# POM ACO Course:

# Session 3 - Managing the Care of ACO Beneficiaries

POM ACO

TRANSFORMING HEALTH CARE TOGETHER


October 8, 2024

MICHIGAN MEDICINE
UNIVERSITY OF MICHIGAN

My Michigan
Collaborative Care Organization

Metro Health
Integrated Network

Northern Michigan
Care Partners

OSP
POWERED BY ADMINISTRATIVE NETWORK

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HEALTH-SPARROW

# 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**<br>September 10, 2024<br>11 am – 1 pm | **Session 2: ACO Quality Measures Essentials**<br>September 25, 2024<br>11 am – 1 pm | **Session 3: Managing the Care of ACO Beneficiaries**<br>October 8, 2024<br>11 am – 1 pm | **Session 4: Specialists and ACO Beneficiaries**<br>October 23, 2024<br>11 am – 1 pm |

**1.75 CE Credits for each session attended*

*(7 CE credits for all 4 sessions)*

# Today's Session

## 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

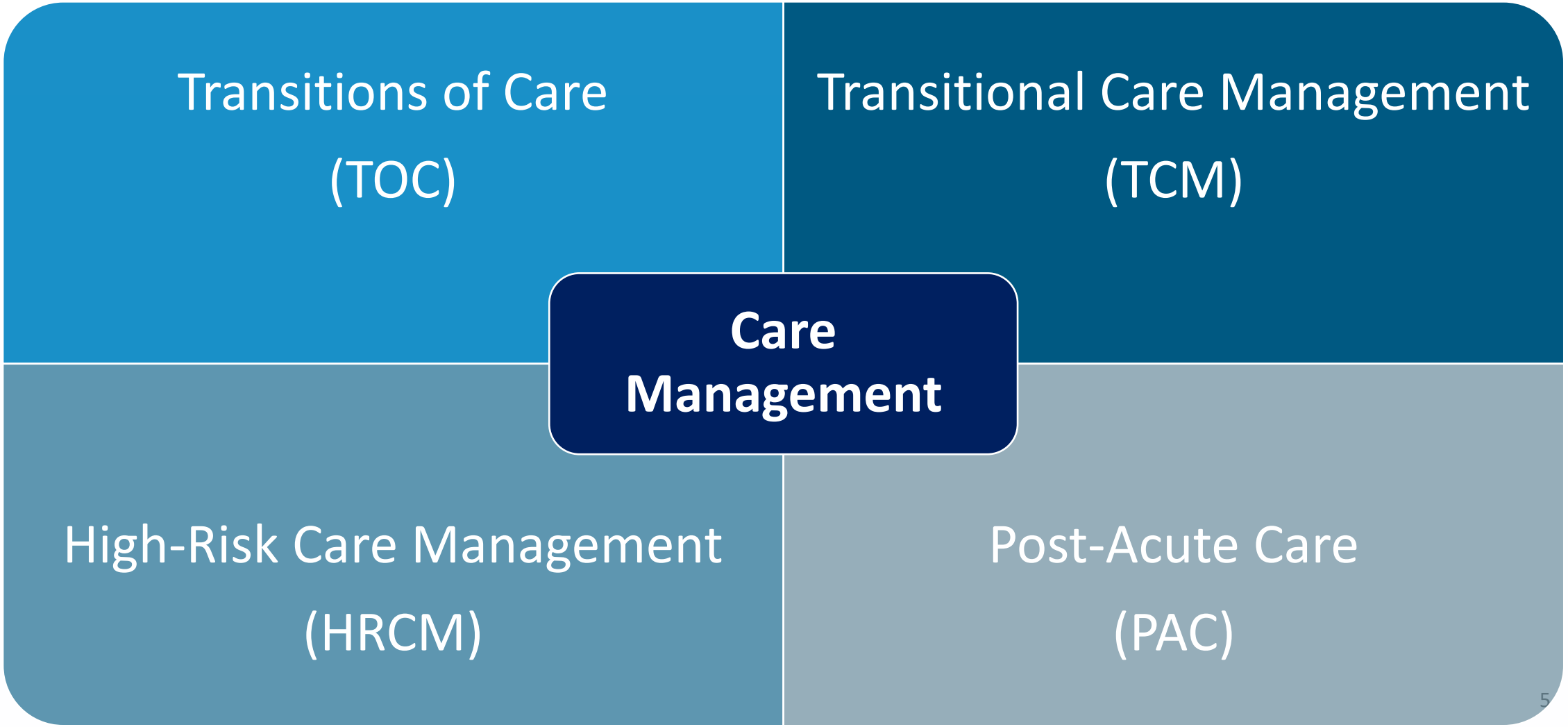
- ✓Define the types of care management programs
- ✓Understand the relationship across care management program types
- ✓Understand how care management programs improve patient care and quality
- ✓Emphasize the importance of your role in care management program coordination and delivery

