

# POM ACO Course: Session 3 - Managing the Care of ACO Beneficiaries



October 8, 2024

COLLABORATION  
COMMUNITY-ORIENTED  
EMPOWERMENT  
INNOVATION  
INTEGRITY  
LEADERSHIP  
QUALITY  
PATIENT-  
CENTERED  
TRANSPARENCY  
VALUE



# Welcome to Value-Based Care Essentials: The Role of ACOs!

- Course comprised of four sessions\*, covering essential topics related to ACOs, including MSSP overview, coding, documentation, care management, and quality measures.
- After the activity, participants will be able to understand the role of ACOs and their functions, as well as apply knowledge learned in the course to better serve patients and fulfill CMS requirements.

## **Session 1: ACO Basics**

September 10, 2024

11 am – 1 pm

## **Session 2: ACO Quality Measures Essentials**

September 25, 2024

11 am – 1 pm

## **Session 3: Managing the Care of ACO Beneficiaries**

October 8, 2024

11 am – 1 pm

## **Session 4: Specialists and ACO Beneficiaries**

October 23, 2024

11 am – 1 pm

*\*1.75 CE Credits for each session attended*

*(7 CE credits for all 4 sessions)*

# Today's Session

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## Speakers

- Jill Fenske, MD  
*Family Physician, Michigan Medicine*
- Ghazwan Toma, MD  
*Assistant Professor Family Medicine, Michigan Medicine*
- Heather Rye, LMSW  
*Program Manager, Complex Care Management, Michigan Medicine*
- Kellie Kippes, PharmD, BCSC, BCACP  
*Clinical pharmacy specialist, Ambulatory Care, Michigan Medicine*

## Objectives

- ✓ Define the types of care management programs
- ✓ Understand the relationship across care management program types
- ✓ Understand how care management programs improve patient care and quality
- ✓ Emphasize the importance of your role in care management program coordination and delivery

# Care Management and the Quadruple Aim

- ACOs are groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high-quality care to an assigned Medicare fee-for-service beneficiary population.
- ACOs aim to lower costs by avoiding unnecessary services or duplicate tests, helping patients find affordable treatment options.

## Care Management Programs Support the Quadruple Aim of ACOs

- Helps members manage their chronic conditions
- Reduces burden of disease

**1**  
Improve  
Population  
Health

**2**  
Enhance  
Patient  
Experience

- Care needs are tailored to the individual member
- Encourages members to play an active role in their healthcare

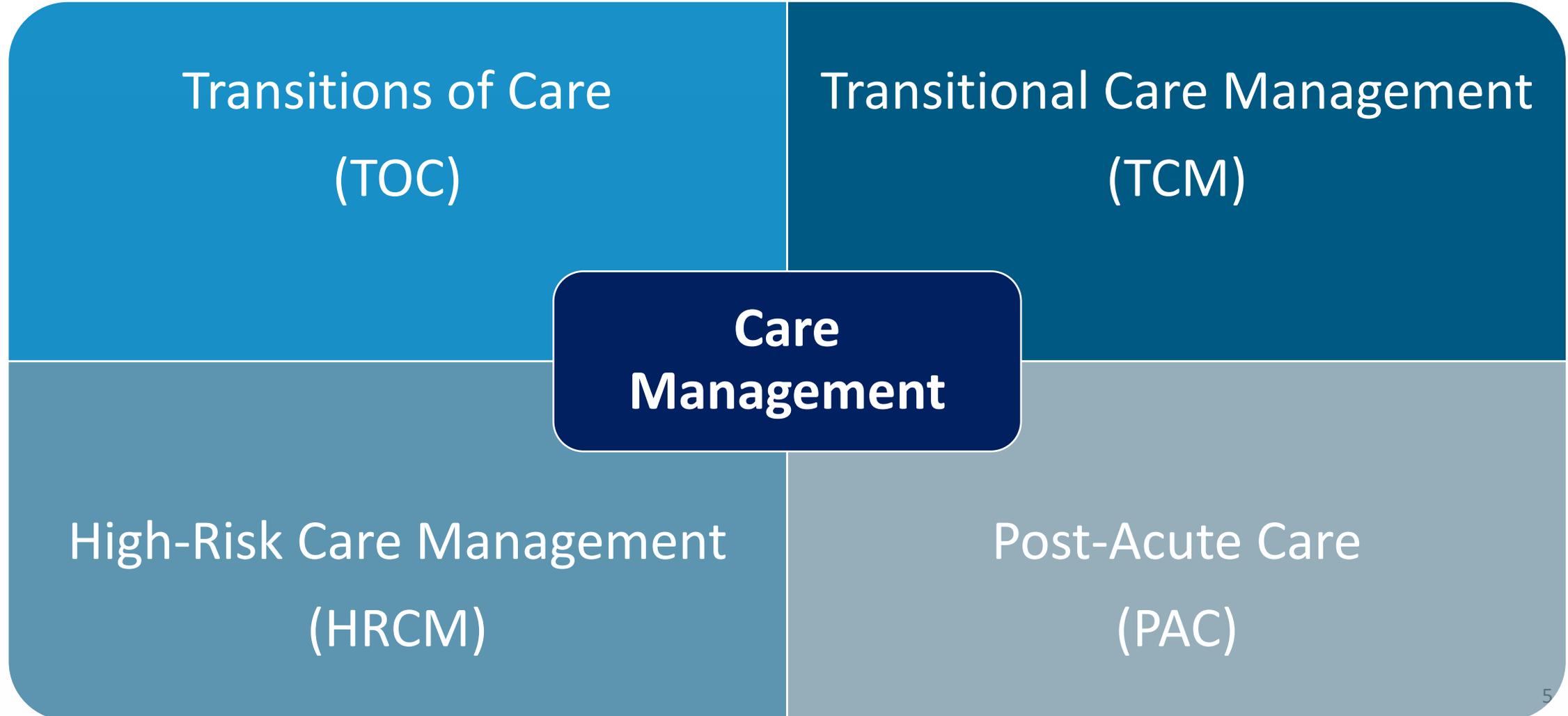
- Prevents avoidable inpatient and ED utilization
- Focuses on preventative care

**3**  
Lower Cost  
of Care

**4**  
Improve  
Clinician  
Experience

- Creates an open environment for learning and shared feedback
- Provides accessible tools

