The Michigan Primary Care Transformation (MiPCT) Project

Moderate Care Management:
Series 1 / 3

Maureen Koval, RN
Rose Seavolt, RN, BSN, CCP

Moderate Care Management Part I Objectives

- Describe the MiPCT Model and population management
- Identify the Care Management 5 step process
- Describe the activities for Moderate Care Management related to referral, screening and enrollment
- Identify strategies to use the MiPCT patient list to identify potential patients for moderate care management

Care Management Activity

Care Manager Caseload Development:

- Care Manager role HCM, CCM, MCM
- MiPCT Model = Population Health
- MiPCT List – identify patients
  - Risk score and PCP recommendation
- Patient Caseload
  - Hybrid Care manager caseload - must include both Moderate and Complex patients
  - *Impact patients within all MiPCT Payers*
    - *BCBSM, BCN, BCBSM Medicare Advantage, Medicare, Medicaid*

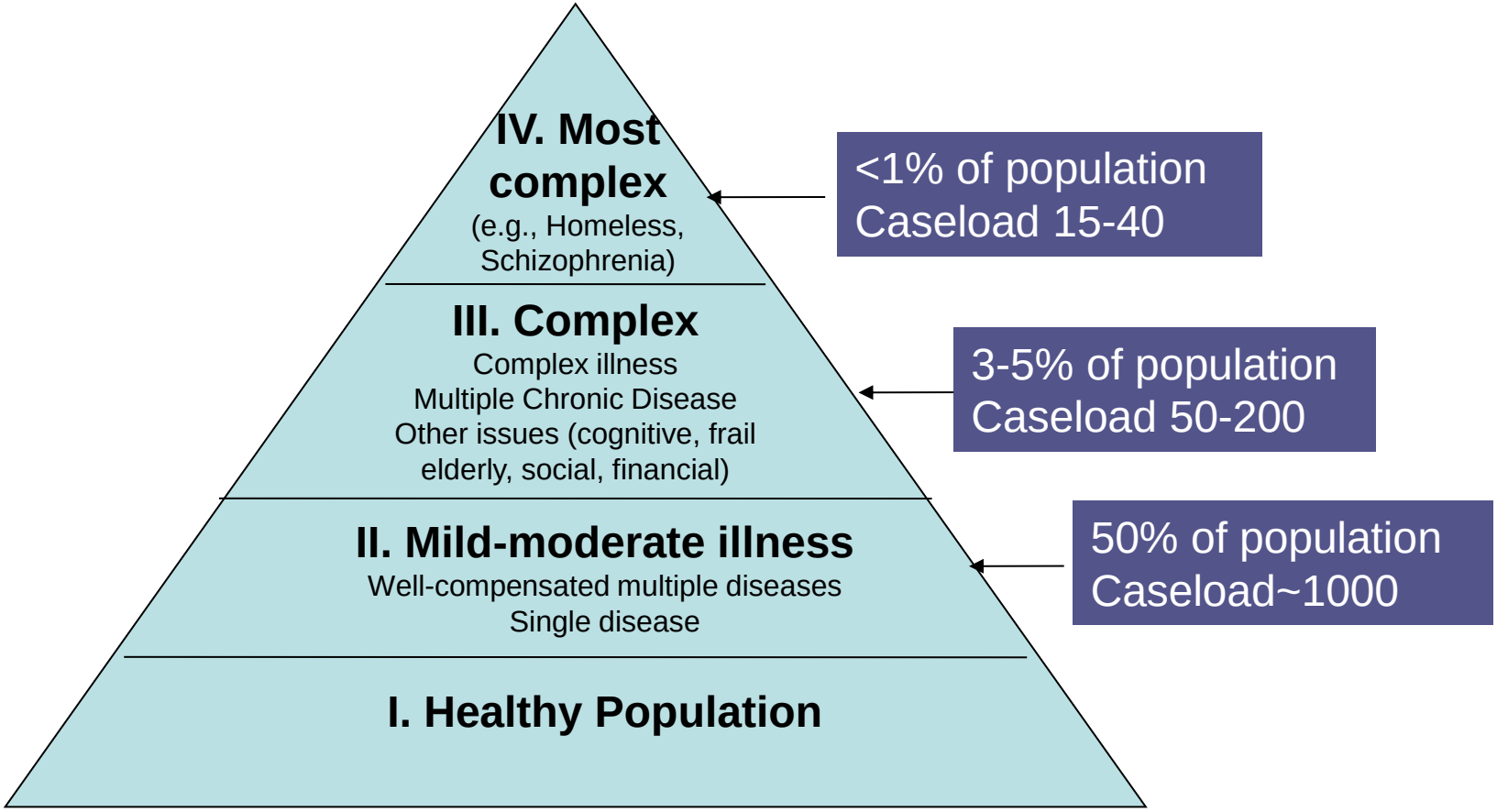
HIGH priority Building Your Caseload

- Moderate Care Management Caseload
  - One MCM per 5,000 patients
  - Case Load: 500 -1000
  - Active patients: 90-100

- Hybrid care manager case mix:
  - 60% Complex and 40% Moderate
  - This ratio of Complex and Moderate risk individuals in your caseload should match your patient population

MiPCT Clinical Model: Optimizing Patient Engagement, Improving Population Health

Managing Populations: Stratified approach to patient care and care management



Michigan Primary Care Transformation Project
Advancing Population Management

PCMH Services

Complex Care Management ***Functional Tier 4***	All Tier 1-2-3 services plus: ▪ Home care team ▪ Comprehensive care plan ▪ Palliative and end-of life care
Care Management ***Functional Tier 3***	All Tier 1-2 services plus: ▪ Planned visits to optimize chronic conditions ▪ Self-management support ▪ Patient education ▪ Advance directives
Transition Care ***Functional Tier 2***	All Tier 1 services plus: ▪ Notification of admit/discharge ▪ PCP and/or specialist follow-up ▪ Medication reconciliation
Navigating the Medical Neighborhood ***Functional Tier 1***	▪ Optimize relationships with specialists and hospitals ▪ Coordinate referrals and tests ▪ Link to community resources

Prepared Proactive Healthcare Team
Engaging, Informing and Activating Patients

PCMH Infrastructure

Health IT