# 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

# Defining Care Management Program Types



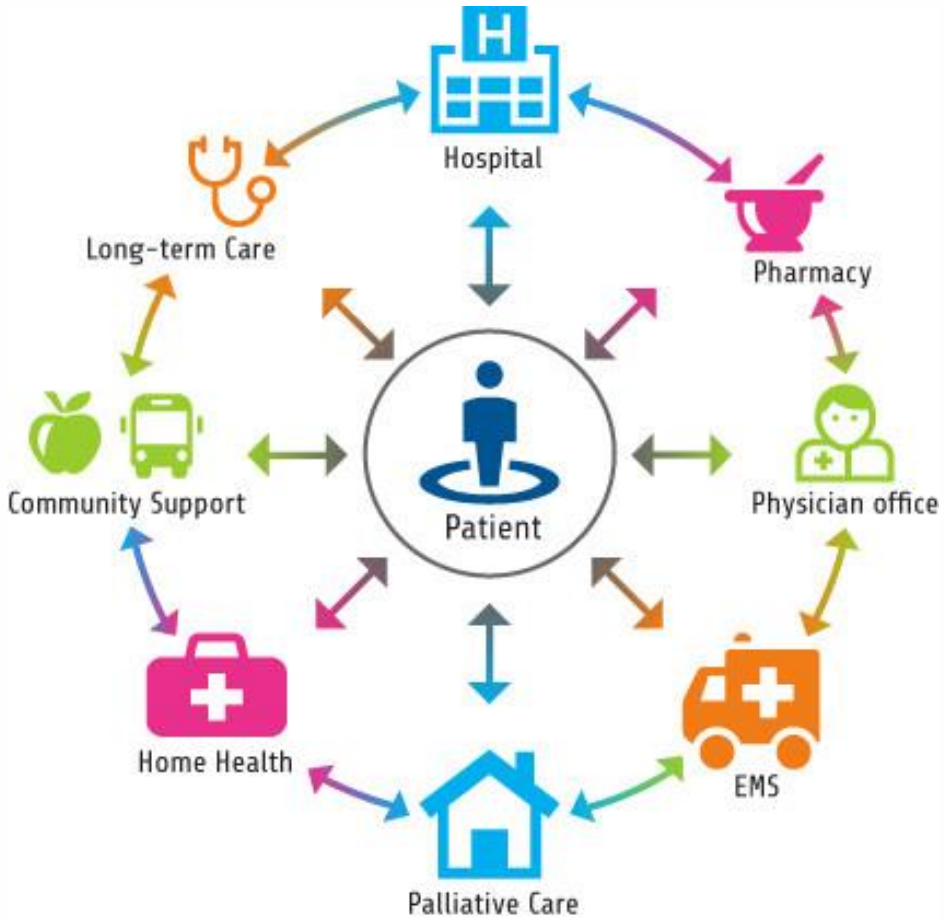
# Transitions of Care (TOC) and Transitional Care Management (TCM)

*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.

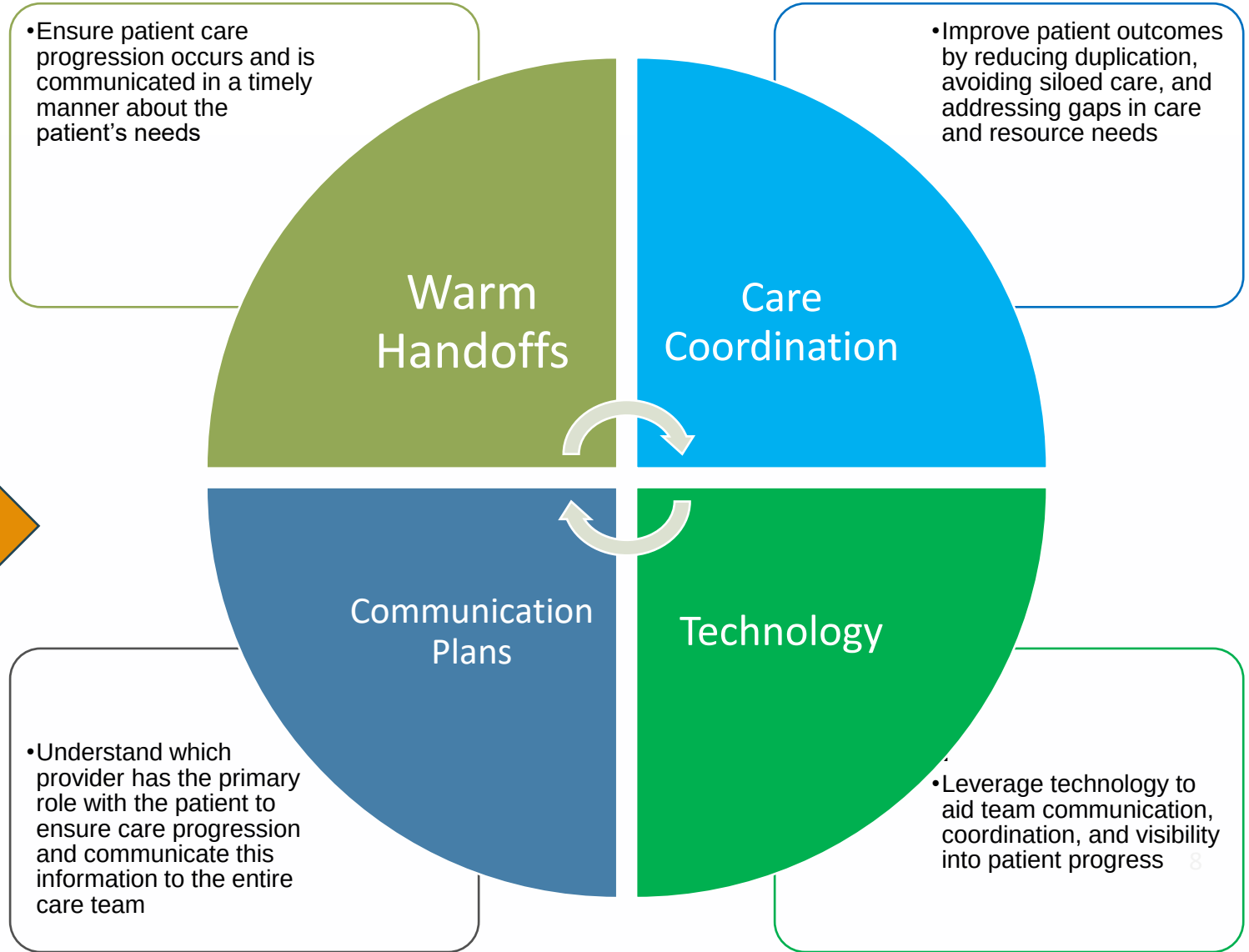
**Your interventions help patients from falling through the cracks of the healthcare system!**