# Defining Care Management Program Types



# Transitions of Care (TOC) and Transitional Care Management (TCM)

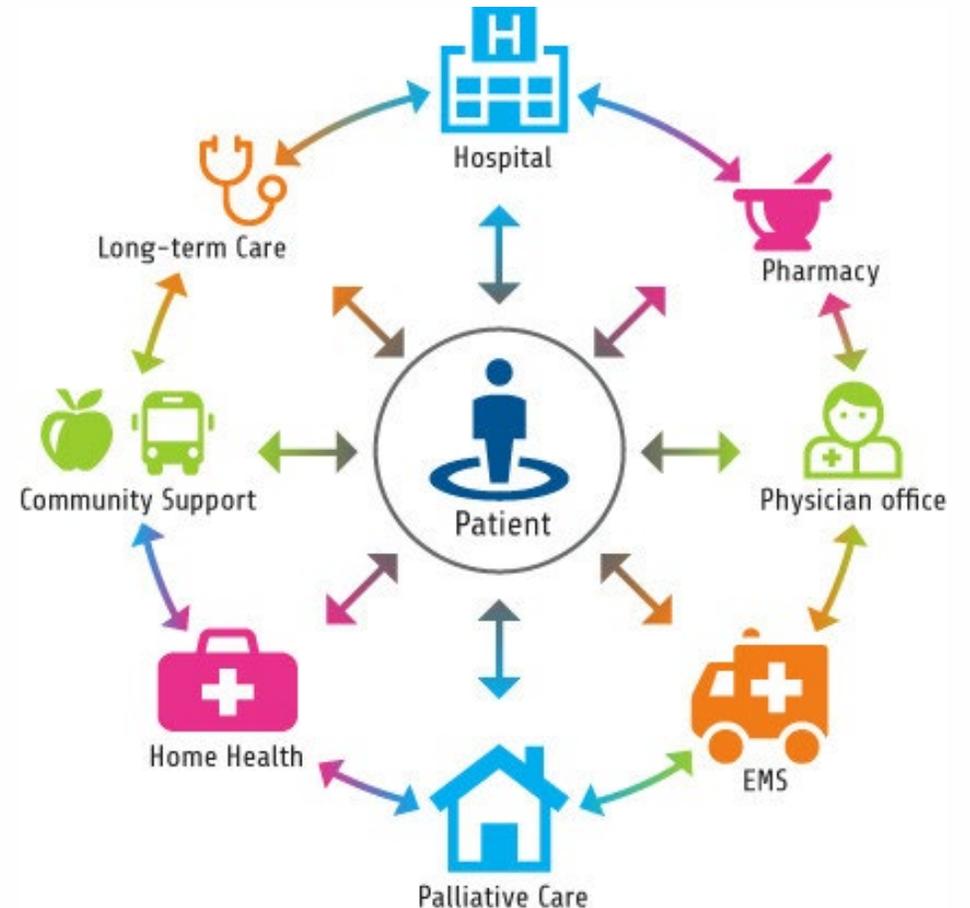
*Kellie Kippes, PharmD, BCSC, BCACP*

*Jill Fenske, MD*

# What is Transitions of Care (TOC)?

- CMS defines TOC as “the movement of a patient from one health care provider or setting to another”.
- TOC outreach is conducted within 24-48 hours on ED visits and IP discharges to reconnect the patient to their PCP.
- When successful, TOC can lower total cost of care for an ACO by reducing readmissions and ED visits; and improve overall quality and experience for the patient.

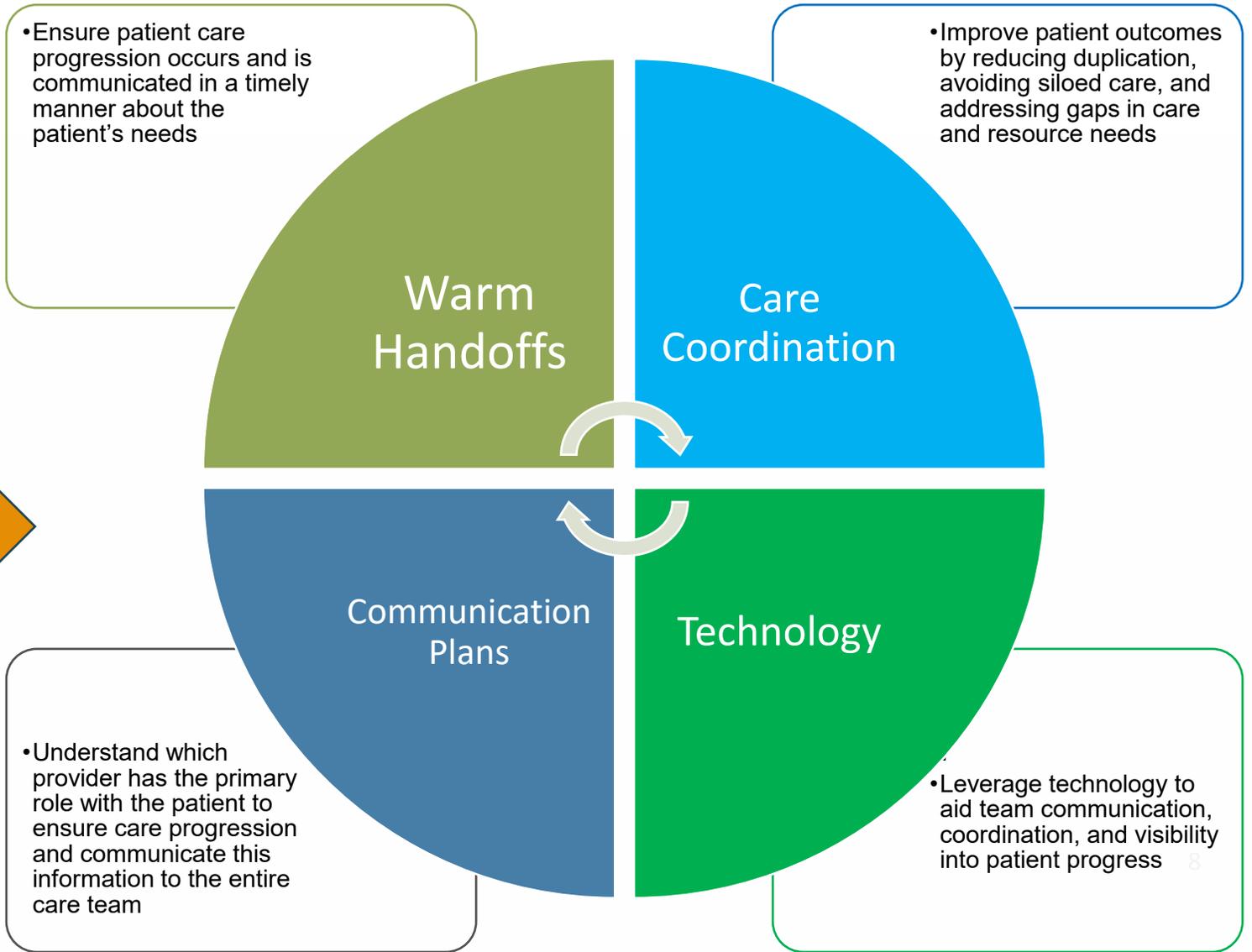
**Your interventions help patients from falling through the cracks of the healthcare system!**



# Cross Continuum Care Team Interventions

- Transitioning between settings or levels of care poses the highest risk for patient confusion, medication issues, lack of follow-through/follow-up, and care team miscommunication.

Are you using these techniques to improve the patient experience?