- Registry / EHR registry functionality *
- Care management documentation *
- E-prescribing (optional)
- Patient portal (advanced/optional)
- Community portal/HIE (adv/optional)
- Home monitoring (advanced/optional)

Patient Access
- 24/7 access to decision-maker *
- 30% open access slots *
- Extended hours *
- Group visits (advanced/optional)
- Electronic visits (advanced/optional)

Infrastructure Support
- PO/PHO and practice determine optimal balance of shared support
- Patient risk assessment
- Population stratification
- Clinical metrics reporting

*denotes requirement by end of year 1

P O P U L A T I O N M A N A G E M E N T

Focus of Moderate Care Management

Proactive Population Management:

1. Optimize control of chronic conditions
2. Prevent and/or minimize long term complications

- Moderate risk patients may have newly diagnosed chronic condition
- Poorly controlled chronic condition
- Be at a state of readiness to actively engage in self-management

Care Management
5 Step Process

1. Identification
    - Referral
    - MiPCT patient lists
    - Self referral
    - Discharge/admission/ER list (Transitions of care)
    - Gaps reports from practice
2. Screening
    - Criteria that indicate a patient is appropriate for care management
3. Enrollment
4. Management
5. Case Closure

1. Patient Identification

- MiPCT list
  - Eligibility
  - Risk scores
  - Chronic diseases
  - ED visits
  - Pharmaceuticals
- PCP Referrals
- Healthcare team members
- Self Referrals
- Use of Registry

MiPCT list – Key Elements:

Provided by PO's

- Pertinent elements include:
  - Pt. Name
  - DOB, Age
  - Gender
  - Payer

- Additional elements for identification of Moderate Care Patients include:
  - Risk Scores
  - ED visits
  - IP stays
  - Pharmaceuticals
  - Chronic Disease(s)

MiPCT list- “Working it”

1. Save document in different name → keeps original intact
2. Viewing data – widen columns or deepen cell heights
3. Freeze Panes - Header
4. Manipulate the list for:
   - Payer group
   - IP & ED visits
   - Risk scores
   - Number of disease conditions
   - Disease Diagnosis
   - Number of Pharmaceuticals, etc.

Common Moderate Care Chronic Conditions

- Diabetes
- Asthma

http://mipctdemo.files.wordpress.com/2011/09/mipct-clinical-metrics-updated-12-10-12.pdf

- Hypertension
- Obesity

Registry ?