# 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

- 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

- 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

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

| | |
|---|---|
| **Purpose** | **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.** |
| **Process** | 1. Implement a defined communication process with standardized documentation.<br>2. Processes that should be in place include: exchange health information, medication reconciliation, TCM appointment tracking, SDOH and readmission risk assessment,<br>3. Call patients 2 days of discharge and transition appointments<br>4. Develop standardized TOC checklist from hospital to PAC: handoff report, PAC admission instructions, patient/ family education plan.<br>5. Develop standardized TOC checklist from at PAC discharge: handoff report, PAC discharge instructions, follow-up TOC appointment and phone call, medication reconciliation. |
| **People** | 1. If possible, centralize 2-day follow-up phone call to improve efficiency.<br>2. Pharmacist outreach ideally between day 3-5 post discharge.<br>3. Staff operates at top of licensure |
| **Technology** | 1. Physician schedules hold TOC slots.<br>2. Leverage technology for monitoring quality and performance metrics. |
| **Metrics** | • TOC 2-day completion rate<br>• 7 & 30 day readmission rates<br>• 7 & 30 day SNF/HHA readmission rates<br>• TCM Revenue Tracking |

# 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

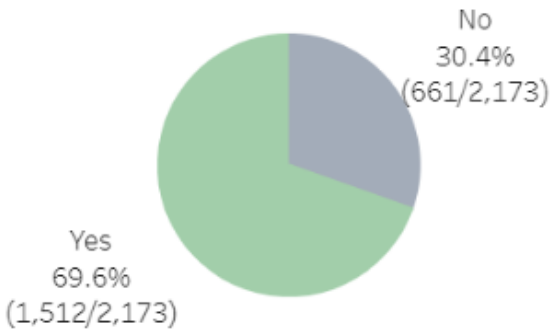
### Encounter Summary
1/1/2024 to 6/30/2024

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

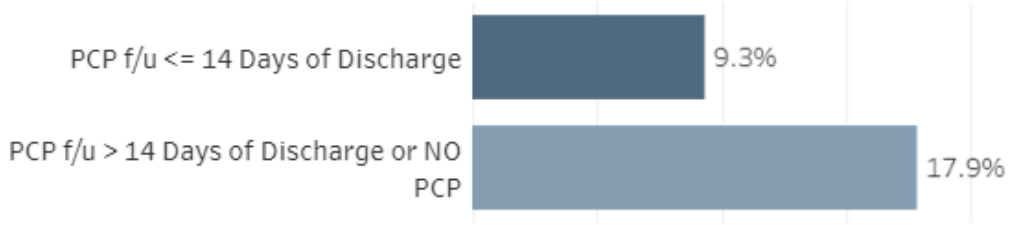
### LACE Scores

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

### 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)

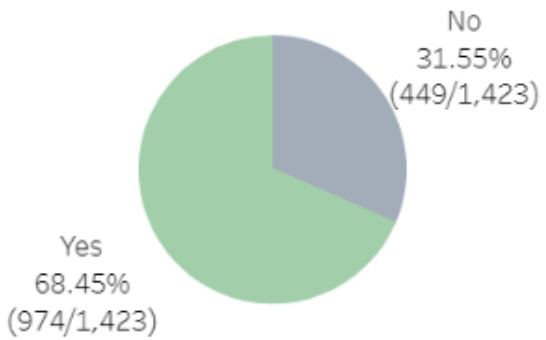
### Encounter Summary
1/1/2024 to 6/30/2024

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

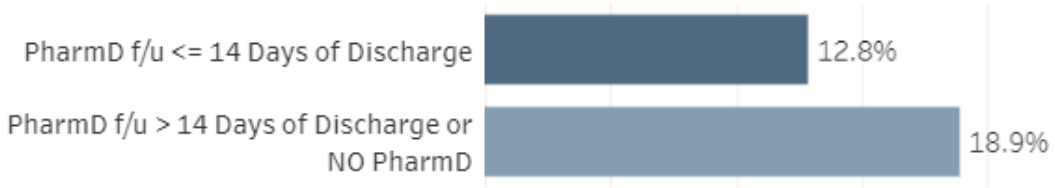
### LACE Scores
Please note, PharmD outreach is now LACE 10+ or POM ACO as of July 2023 discharges.

| | LACE SCORES | | | |
|---|---|---|---|---|
| | Low Risk (<=9) | High Risk (10-12) | Highest Risk (>=13) | Denominator |
| 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%)** |
| Total | **214 (15.04%)** | **706 (49.61%)** | **503 (35.35%)** | **1,423 (100.00%)** |