# Post Acute Care TOC Leading Practices

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- Clear notification and communication process regarding discharge status
- Post discharge checklist or template for standardized outreach
- Transitional Care Management Process:
  - Patient interaction within 2 business days of discharge
    - Call elements include review of symptoms and instructions to call a provider or seek medical attention for certain symptoms, medication reconciliation, safety questions, and review of follow-up appointments
  - A transitional care management appointment is set with the PCP prior to the patient's discharge
    - *Appointment should occur within 14-days for moderate decision making; 7-days for complex*
- For discharges from SNF to HHA, a HHA agency has been secured and start of care date is obtained

# TOC at Michigan Medicine

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- Centralized nurse care navigator call within 2 business days
- Pharmacist outreach ideally between day 3-5 post discharge
  - Ideally pharmacy calls are scheduled prior to discharge but is not then appointments are scheduled post-discharge
  - Call elements include:
    - Medication history and reconciliation
    - Symptom assessment
    - Comprehensive medication review
    - Note is documented and routed to provider
- Provider follow-up within 7-14days

# Components of Pharmacist's TOC Call

## CHRONIC CARE MANAGEMENT SERVICES

@NAME@ is a @AGE@ @SEX@ who was called for post-hospitalization medication review to determine how the patient is using medications and identify recommendations to simplify or optimize the medication regimen. Information was obtained from {TRinfo:27944}.

TRANSITIONAL CARE APPOINTMENT: \*\*\*

The patient was discharged from hospital \*\*\* after treatment for \*\*\*.

### Medication changes since hospital admission:

Medications added: \*\*\*

Medications changed: \*\*\*

Medications stopped: \*\*\*

### Medications:

\*\*\*sorted by indication\*\*\*

# Components of Pharmacist's TOC Call

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## Medication adherence/cost:

Medications are managed by {TRinfo:27944}. Patient is missing \*\*\* doses since hospital discharge. Prescription copay {is/is not:24382} a financial concern for the patient.

## Patient's assessment of efficacy and tolerability:

\*\*\*

## Pain assessment:

\*\*\*

## Symptoms:

\*\*\*

## Self monitoring:

\*\*\*

## Significant drug interactions:

\*\*\*

# Components of Pharmacist's TOC Call

## ASSESSMENT/PLAN:

The following recommendations are related to recently changed medications or reason for recent hospitalization:

1. \*\*\*
2. \*\*\*
3. \*\*\*

The following recommendations are suggested to improve the patient's other drug therapy:

1. \*\*\*
2. \*\*\*
3. \*\*\*
4. Monitor patient as clinically appropriate due to significant drug interactions. Details included above.

Follow-up: recommendations will be available to Dr. \*\*\* for consideration at upcoming visit.

TIME SPENT: \*\*\* minutes, PHONE

PATIENT VERBALIZED UNDERSTANDING OF CARE PLAN: Y

PATIENT ADVISED TO CALL BACK WITH QUESTIONS, CONCERNS, OR CHANGE IN SYMPTOMS.

Reconciled current and discharge medications: {TOC Yes1111F/No:58456}

Phone charge completed: {yes, no:22372}

# Components of a Successful TCM 2-Day Follow-up Call

<https://www.cms.gov/files/document/mln908628-transitional-care-management-services.pdf>

## ***Interaction Requirements per the CMS Medicare Learning Network from May, 2023***

- You (or clinical staff under your direction) must contact the patient or their caregiver by **phone, email, or face-to-face** within 2 business days after the patient's discharge from the inpatient or partial hospitalization setting
  - "Clinical staff" means someone who's supervised by a physician or other qualified health care professional and is allowed by law, regulation, and facility policy to perform or assist in a specialized professional service, but doesn't individually report that professional service
- The interactive contact must be performed by clinical staff who can address patient status and needs beyond scheduling follow-up care
- You may report the service if you make 2 or more unsuccessful separate contact attempts in a timely manner (and if you meet the other service requirements, including a timely face-to-face visit)
- Document your attempts in the patient's medical record
- Continue trying to contact the patient until you're successful
- If the face-to-face visit isn't within the required timeframe, you can't bill TCM services (see the face-to-face section)

# Components of a Successful TCM Visit

## Face-to-Face Visit

- You must provide 1 face-to-face visit within the timeframes described by these 2 CPT codes:
  - **99495** — Transitional care management services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge At least moderate level of medical decision making during the service period Face-to-face visit, **within 14 calendar days of discharge**
  - **99496** — Transitional care management services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge High level of medical decision making during the service period Face-to-face visit, **within 7 calendar days of discharge**
- Don't report the TCM face-to-face visit separately.

## Telehealth Services

- You can provide CPT codes 99495 and 99496 through telehealth. CMS pays for a limited number of Part B services that you provide to an eligible patient using a telecommunications system. Telehealth Services fact sheet has more information.

## Medication Reconciliation & Management

- You must provide medication reconciliation and management on or before the face-to-face visit date.

# TOC Plan Example

**Goal:** Improve TOC and PAC outreach to effectively assist patients in re-integrating with their PCP and reducing readmissions

<b>Purpose</b>	<b>PAC transitions of care process is designed to improve patient engagement, outcomes, and experience by identifying and mitigating risks such as readmissions and improve coordination within a care team.</b>
<b>Process</b>	<ol style="list-style-type: none"><li>1. Implement a defined communication process with standardized documentation.</li><li>2. Processes that should be in place include: exchange health information, medication reconciliation, TCM appointment tracking, SDOH and readmission risk assessment,</li><li>3. Call patients 2 days of discharge and transition appointments</li><li>4. Develop standardized TOC checklist from hospital to PAC: handoff report, PAC admission instructions, patient/family education plan.</li><li>5. Develop standardized TOC checklist from at PAC discharge: handoff report, PAC discharge instructions, follow-up TOC appointment and phone call, medication reconciliation.</li></ol>
<b>People</b>	<ol style="list-style-type: none"><li>1. If possible, centralize 2-day follow-up phone call to improve efficiency.</li><li>2. Pharmacist outreach ideally between day 3-5 post discharge.</li><li>3. Staff operates at top of licensure</li></ol>
<b>Technology</b>	<ol style="list-style-type: none"><li>1. Physician schedules hold TOC slots.</li><li>2. Leverage technology for monitoring quality and performance metrics.</li></ol>
<b>Metrics</b>	<ul style="list-style-type: none"><li>• TOC 2-day completion rate</li><li>• 7 &amp; 30 day readmission rates</li><li>• 7 &amp; 30 day SNF/HHA readmission rates</li><li>• TCM Revenue Tracking</li></ul>

# You Can't Improve What You Don't Measure!

## Example of TOC Metrics

- Tracking progress by developing meaningful metrics provides important insight into:
  - Where Opportunities for improvement exist
  - Which initiatives are working
  - Productivity of Staff

Measure Example	Measure Type	Data Source	Data Elements
% of Transitions with a 2-day interaction	Productivity	EHR	Number of patient with ToC interaction/# of patients discharged.
% of Transitions with a TCM visit within 14 days	Productivity	EHR	Number of patients with TCM visit/# of patients discharged

# You Can't Improve What You Don't Measure!

## Example of TOC Metrics

### PCP Follow-Up

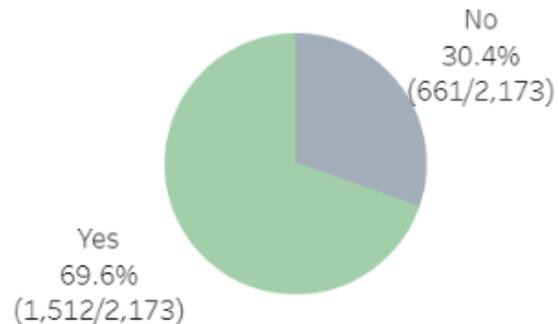
#### Encounter Summary 1/1/2024 to 6/30/2024

