and/or another physician. Does not require patient to be involved.
PH: Limited one per practice/ per patient. Coordinated care delivered by a physician which must include patient and other care team member involved in oversight of services.

Billing Review: Video Examples

Role	Role Player	Affiliation
Patient	Tara Truax	Michigan Medicine/Complex Care Manager
Care Team Member (RN)	Stacey Thibault	Sterling Area Health Center
Medical Biller	Stephanie Gradowski	Sterling Area Health Center

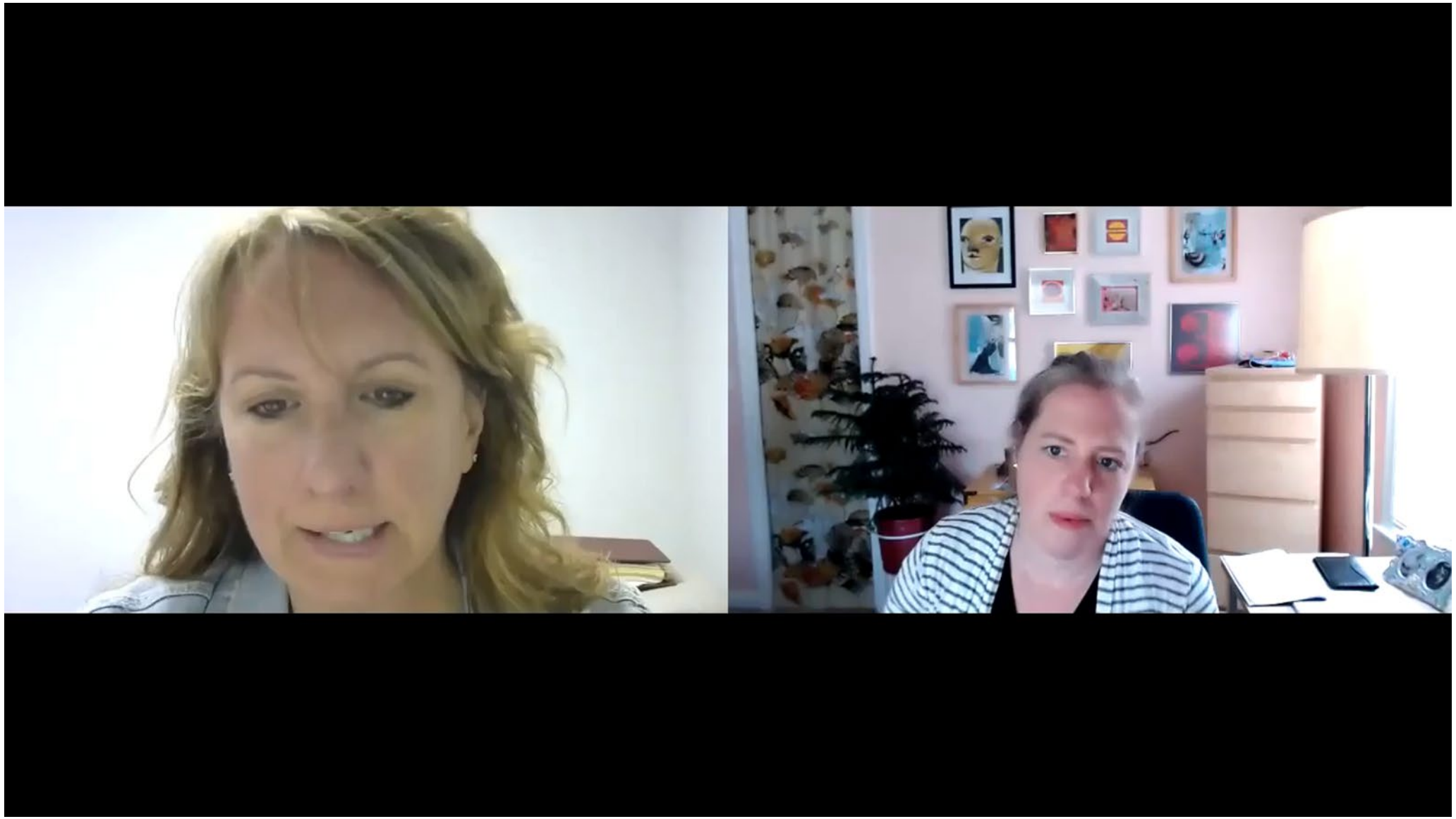
Case Study

Tara is a 43-year-old woman

- **Past Medical History:** Type 2 diabetes, depression, anxiety, hypertension, GERD, tobacco use, obesity
- **Social History:** recently divorced, has one school aged child, lives in an apartment with monthly rent and works full-time outside of the home
- **Current Needs:** dietary needs (pertinent to HTN & diabetes), has traditional BCBSM, her insulin and diabetic testing supplies are expensive with insufficient pharmacy coverage
- **Presenting to the PCP:** she has not been seen in the clinic in over a year, during that time she has presented to ED 6 times within the past 3 months

Current Medication List

- **Lantus** 55 units QPM
- **Metformin** 1000 mg BID
- **Novolog** 5 units TID with meals
- **Sertraline** 100 mg daily
- **Alprazolam** 0.5 mg daily prn
- **Bupropion** 300 mg daily
- **Metoprolol succinate** 100 mg daily
- **Trazodone** 50 mg QHS prn
- **Lisinopril** 20 mg daily
- **Ranitidine** 150 mg daily



Initial Outreach/ED Follow Up
Billing Code: 98967

Physician Interaction

Physician addresses:

- Frequent ED visits