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




### Readmissions Within 30 Days

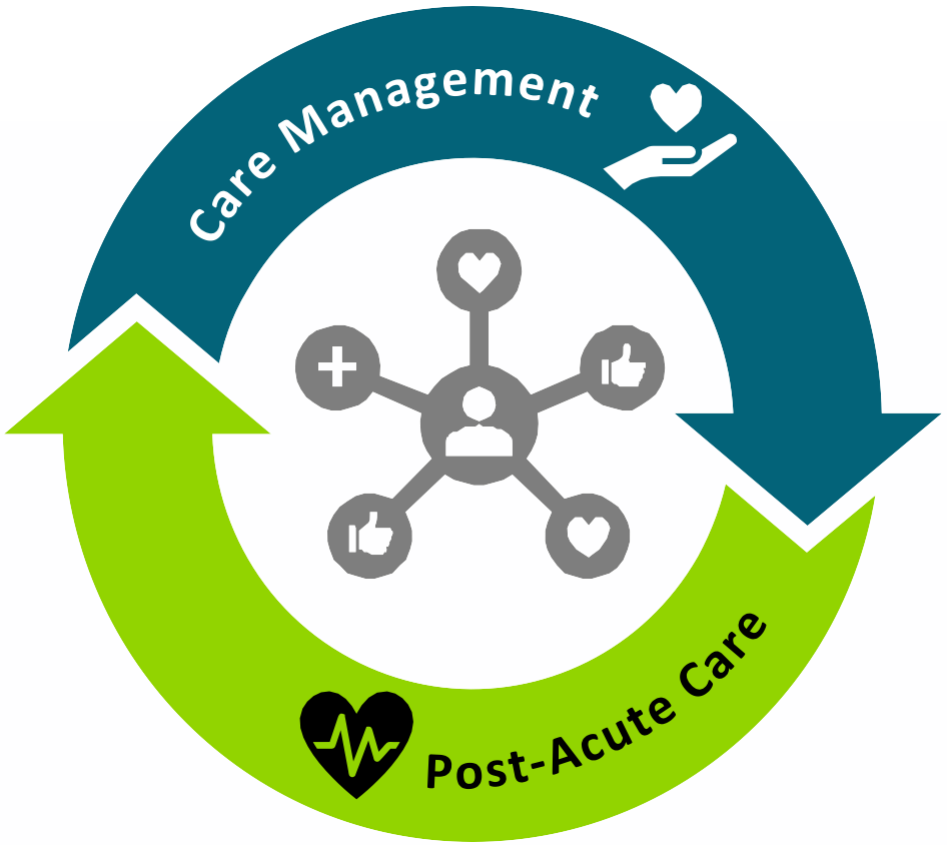


# You Can't Improve What You Don't Measure! Example of TOC Metrics

# Post Acute Care Services

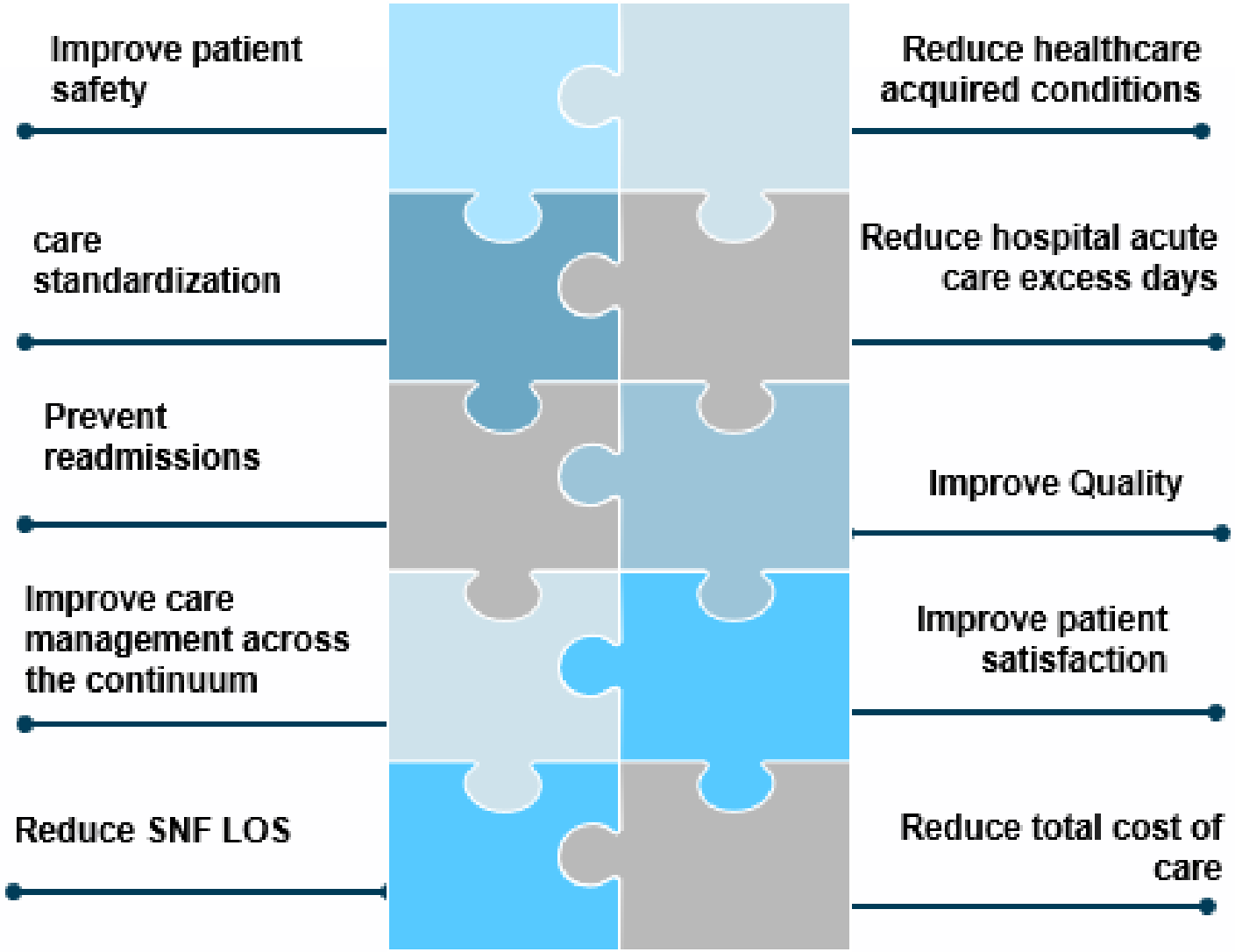
*Ghazwan Toma, MD*

# 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



- **Target patient populations**
  - High risk for readmission
  - High utilizers
  - Diagnoses that will benefit from close vita 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.

# 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 Heath 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 | % |
| **With MM MDs** | 18 | 308 | 5.8% | 26 | 308 | 8.4% | 19 | 260 | 7.3% | 48 | 260 | 18.5% |
| **Without MM MDs** | 25 | 164 | 15.2% | 32 | 164 | 19.5% | 13 | 132 | 9.8% | 34 | 132 | 25.8% |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# POM ACO PACC SNF Partners *(effective 1/1/2025)*

| SNF Name | City | SNF Name | City |
|---|---|---|---|
| Alpena Opco LLC | Alpena | Atrium Grayling | Grayling |
| Clare Opco LLC | Clare | Paul Oliver Memorial Hospital | Frankfort |