Total Encounters (Alive Patients)	2,185
Encounters without LACE	12
Total Encounters	2,185

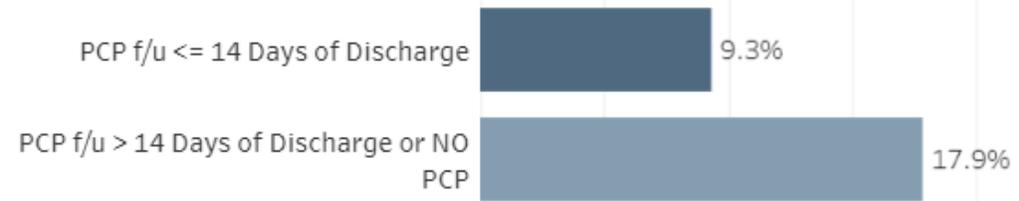
#### LACE Scores

	LACE SCORES			Denominator
	Low Risk (<=9)	High Risk (10-12)	Highest Risk (>=13)	
PCP f/u <= 14 Days of Discharge	678 (44.8%)	504 (33.3%)	330 (21.8%)	<b>1,512 (100.0%)</b>
PCP f/u > 14 Days of Discharge or NO PCP	286 (43.3%)	202 (30.6%)	173 (26.2%)	<b>661 (100.0%)</b>
Total	<b>964 (44.4%)</b>	<b>706 (32.5%)</b>	<b>503 (23.1%)</b>	<b>2,173 (100.0%)</b>

#### Was there PCP Follow-Up within 14 Days of Discharge?



#### Readmissions Within 30 Days



# You Can't Improve What You Don't Measure!

## Example of TOC Metrics

### PharmD (Note)

#### Encounter Summary

1/1/2024 to 6/30/2024

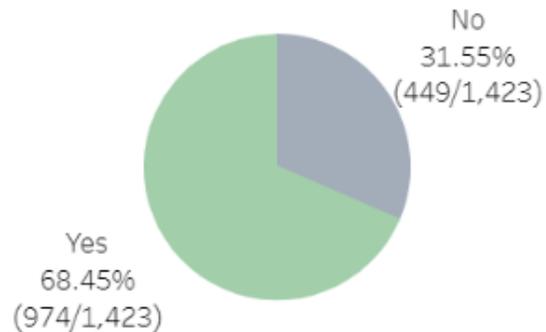
Total Encounters (Alive Patients)	1,427
Encounters without LACE	4
Total Encounters Used for Analysis (PharmD)	1,423

#### LACE Scores

Please note, PharmD outreach is now LACE 10+ or POM ACO as of July 2023 discharges.

	LACE SCORES			Denominator
	Low Risk (<=9)	High Risk (10-12)	Highest Risk (>=13)	
PharmD f/u <= 14 Days of Discharge	144 (14.78%)	484 (49.69%)	346 (35.52%)	974 (100.00%)
PharmD f/u > 14 Days of Discharge or NO PharmD	70 (15.59%)	222 (49.44%)	157 (34.97%)	449 (100.00%)
<b>Total</b>	<b>214 (15.04%)</b>	<b>706 (49.61%)</b>	<b>503 (35.35%)</b>	<b>1,423 (100.00%)</b>