- Gaps in Care
- Inquires about diabetes management

Physician orders:

- Mammogram, and flu shot for gaps in care
- Labs (for diabetes)

Physician refers:

- Social Worker to discuss anxiety and depression
- RN for care coordination, care management, and Plans of Care adherence

Physician Interaction Outcomes

Based on complexity of needs, Physician would like to involve the clinic care manager to continue the visit so patient does not need to come back at another time (and reduce the number of times she has to come to the office).

"I'd like to enroll you in our CM program. I'd also like you to see our social worker. It sounds like you have a lot that may be distracting you from your health."

Physician Interaction
Billing Code: G9008

RN/Patient Interaction
Billing code: G9002
30 minutes

Social Worker Interaction
Billing Code: G9002
Same Day, Quantity Bill
30 minutes

RN/LMSW Care Coordination

RN addresses:

- Contacts DME provider to assist with obtaining new supplies – Glucometer
- Inquires about diabetic education class
- Discussion with dietician

LMSW coordination of services

- Community resources: contacting agencies for assistance with child care
- Behavioral health referral: coordinating appointment
- Connecting with legal aid

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.

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.

Identify the code:
98968 BCBSM

Gaps in Care

- 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.

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.

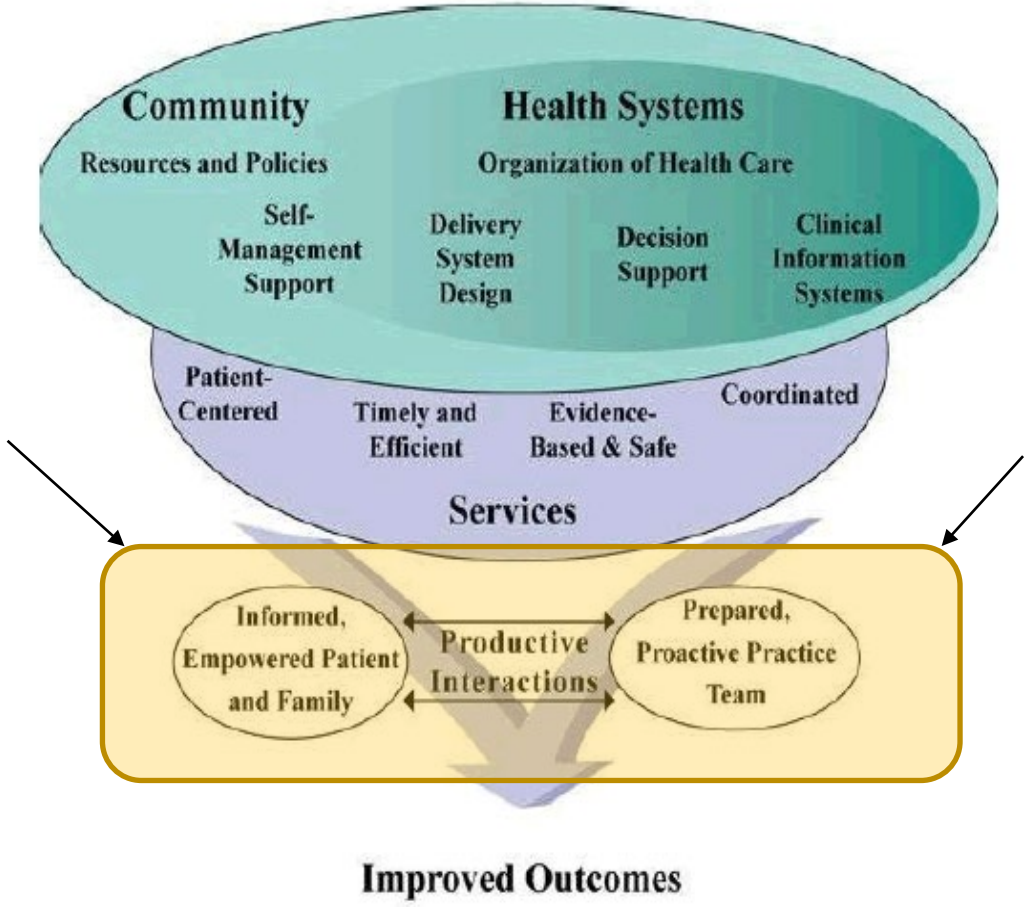
Identify the codes:
3 patients 98961
6 patients 98962

