PCMH User Group Highlights 04/26/16

Slides from presentations and handouts (if applicable) are attached to email and on website (slides and highlights under PCMH User Group)

April 26, Tuesday

Care Management panel consists of:

- Carrie Minto, Cherry Bend
- Lauren Fine, West Front Primary Care
- Cherie Bostwick, Munson Family Practice
- Tara Stone, Northern Pines

Questions about Care Management:

- *How long has the practice been providing care management? How long have you been in this role*?
    - Most of these practices are just getting started with Care Management. West Front, as a MiPCT practice, has been providing CM for a few years and has many Care Managers.
- *How many hours per week do you provide care management?*
    - Depending upon the size of the practice and their additional roles within the practice, CMs may work between 10 and 40 hours/week.
- *Please describe the process in your practice: How are patients identified as needing care management? What type of patients?*
    - In most practices, patients are identified by the physician in a regular office visit. Some CMs perform research to identify patients that may benefit from CM. Patients that seem to benefit the most, include but are not limited to:
        - DM with impaired fasting glucose
        - Elderly patients who have suffered from a stroke
        - Patients struggling with obesity.
    - MFPC is training residents to use CM for their own practices.
- *How is the initial contact made with the patient?*
    - A warm hand off is done in the office by all practices when possible and is preferred.
    - West Front's sample script is included in the email – West Front says it takes about 2 minutes to get through.
- *What does the first encounter with the patient look like?*
    - This initial visit with the patient usually takes a full hour and is face to face.
    - A full comprehensive assessment is completed
    - CM service is explained to the patient
    - Any questions patient may have are answered
    - Health-care goals are created.
- *What happens next with the patient? Visits? Calls?*

- For most practices, at the time the patient is identified as being a candidate for CM and has gone through the warm handoff, the patient is often scheduled to return for a face to face visit, if possible.
- Follow-up phone calls and subsequent office visits may be made afterwards, as appropriate.
- Calls can be made at 1-2 week intervals. The patient can be advised to call the CM if desired.
- Helpful to start identifying criteria for closure, too.

- *What is documented in the EMR by whom and how often?*
  - For most practices, most documentation is done in the EMR by the CM.
  - Visit notes are documented after each visit.
  - Some CMs choose not to document while in the room with the patient, as they feel that this would take away focus from the patient. Their documentation is then completed at the end of the day.
  - Most practices have created their own template tailored to their individual practice.
  - Sample template included in email.
- *How and how often is physician updated/consulted?*
  - Most CMs state they update the physicians at every visit. Notes are routed to the physician and the physician signs off on them.
- *How long is a patient in CM? How is CM ended?*
  - Since this is so new for many practices, most have had just one person complete the process. It is certainly very individualized due to the patient needs/desires.
- *What does your average day look like? How many patients seen? Called?*
  - At one practice, where the CM also performs physicals and acute visits, CM patients are mixed in at about 5-6 a day. Larger practices may see more than that on an average day.
- *How many patients are actively in CM at a time?*
  - Between 33 and 72, at this time, depending on the size of the practice.
- *What resources (community, personal) do you see patients need most?*
  - Nutrition Guidance
  - Area on Aging
  - Commission on Aging
  - Transportation services
  - DM support (use the MiPlate educational resources)
  - Housing assistance (VA can assist)
  - GoodRx (and other medication assistance tools)
- *Which payers are being billed? Is the Medicare TCM being used?*
  - Payers being billed include: BCBSM, PH, Meridian.
  - Some practices are using Medicare TCM and some are not, at this time.
  - One CM will refer a patient to the payer CM if payer does not pay for CM after initially taking care of any emergent needs.
- *What has been your most gratifying success story? Some stories were:*
  - One practice had a girl struggling with weight loss and keeping it off. This patient had multiple co-morbidities keeping her from moving forward. After working with her for approximately six months, she was able to lose 30 lbs. The patient now uses less pain medication and has less frequent pain flare ups. She is able to cope with her pain much more effectively. The patient now understands that it is a lifetime behavioral change. She now speaks in terms of enjoying the

journey. Her family is also on board and she doesn't let things get in the way of working for her goal.

- Another practice had a patient that suffered from a lot of stress and anxiety. The CM began asking the patient questions about what she used to do in her free time that made her feel relaxed and joyful. The patient remembered that she really used to enjoy painting. The CM suggested she start painting again. At the patients' next visit, the patient brought in a painting that she had done and expressed how much better she felt when she was painting.
- A patient, in another practice, was noted to have improvement with her Diabetes A1c control due to DM management education and reinforcement through CM services. Food choices were a major issue (lots of carbs) and required meal planning and food education. MiPlate was a resource used.
- A patient was found to be "couch surfing", and due to a lack of life stability, ending up in the ED almost weekly. This patient is a veteran; the CM accessed housing assistance resources and the VA for assistance. This patient has now moved into an apartment and has reduced ED visits; without CM, he would still be "couch surfing" and frequently in and out the ED.
- A male patient was very ill, having multiple chronic conditions, including obstructive sleep apnea. Initially, he was very hard to communicate with as he would fall asleep during conversations. The patient had piles of mail that he was unable to sort through on his own. Through CM, patient started coming to the Dr regularly. He was offered assistance with sorting through his mail, etc. The pt. was able to become more compliant with his care. He can now have a full conversation, is more coherent in his though processes and is appreciative that someone cared enough to help. He has dropped 100 lbs. and is functioning at a much better level.

- *In a perfect world, what would you like to see? (This is a chance to throw that wild idea out there!)*
  - In an ideal world, it would be nice if patients were not limited by their insurance, and that CM was offered for all patients. Payer consistency would be nice.
  - Fewer criterions required for utilizing community resources.
- *The CMs were asked how they work to ensure quality gaps are closed for patients in CM.*
  - Chart prep can be done to flag gaps. Some EMRs have gaps as easily identifiable. Gap closure can be included and is being included in some CM's work.

2016 Meeting Dates – all meetings from 11:30 AM – 1PM:

- May 25, Wednesday
  - Heather Gould and Kathy Sterling from West Front will share how their pod system is working and the details of their "meet and greet" process with new patients.
- August 25, Thursday
- Sept 29, Thursday
- October 26, Wednesday

PLEASE NOTE: If you plan to attend the next meeting either in-person or telephonically, please either email kelliott@npoinc.org or call NPO at 231-421-8505 to RSVP. After we receive your RSVP, we send you an Outlook appointment. Please bring in parking garage tickets for validation.