#### Was there a PharmD Call or Note within 14 Days of Discharge?



#### Readmissions Within 30 Days



# You Can't Improve What You Don't Measure!

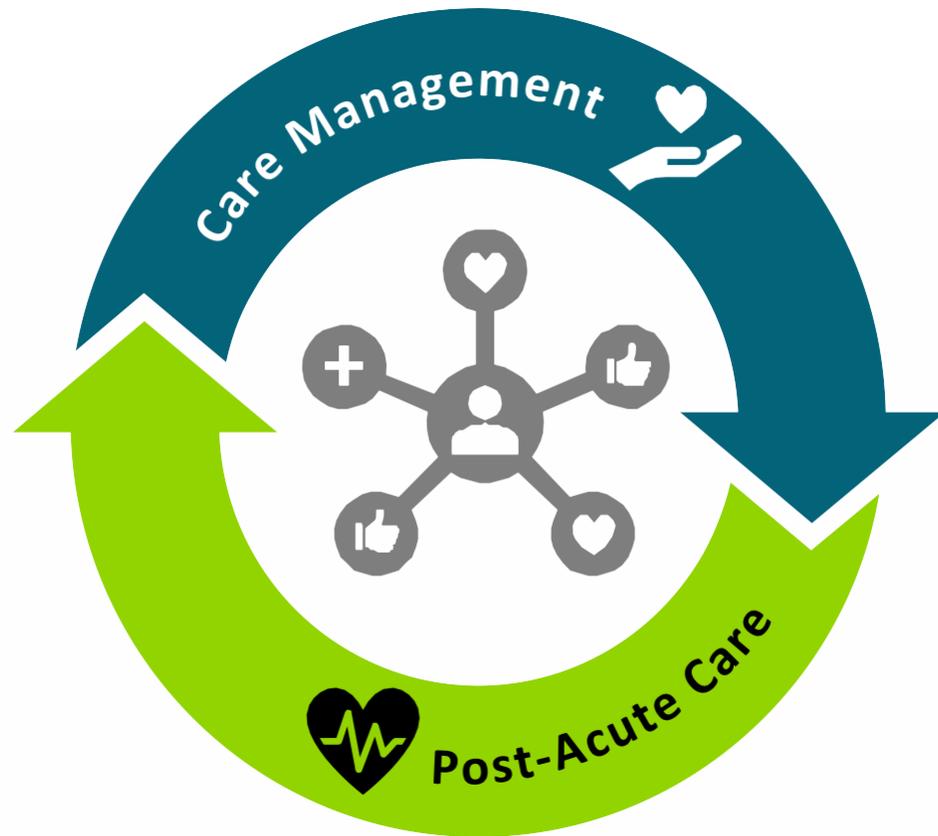
## Example of TOC Metrics



# Post Acute Care Services

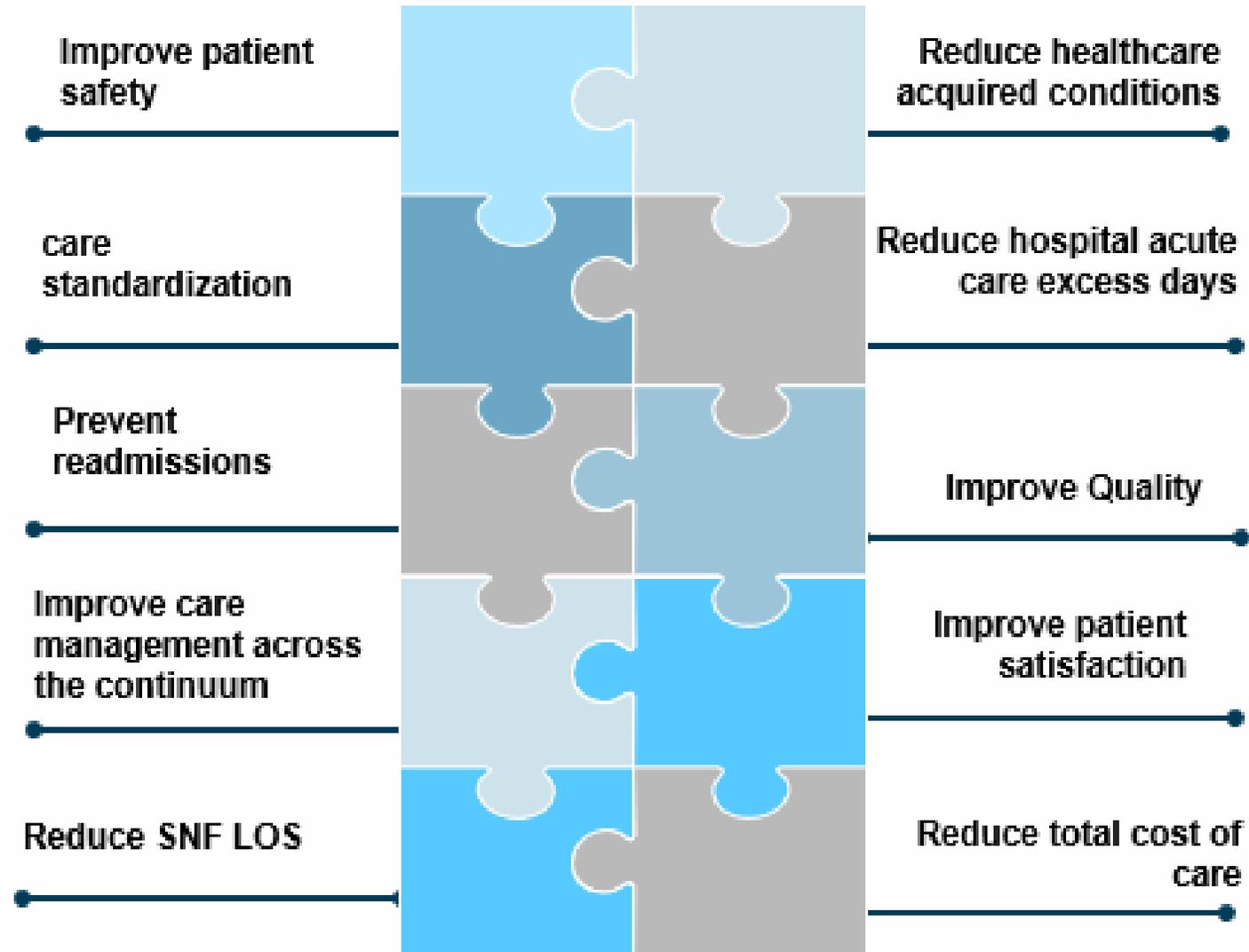
*Ghazwan Toma, MD*

# Intersection of Post-Acute Care and Care Management



- ✓ Significant portion of beneficiary cost is related to Post-Acute Care.
- ✓ ~**40%** of Medicare beneficiaries after discharge from hospital utilize Post-Acute Care.
- ✓ Key for Care Management to appreciate what occurs during post-acute care episode and the transition back to home.

# Why Focus on Post-Acute Care?



# What are main Post Acute Care services at Michigan Medicine?

Subacute rehab

House Call

Michigan Visiting Nurses

Patient Monitoring at Home

Community Paramedics

Wheelchair seating

# Patient Monitoring at Home

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- **Target patient populations**
  - High risk for readmission
  - High utilizers
  - Diagnoses that will benefit from close vital signs and symptoms monitoring
    - Such as Uncontrolled CHF, Cirrhosis, HTN, respiratory diseases on oxygen... etc
- All peripheral items are bluetooth connected
- Patient can be anywhere **in Michigan**,
  - Not in Assisted living or Skilled Nursing facility.
- Hours of operation 8 am to 6 pm,
  - **seven days a week.**



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# House Calls Program

- Serving patients since 2003
- Counties Served: Washtenaw County and Belleville
  - expanding to Brighton and Northville.
- Interdisciplinary team which specializes in home-based management of medically complex patients.
- The House Calls Program offers:
  - Home Based Primary Care (closed for new referrals)
  - Care Management model with PCP (Formerly known as GRACE - Geriatric Resources for Assessment and Care of Elders)
  - Transition of Care Home in person and Virtual Visit

# Home Health Agency 'Michigan Visiting Nurses'

- Registered nurses
- Physical therapists
- Occupational therapists
- Home health aides

Summary Table of Domains and Measures Proposed for the HH Value-Based Purchasing Program				
Category/Weight	NQS Domain	Measure	In-Category Measure Weight	Minimum Case Count per Year
OASIS-Based 35%	Clinical Quality of Care	Improvement in Dyspnea/Dyspnea	16.67%	20
	Communication & Care Coordination	Discharged to Community	16.67%	20
	Patient Safety	Improvement in Management of Oral Medications/Oral Medication	16.67%	20
	Patient and Family Engagement	Total Normalized Composite Change in Mobility/TNC Mobility (Composite Measure)	25%	20
		Total Normalized Composite Change in Self-Care/TNC Self-Care (Composite Measure)	25%	20
Claims-Based 35%	Efficiency & Cost Reduction	Acute Care Hospitalization During the First 60 Days of Home Health Use/ACH	75%	20
		Emergency Department Use without Hospitalization During the First 60 Days of Home Health/ED Use	25%	20
HHCAHPS-Based 30%	Patient & Caregiver-Centered Experience	Care of Patients/Professional Care	20%	40
		Communications between Providers and Patients/Communication	20%	40
		Specific Care Issues/Team Discussion	20%	40
		Overall rating of home health care/Overall Rating	20%	40
		Willingness to recommend agency/Willing to Recommend	20%	40

# Subacute Rehabilitation

To address your other email re: SNF performance with our MDs vs without, here is what the data looks like (rolling year Jan 2023-Dec 2023):

	ED During			ED Visits in 30 Days			7 Day Readmission (from IP Discharge)			30 Day Readmission (from IP Discharge)		
	Num	Den	%	Num	Den	%	Num	Den	%	Num	Den	%
<b>With MM MDs</b>	18	308	5.8%	26	308	8.4%	19	260	7.3%	48	260	18.5%
<b>Without MM MDs</b>	25	164	15.2%	32	164	19.5%	13	132	9.8%	34	132	25.8%

# What are Post Acute Care Collaboratives?

- Many ACO's choose to create Post Acute Care Collaboratives (PACC), or partnerships, with PAC facilities to accomplish goals.
- The skilled nursing facilities and home health agencies were selected based on a set of quality metrics and referral volumes provided by outside consultant.
- Currently, each of the physician organizations (PO) within POM-ACO have post-acute care collaboratives with Skilled Nursing Facilities and Home Health Agencies.
  - The SNFs and HHAs meet with leadership from the PO and the PACC regularly to go over quality metrics that are provided by the ACO on a quarterly basis.
    - The Post-acute care collaboratives also serve as an educational forum for one another to share quality improvement efforts
    - Also, to discuss challenges at the post-acute care level or with transitions out of the hospital or from Post-acute care to home.