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.

Productive Interactions, Outcomes, and Sustainability

Many productive interactions with individual patients will lead to improved outcomes that can be measured at a *population level.*



Productive interactions are also *billable* interactions, which supports the sustainability of the care management program through payments and successful incentive program participation.

Frequent Asked Questions

Q: How can I get reimbursed for time spent coordinating services with other providers/services (i.e., home health, specialty offices, community resources, etc.)?
A: When providing non-face-to-face clinical coordination with the patient centered medical neighborhood, a care team member can add up time spent within a calendar month and bill using codes: 99487 and 99489.

Q: Do Z codes count as primary diagnoses?
A: Yes

Q: Can a care team member bill if the initial assessment was completed and a patient declines services?
A: A provider may bill once per condition, per year when a PDCM program is discussed with a patient and patient declines engagement.

Q: Can a care team member bill for advance care planning conversations?
A: Yes, care team members who complete end of life (advance care planning) conversations with either the patient or “surrogate” can bill S0257.

Q: Can care management services be billed the same day the patient sees the physician?
A: Yes

Q: Can care management services be provided and billed virtually?
A: Yes, services identified as virtual may require GT modifier.

Agenda

Intro → Why, What, Who, and How: Team-Based Care → Care Management Process → Outcomes and Triple AIM → Billing Applications → **Putting It All Together and Wrap-Up**

What have we discussed?

We have covered four main topics:

1. The why, what, who, and how of successful team-based care.
2. The care management process: how to identify, assess and collaboratively create a plan of care, how to implement that plan of care, and how to close out a patient.
3. Outcome measures and how the care team member can improve the measures.
4. The importance and application of billing codes.

Learning Objectives

1. Define the team-based model of care.
2. Explain how the team-based care model improves patient outcomes.
3. Identify how to apply these concepts in clinics when acting in the role of a care team member.
4. Define key components of the care management process and the impact on the effectiveness of team-based care.
5. Describe how team-based care can impact outcome measures.
6. Demonstrate the selection of appropriate billing codes for daily care team activities to promote sustainability.
7. Examine opportunities to integrate concepts of team-based care into your own clinical practice.

What, if anything, will change with your elevator speech?

Have we covered what you defined as your learning goals for the day?

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

Recommended Next Steps:

Ask your practice:

- Does your practice conduct virtual and telehealth visits?
- What screening tools does your practice use?
- What clinical guidelines is the practice following?
- What outcome measures are your practice's area of focus?
- What role do you play in ensuring the metrics are being met?
- Can you shadow your team members?

Set yourself up for success:

- 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

What's Next – Additional Training Opportunities

- **Patient Engagement Training**: learn how to use evidence based motivational interviewing and self-management support skills to engage with patients. This training is reimbursable to your affiliated Physician Organization.
- **CM Fundamentals MICMT Webinar Series**: participate in monthly on-going educational webinars for care management teams new to their role by addressing topics relevant to their daily work.
- **General MICMT Webinar Series**: participate in multiple monthly webinars on various topics.