| Mt. Pleasant Opco LLC | Mt. Pleasant | Traverse City Opco, LLC | Traverse City |
| Midland Opco LLC | Midland | GTC Opco, LLC | Traverse City |
| Manistee County Medical Care Facility | Manistee | Leelanau Opco, LLC | Suttons Bay |
| Orchard Creek Health Care, Inc | Traverse City | Gaylord Opco, LLC | Gaylord |
| Atrium King Center, INC. | Houghton Lake | Rose City OPCO LLC | Rose City |
| Munson Healthcare Otsego Memorial Hospital | Gaylord | Glacier Hills Inc. | Ann Arbor |
| Munson Healthcare Grayling | Grayling | United Methodist Retirment Communities, INC | Chelsea |
| Munson Healthcare Charlevoix Hospital | Charlevoix | Symphony of Brighton Healthcare Center, LLC | Brighton |

# 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

- **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

- 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

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 provider more information to patients and families about care
    - Metrics that may influence which post-acute care service they choose

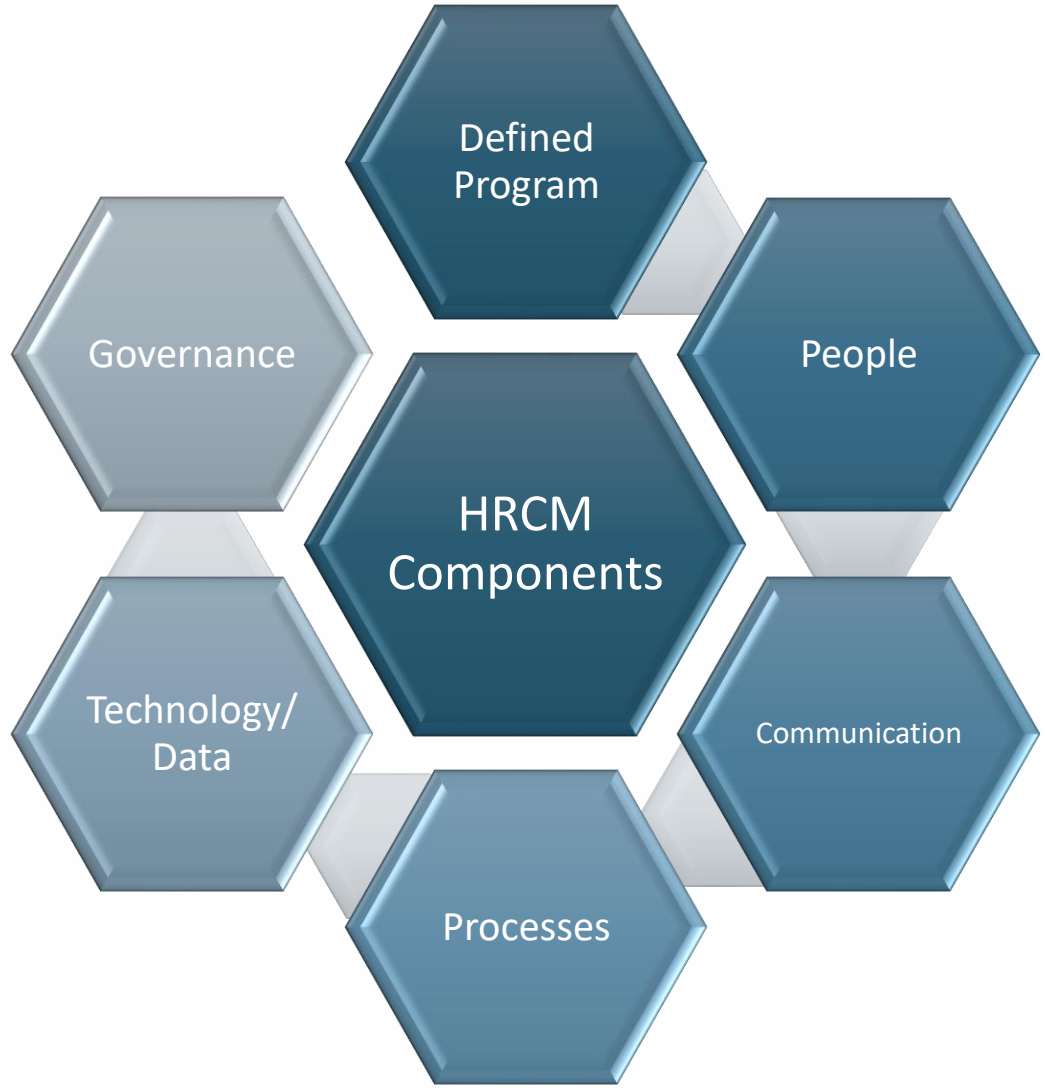
Ultimately these Post-Acute Care Collaboratives will serve as a mechanism to further select from.