# Shared Goals for Post Acute Care Collaboration

PACC goals align with the **The Quadruple Aim of Healthcare.**

1. Improve patient experience
2. Improve transitions of care across the continuum.
3. Reduce readmissions
4. Improve quality
5. Decrease cost



# Impact on Patient Care

- **Seamless Continuum of Care:** Accountable Care Organizations (ACOs) prioritize preventive health and quality outcomes. They achieve this by creating a network of preferred post-acute providers.
  - As a result, patients experience a smooth transition from acute care to post-acute care, ensuring coordinated management of their health.
- **Improved Outcomes:** A well-structured post-acute network helps fill gaps in patient care, leading to better quality outcomes.
  - Patients receive appropriate services to reduce the risk of complications and readmissions.
- **Cost Control:** ACOs strive to reduce costs while maintaining quality.
  - By directing patients to cost-effective, high-quality post-acute settings, they minimize the overall financial burden on patients and the healthcare system.

# Patient Informed Choice in Post-Acute Care Collaboration

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- **Definition:** Empowering patients to make decisions during the transition from acute care to post-acute care settings
- **CMS Rules:** New regulations emphasize informed choice, ensuring patients receive quality and resource information about post-acute providers.
- **Discharge Planning:** Hospitals share data on skilled nursing facilities, home health agencies, etc., aligning with patient preferences.
- **Interoperability:** Promotes seamless exchange of patient information across healthcare settings.
- **Goal:** Enhance care transitions and empower patients to choose high-quality post-acute care providers based on individual needs.

# Examples of Post-Acute Care and ACO Partnership Actions

- **Medical Director Forum:**
  - Establishing a forum for medical directors can facilitate knowledge exchange and collaborative efforts among Skilled Nursing Facilities (SNFs) and health systems. This can help to enhance the standard of care across participating facilities.
- **Data Analytics:**
  - Utilizing data analytics to monitor and improve care quality at regular meetings
- **Improved Patient Care Communication:**
  - Working with organizations like the Michigan Health Information Network (MiHIN) to facilitate the sharing of health information across different care settings.
  - Working with EPIC Care Link to allow Post-acute care providers real-time access to notes and medication lists
- **SNF Three-Day Waiver Program:**
  - SNFs who meet 3-star quality rating can partner with hospitals/ED to accept patients earlier in hospital stay (decreasing hospital LOS costs, and increasing referrals to SNFs)

# Post Acute Care Collaboratives – Future Vision

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- These Post-acute Care Collaboratives are in their infancy now.
  - Currently they are used to share information with one another and acquaint each other on the successes and challenges each post-acute care facilities face.
- In the next years, based on performance and engagement for patient informed choice, The physician organizations will have sufficient data to be able to determine which entities provide the best valued care (Based on quality, safety, patient experience and cost)
  - Ultimately, ACOs can begin to provide more relevant information.

# Post-Acute Care Collaborative- Future State

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Post- Acute Care Collaboratives over time will transition to a “select” group of entities who sustain high quality/low cost (value) care for ACO patients and stay engaged with health systems

- Patient will be informed of the Choices in Post-Acute Care
- Inpatient discharge planning will allow for post-acute care lists that “highlight” partners in a Post-Acute Care collaborative
- ACOs will be able to provide more information to patients and families about care
  - Metrics that may influence which post-acute care service they choose

Ultimately these Post-Acute Care Collaboratives will serve as a mechanism to further select from.