MICMT webinars are free of charge and recorded/posted to the MICMT website.
Feel free to send MICMT your ideas at micmt-requests@med.umich.edu.

For additional information on the Training Framework and Training Opportunities

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.

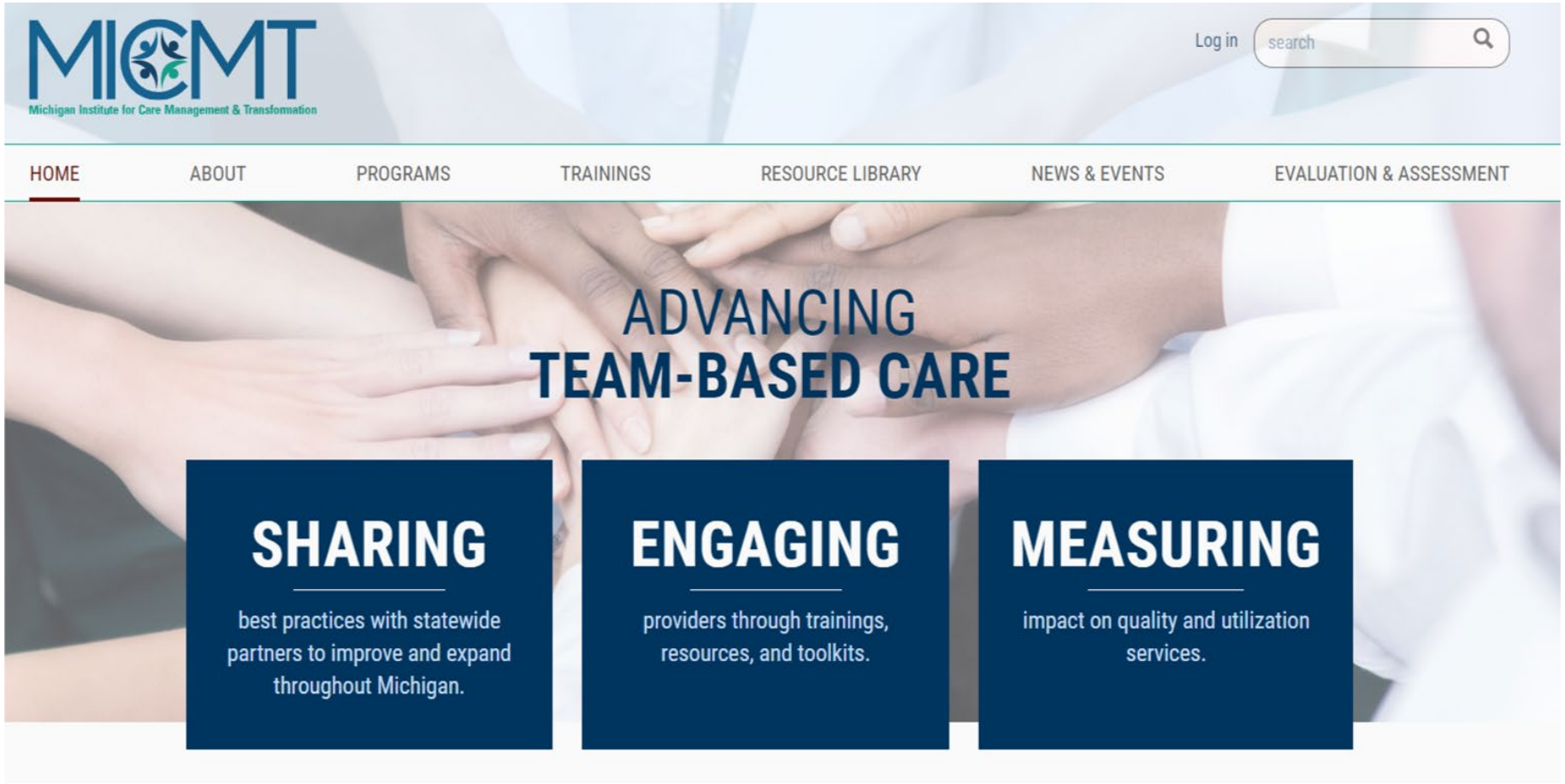
Contact Us

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
  - Chronic Care Management
  - Behavioral Health Integration