We Need Help! Integrating a Care Manager Into Your Practice

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Disclosures

Nothing to Disclose

(for either of us!!)

Learning Objectives

- Discuss the financial and educational benefits of adding a Nurse Care Manager to your residency practice.
- Develop effective workflows for a Nurse Care Manager within your residency practice.
- Discuss with administration the financial and educational benefits of adding a Nurse Care Manager to your residency practice.

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Poll Question

Where is your program in the process of care management?

A. Thinking about hiring a care manager
B. Have started the process to obtain funding for a care manager
C. Started the process of hiring care manager
D. Already have a care manager, but could refine what they do
E. Confident in hiring and utilizing a care manager

MidMichigan Journey

- ***12/2007*** Faculty member attends PCMH conference
- ***2008-2009*** Faculty PCMH champion brings PCMH ideas to hospital administration
- ***2009-2010*** Faculty champion, office manager, and few administrators form PCMH executive team for hospital/health system

MidMichigan Journey

- ***2009-2011*** PCMH executive team works with physician champions from around Michigan and within local industry to help educate hospital administration about why PCMH is important
- ***2010-2011*** Largest local employer asks health system to focus on quality and cost containment in meaningful way
- ***2011*** Residency becomes first BCBS designated PCMH within health system

MidMichigan Journey

- ***2010-2012*** PCMH executive team arranges local PCMH presentations with outside experts discussing need for care management
- ***2012*** Speaker from MiPCT discussed a goal of 1 care manager per 1000 patient lives for their initiative

Administration considering joining ACO

MidMichigan Journey 2012-2013

- BCBS PCMH designation contingent upon expanding PCMH capabilities
- Already had practice-supported dietician, social worker, registry assistant and Medicare wellness coach
- 7 of 100 capabilities directly dependent upon care manager
- Next logical step to ask administration for support for care manager
- Asked for nurse care manager if we were to participate in ACO-hired October 2013

What We Learned

- Important to build strong PCMH/quality foundation
- Leverage success of other quality/cost initiatives
- Multidisciplinary leadership team useful
- Educated local business leaders can be great allies as they shop for quality health products
- Persistence

Poll Question

Where do you see the most need for a care manager in your office?

A. Transitions of care
B. Direct resident education
C. Coordination of ancillary services
D. Wellness coaching
E. Home visits
F. Other

Nurse Care Manager

- Nurse in our system for 32 years
- Has been with the practice since October 2013
- Fully embedded within our practice full time (40 hours/week)

Care Manager Typical Day

- Attend morning report with residents
- Contact inpatient social workers/case managers
- Review all patients of practice seen in ED or as inpatient in the hospital (ADT information)
- Follow up with any nursing home discharges
- Supervise distribution of calls regarding above
- Phone calls/patient visits

Patient Story

Successes and Limitations

Interaction with Resident Education

- Morning Report
- Referrals/consultation
- Monthly PCMH Meetings
- Home Visits
- PCMH Required Rotation
- Care Management Elective

Morning Report

- Care manager
  - Provides significant background
  - Discusses how plan of care disrupted
  - Discusses how plan of care can be improved
- Residents
  - Identify new patients that may need services
  - Discuss how plan of care can be improved

Referrals/Consultation

- Many patient visits scheduled for resident and care manager at same time
  - Collaborate on best timing of visit
  - Share information
  - Care manager usually able to spend more time
- Walk in referrals available if care manager available
- Many patients meet care manager with their doctor to foster team concept

Referrals/Consultation

- High utilizing patients have usually already spoken with care manager
- Provides notes for resident physician prior to visit
- Prior to visits, discuss pharmaceutical choices and compliance

Monthly PCMH Meetings

- Care manager presents areas where she can be better utilized
- Discusses success stories
- Discusses patients all residents on call need to be aware of
- Discusses plans for appropriate utilization if applicable

PCMH Required Rotation

- During rotation residents must spend time with care manager to learn what the role is
- Discuss proper case management referrals
- Must understand role of care management in our office and how they could incorporate in future

Care Management Elective

- Required in outpatient PCMH area of concentration
- Understand how a practice keeps track of ADT information on patients
- Learn to make transition of care calls
- Arrange home visit if applicable
- Learn more about motivational interviewing

Poll Question

How do you envision paying for a care manager?

A. From existing staff pool
B. Direct patient visits
C. Value-based insurance contracts
D. Increased productivity
E. Other

Funding MidMichigan's Care Manager

- BCBS Patient Centered Medical Home
- BCBS Care Management
- Direct Billing
- Increased Transitional Care Management Costs
- Medicare Shared Saving Program
- CPC+

BCBS Patient Centered Medical Home

- 10% Value Based Reimbursement for PCMH designation
- Designation based on quality and # of capabilities
- 7/100 capabilities related to care management
- Would be more difficult/expensive to obtain without care manager
- 2015 $36,000: 2016 $50,000 (est)

BCBS Care Management

- 5% Value Based Reimbursement for billing care management services to designated number of patients
- 2016 $25,000 (est)

Direct Billing

Code	Reimbursement	How provided	Frequency	Provider
G9001	$118.55	Initial face to face	1/year/patient	Care manager
G9002	$59.28	Subsequent face to face	Daily	Care manager, PharmD, LMSW
G9008	$50.15	Initial referral	1/doctor/lifetime	Doctor
G9007	$30.09	Doctor discuss with care team	Daily	Doctor
S0257	$30.00	Advanced Care Planning	Daily	Care manager

Direct Billing

Code	Reimbursement	How provided	Frequency	Provider
98966	$13.68	Phone with pt 5-10 min	Daily	Care manager, PharmD, LMSW
98967	$29.27	Phone with pt 11-20 min	Daily	Care manager, PharmD, LMSW
98968	$42.19	Phone with pt 21-30 min	Daily	Care manager, PharmD, LMSW

Increased Productivity

- Increased provider time to see patients
- Increased visits from appropriate ER follow-up patients
- Transitional Care Management generally reimbursed higher than standard office visit

Transitional Care Management

	Medicare	Medicaid	BCBS	Cofinity
99495	$158.58	$91.52	$229.37	$257.60
99214	$104.59	$79.66	$107.33	$136.83
Difference	$53.99	$11.86	$122.04	$120.77

Medicare Shared Saving Program

- First and largest group from our health system in our ACO MSSP
- All cause readmission rate has decreased 16% 2015 to 2016
- Office visits within 30 days of discharge 799 per 1000 over baseline 750 per 1000
- Current cost per member per month down $438 2015 to 2016

CPC+

- Clinic just notified of admission into Comprehensive Primary Care Plus program
- Makes funds available for care coordination services
- Have used the funds for a second care manager focused on chronic disease management

Summary

- Process of hiring care manager requires concerted effort
- Care manager can fill multiple roles in a practice
- Care manager can provide meaningful resident education
- Multiple funding sources are available for care management services

Thank You

Questions?

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