# High-Risk Care Management

*Heather Rye, LMSW*

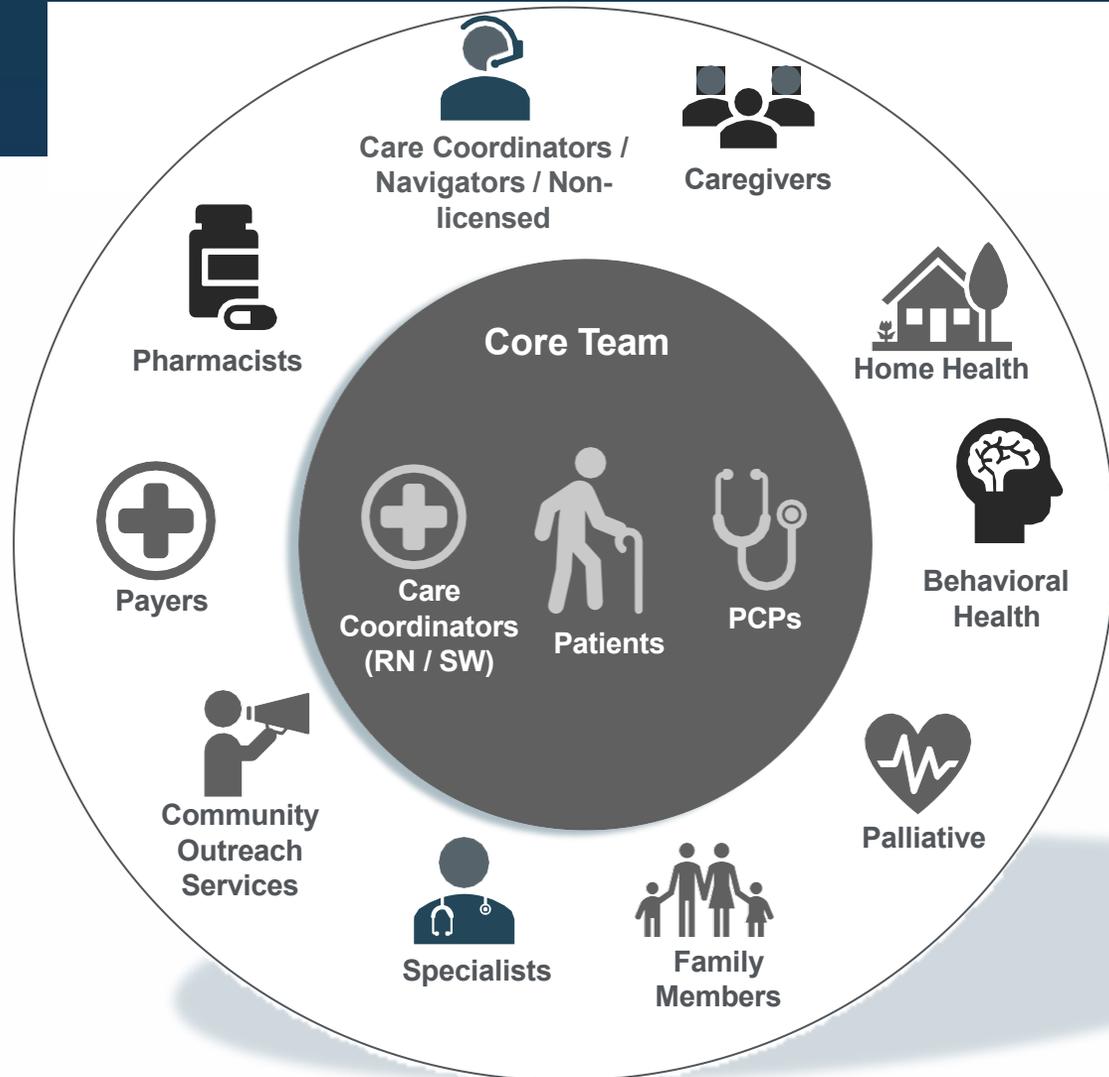
*Jill Fenske, MD*

# High-Risk Care Management Components

Improving any of these components can potentially improve HRCM program outcomes



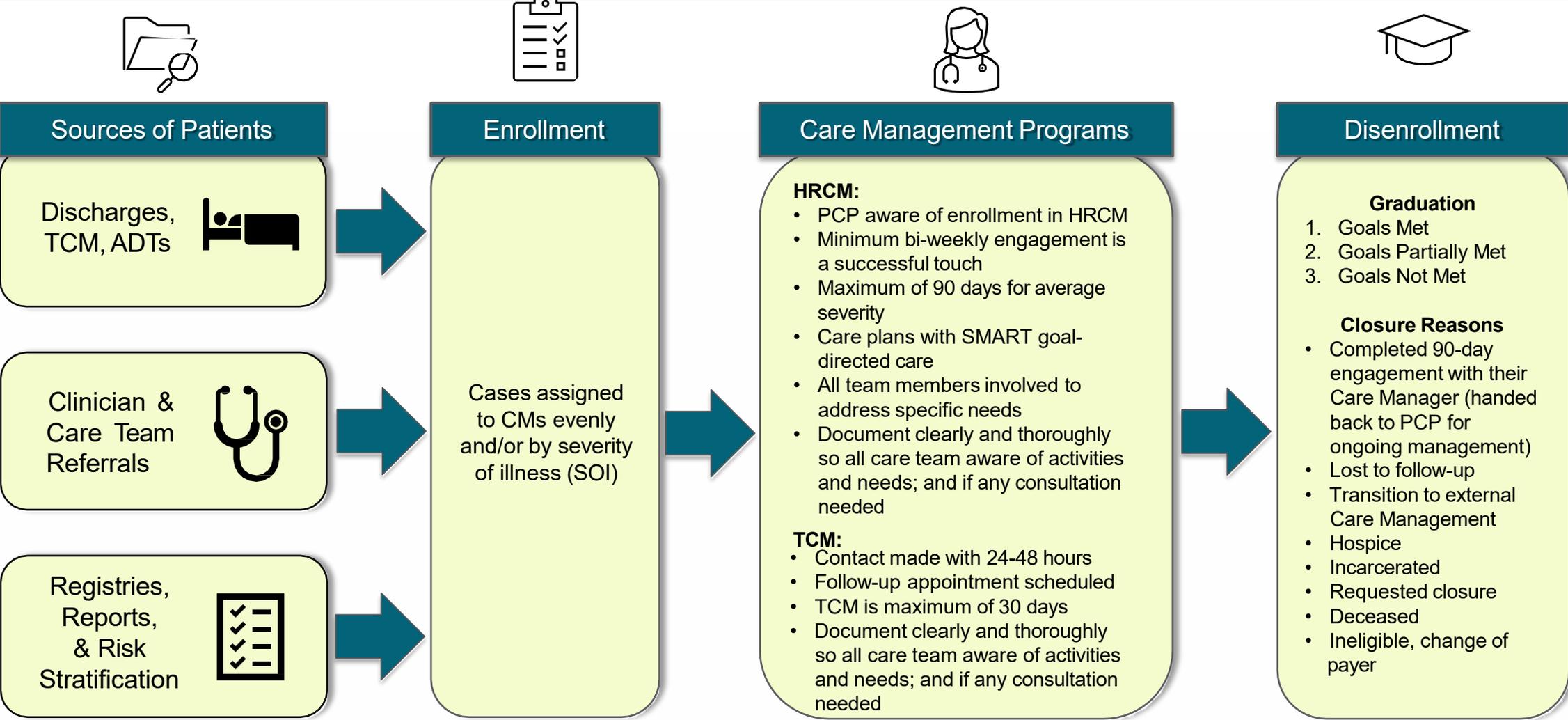
# The Care Team: It Takes a Village



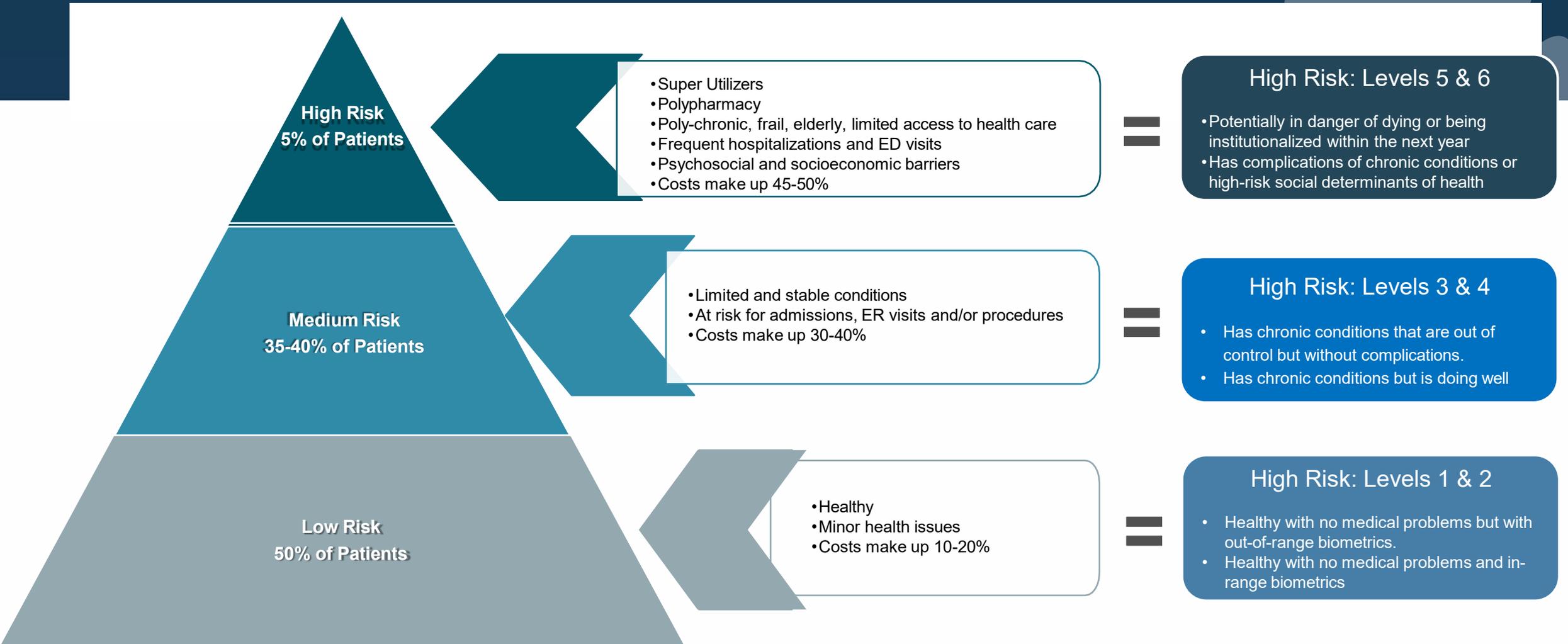
## ***A Team-Based and Goal-Focused Approach to CM:***