# High-Risk Care Management

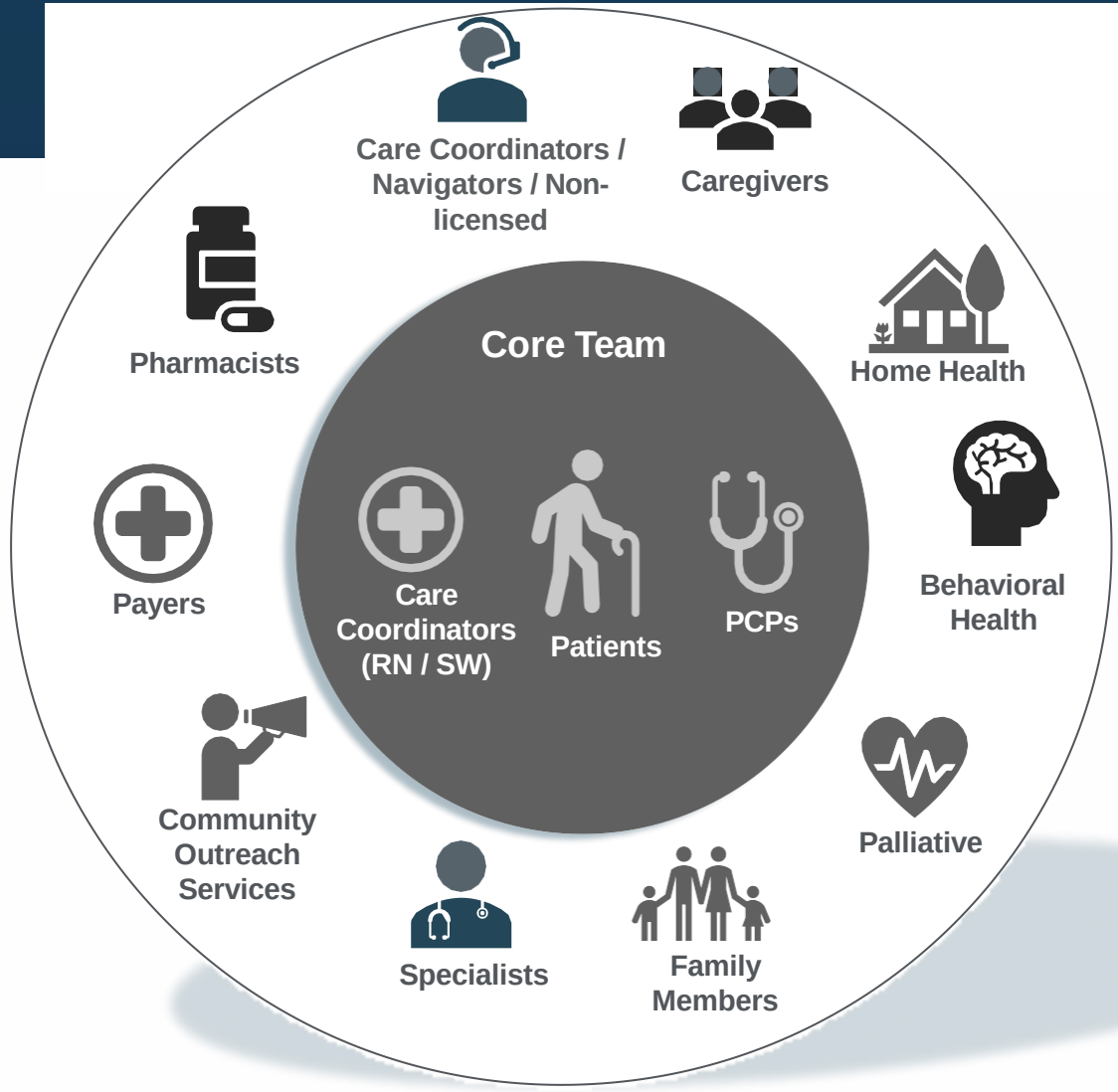
*Heather Rye, LMSW*
*Jill Fenske, MD*

# 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

## Sources of Patients

Discharges, TCM, ADTs

Clinician & Care Team Referrals

Registries, Reports, & Risk Stratification

## Enrollment

Cases assigned to CMs evenly and/or by severity of illness (SOI)