- The main purpose of a registry is to assist physicians and office staff in providing evidence based care for patients
  - Identifies the presence of standards of care for preventive services and management of chronic conditions
- Some specific functions that registries provide include:
  - Printable patient reports
  - Exception reports
    - ❑ Preventive measures
    - ❑ Gaps in care
  - Identification of focused patient populations
    - ❑ Specific chronic diseases
    - ❑ Labs outside of goal range

http://www.hrsa.gov/healthit/toolbox/HealthITAdoptiontoolbox/EvaluatingOptimizingandSustaining/diseaseregistry.html

Use of Registry:

- Identify patients with common disease conditions
- Gaps in care – per evidence based guidelines
  - Schedule f/u appt
  - Obtain needed diagnostic tests
  - Uncontrolled disease state – labs outside of goal range

Registry Requirements

- MiPCT practices were required to have an “all payer” and “all patient” registry by the end of 2012.

ADT's:

- Admission lists
- Hospital d/c lists
- ED visits

Difference between CCM & MCM usage of ADT information:

CCM:

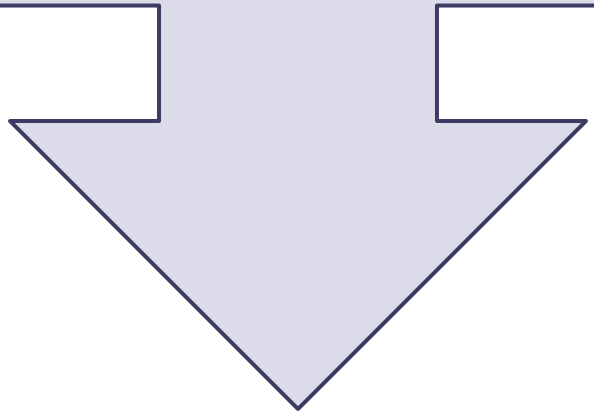
- Identify pts in need of TOC management.

MCM / Hybrid:

- Uncontrolled disease state
- Assess Self-management readiness
- Evaluate need of a “warm hand-off” to the CCM.

2. Screening

- Review medical record
- Claims history
- Clinical condition
- Resource utilization
- Registry
- PCP recommendation



3. Enrollment

- Assessment – demonstrates ongoing need for management of care path
  - Assess and identify barriers to treatment plan
  - Willingness to engage in self-management
- PCP in agreement
- Consents to participate – verbally or written
- Document enrollment date, consent by whom and date, and CM signature

MiPCT: Care Management

MiPCT Care Managers

- Moderate Care Managers =81
- Hybrid Care Managers = 182
- Complex Care Managers = 81
- No Role Identified = 11
- Total Care Managers = 368

Care Management Activity

Care Manager Caseload Development:

- Care Manager role HCM, CCM, MCM
- MiPCT Model = Population Health
- MiPCT List – identify patients
  - Risk score and PCP recommendation
- Patient Caseload
  - Hybrid Care manager caseload - must include both Moderate and Complex patients
  - *Impact patients within all MiPCT Payers*
    - *BCBSM, BCN, BCBSM Medicare Advantage, Medicare, Medicaid*

BCBSM & BCN patients

- Patient profile is different from Medicaid and Medicare population.

- Common differences may include:
  - Financial status varies
  - May have fewer transportation issues
  - May or may not have higher literacy rate
  - May have higher functional level for ADL's
  - Support systems may be greater
  - Many are working
  - IT savvy
  - Accessibility to the PCP office outside of "normal" working hours

Challenges:

- Reaching them via phone
- Realization of need to Self-manage a disease condition or accept CM services as they are “healthy”
  - Working
  - Living life “fully”
- IT savvy – self diagnose, use websites that are not evidence based for information and management info
- Methods of communication vary

Suggestions:

Reaching the pt:

- Extended phone hrs. 2-3 days/wk
- LVM-be available for return call during the pts. lunch period or break
- Send a letter with dates and times of availability for patient to choose when to return the call
- Keep call brief and focused initially

Engaging with patient:

- Discuss out of goal range lab / diagnostic not completed
  - Avoid progression of disease process when managed early
- Ability to reduce out-of-pocket costs by working towards getting off medications
- Decrease time away from work for medical appts. when condition is stable
- Decrease sick days, improve performance and quality of daily living.
- Impact on later years and quality of life during this time
- Work in collaboration with your PCP. CM is able to provide more interactive time with patient.

Questions ?

Discussion ?