- ✓ The key to improving health outcomes is leveraging the patient-clinician relationship
- ✓ PCPs coordinate care and the Ambulatory Care Management team acts as an extension of the PCP so that they can reach patients during and between office visits
- ✓ Care Management can be successfully conducted completely virtually with patients, as organizational policy and technology allows
- ✓ Team-based care acknowledges that there are multiple key players treating a patient and that each of them must work with one another in order to drive optimal care outcomes
- ✓ Team-based care can be successful when all members are on the same page and have:
  - A clear, common goal
  - A culture shift that facilitates teamwork
  - Supportive organizational frameworks
  - Effective teamwork, handoffs, and coaching

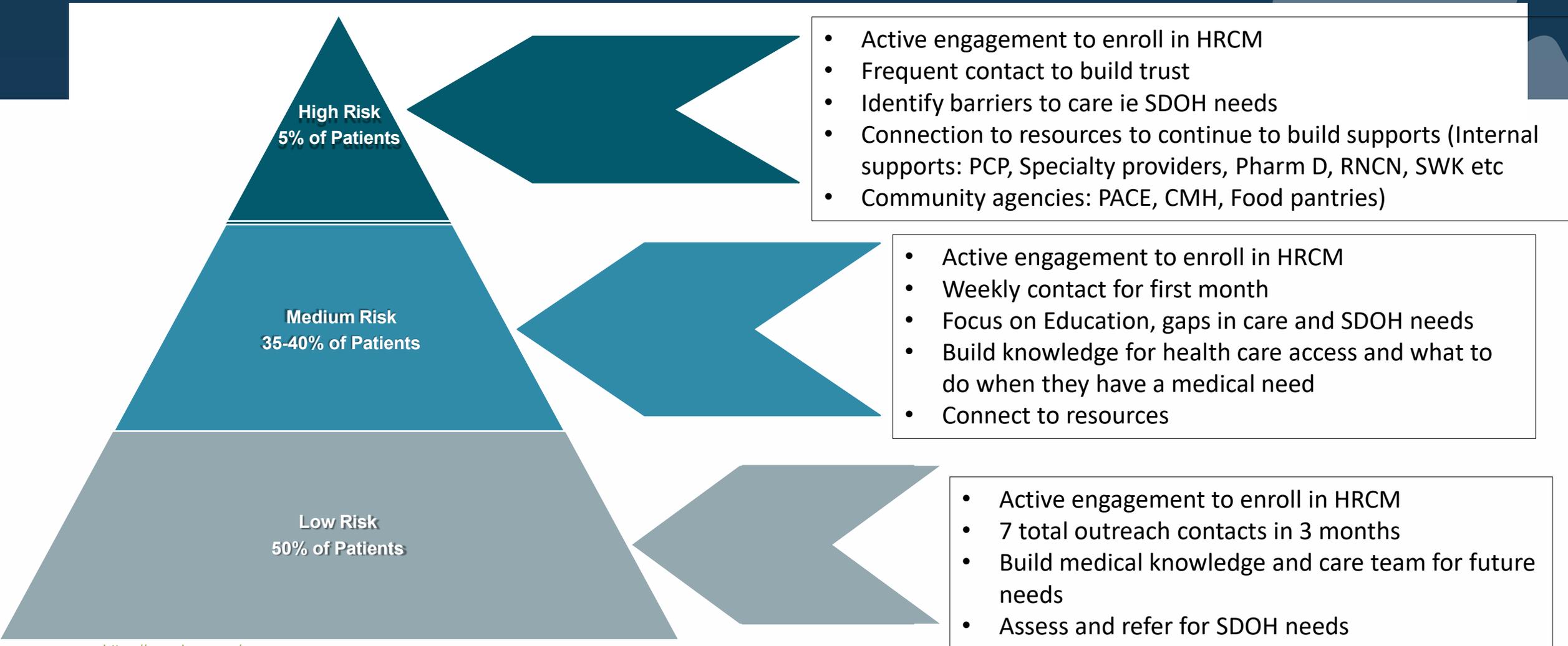
# High-Level Care Management Workflow



# Stratifying your Population is a Key Success Driver



# Targeted interventions by Risk Group



<https://www.hrsa.gov/>

# Documentation

Accurate record keeping supports the care manager in planning, implementing, and evaluating services for each patient.



## Record Keeping

Accurate record keeping supports the care manager in planning, implementing, and evaluating services for each client



## High-Level Tracking

Illustrates patterns of effective or ineffective interventions



## Quality

Enhances quality of service – especially with heavy case loads/crisis



## Compliance

Follows the agency/funder/state or other governing body protocols



## Point of Contact

Reflects any significant client, family, or secondary service provider contact



## Outcomes

Measures outcomes and impact of the work



## Practical Management

Reminds care managers of services to be provided



## Accuracy

Presents accurate history of crisis patterns

# Addressing The Challenges of Patient Engagement

## Communication and Language

- Virtual visit and secure text messaging offerings
- Telehealth technology with multiple languages
- Translation services
- Incorporating the caregiver into communication
- Offer training on improving interpersonal communication (avoiding medical jargon, how to slow down, assuring understanding, asking the right questions, etc.)
- Emphasize non-verbal communication and body language

## Health Literacy

- Custom condition-specific educational videos
- Teach back quizzes
- Provide education in patient preferred formats (demonstrations, graphics, brochures, videos, one-on-one teaching, checklists etc.)
- Share appointment notes
- Learn what the patient knows, correct misinformation
- Include family members and caregivers
- Help the patient understand symptom trends

## Social Determinants of Health (SDOH)

- Leverage SDOH screenings
- Prescribe affordable food options
- Connect patients with food and affordable housing options through partnerships
- Offer medical transportation
- Provide alternatives to in person care with telehealth
- Combat social isolation

## Patient Trust

- Focus on empathy and body language
- Provide access to the patient portal to involve patients in the healthcare process
- Offer culturally competent / responsive patient care
- Create a non-judgmental environment and avoid “medical fat shaming” as a strategy to motivate behavior change
- Level with the patient—be transparent about treatment and prognosis
- Educate staff to be aware of bias

# Considerations for a Successful CM Program

## Risk Stratification

- Do you know risk scoring methodology your organization is using to stratify your patients?
- Are you aware of the sources used to stratify your patients?
- Do you know who your target population is?

## Care Plans and Episodes

- How well do you know the standard tools within your EHR that may help with CM activities?
- Do you have standard note templates?

## Outreach and Engagement

- Can you describe your referrals processes? Who reviews the incoming referrals and what is their workflow?
- Are you adding cases and/or targets based on referrals? How are referrals linked to your CM activities?
- Are you reviewing your cases on a regular basis to assess whether they can be disenrolled from your CM program?

## Analytics

- Do you have all the information/data you need to manage your patients effectively?
- Do you know who to contact to get additional information/data?

Thank you!