## Care Management Programs

**HRCM:**

- PCP aware of enrollment in HRCM
- Minimum bi-weekly engagement is a successful touch
- Maximum of 90 days for average severity
- Care plans with SMART goal-directed care
- All team members involved to address specific needs
- Document clearly and thoroughly so all care team aware of activities and needs; and if any consultation needed

**TCM:**

- Contact made with 24-48 hours
- Follow-up appointment scheduled
- TCM is maximum of 30 days
- Document clearly and thoroughly so all care team aware of activities and needs; and if any consultation needed

## Disenrollment

**Graduation**

1. Goals Met
2. Goals Partially Met
3. Goals Not Met

**Closure Reasons**

- Completed 90-day engagement with their Care Manager (handed back to PCP for ongoing management)
- Lost to follow-up
- Transition to external Care Management
- Hospice
- Incarcerated
- Requested closure
- Deceased
- Ineligible, change of payer



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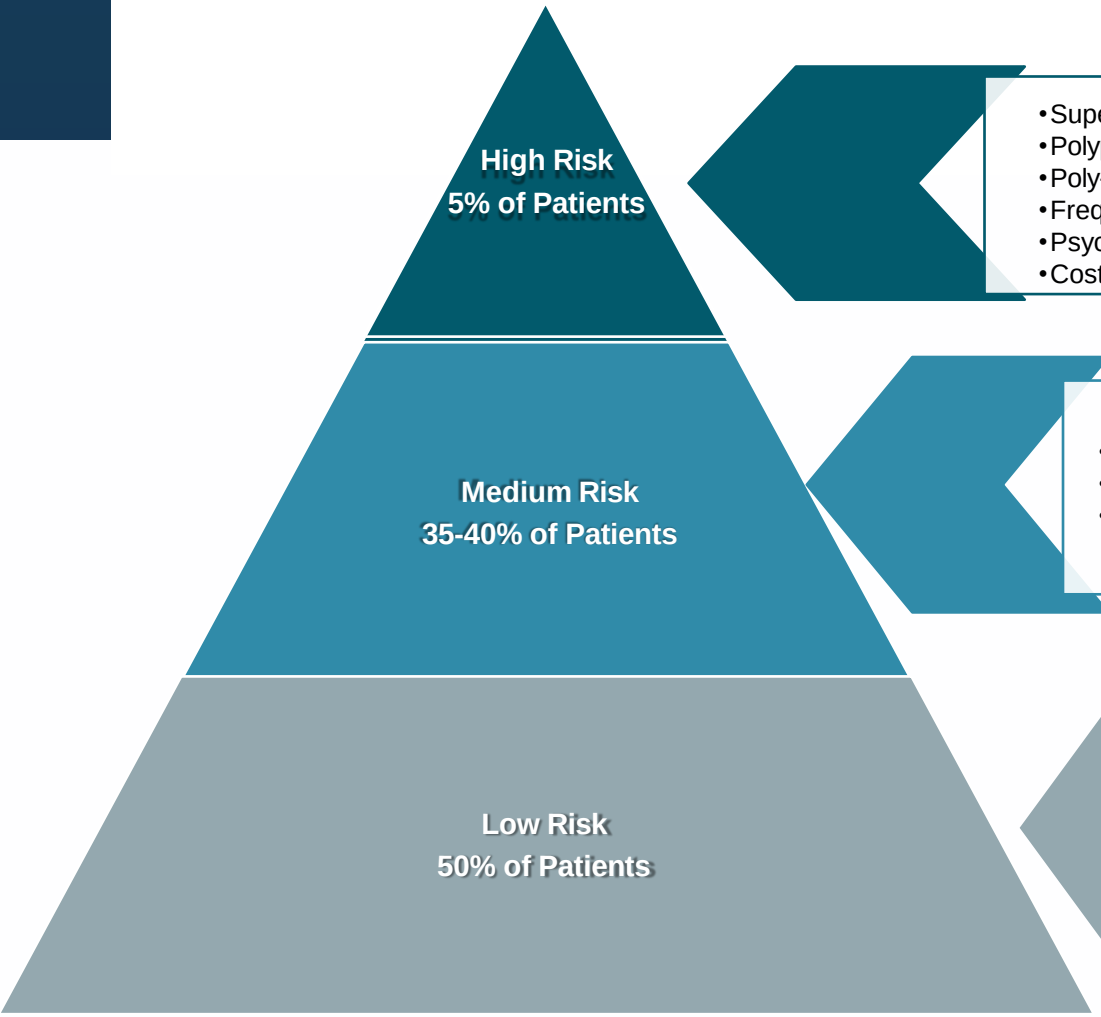
# Stratifying your Population is a Key Success Driver




- Super Utilizers
- Polypharmacy
- Poly-chronic, frail, elderly, limited access to health care
- Frequent hospitalizations and ED visits
- Psychosocial and socioeconomic barriers
- Costs make up 45-50%

**High Risk: Levels 5 & 6**

- Potentially in danger of dying or being institutionalized within the next year
- Has complications of chronic conditions or high-risk social determinants of health

- Limited and stable conditions
- At risk for admissions, ER visits and/or procedures
- Costs make up 30-40%

**High Risk: Levels 3 & 4**

- Has chronic conditions that are out of control but without complications.
- Has chronic conditions but is doing well

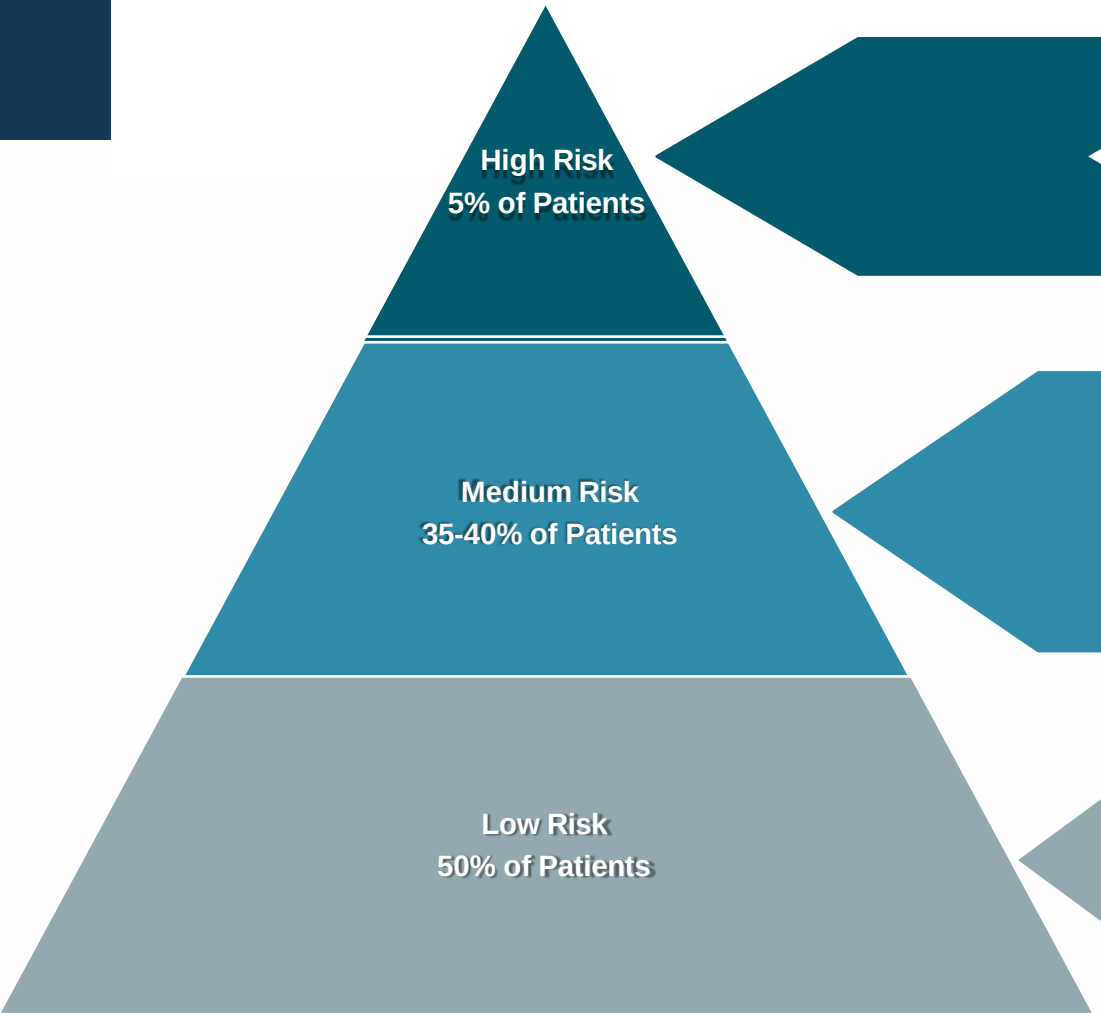
- Healthy
- Minor health issues
- Costs make up 10-20%

**High Risk: Levels 1 & 2**

- Healthy with no medical problems but with out-of-range biometrics.
- Healthy with no medical problems and in-range biometrics

https://www.hrsa.gov/

# Targeted interventions by Risk Group




- Active engagement to enroll in HRCM
- Frequent contact to build trust
- Identify barriers to care ie SDOH needs
- Connection to resources to continue to build supports (Internal supports: PCP, Specialty providers, Pharm D, RNCN, SWK etc
- Community agencies: PACE, CMH, Food pantries)

- Active engagement to enroll in HRCM
- Weekly contact for first month
- Focus on Education, gaps in care and SDOH needs
- Build knowledge for health care access and what to do when they have a medical need
- Connect to resources

- Active engagement to enroll in HRCM
- 7 total outreach contacts in 3 months
- Build medical knowledge and care team for future needs
- Assess and refer for SDOH needs

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

https://www.networkjhsa.org/wp-content/uploads/2021/08/Case-Management-Resources-and-Presentation.pdf

# 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 you 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!

# POM ACO Administrative Team

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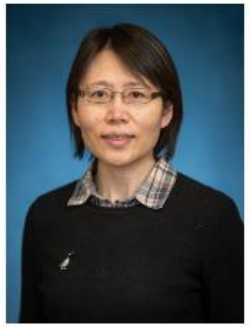

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For questions about the course or how to obtain your CE credits, please contact Eman Sater at emank@med.umich.edu

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