



MiHIN
Shared Services

Building Michigan's Coordination Of Care Infrastructure

*Findings from the Coordinating the Care Coordinators
Workshop Series 2017*

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Executive Summary

“Care coordination is not about seeing the patient, but seeing the individual.”

- Attendee, Coordinating the Care Coordinators Workshop

The coordination of care is a critical component to providing person-centered care in clinics and communities in Michigan. However, fragmentation and silos inhibit optimal coordination across organizations. Michigan needs to strengthen its statewide infrastructure to help coordinate care coordinators.

The primary goal of this white paper is to help the Michigan Health Information Technology (HIT) Commission understand specific actions stakeholders can take together to improve aspects of coordination of care coordinators related to technology. In order to provide sufficient context for the actions, the paper describes the status quo around the coordination of care in Michigan and the broader vision that directly impacts the proposed actions. The HIT Commission is responsible for facilitating and promoting the design, implementation, operation, and maintenance of an interoperable health care information infrastructure in Michigan.

A secondary goal of the white paper is to acknowledge that technology development must be incorporated into broader opportunities to build a statewide coordination of care infrastructure that may relate to reimbursement, care delivery, workflow, or regulation. The ultimate goal is well coordinated care with all participants in the care process working together with common information, care plan, and goals.

The white paper seeks to describe these broader opportunities with enough detail that individuals and organizations can consider working together to implement common solutions. The target audience for these broader opportunities includes all individuals who participated in the workshop series and other leaders committed to implementing the white paper's next steps.

The Coordinating the Care Coordinators Workshop Series

The *Coordinating the Care Coordinators Workshop* series was hosted by the Michigan Primary Care Consortium (MPCC) with support from the staff of the Michigan Health Information Network Shared Services (MiHIN). The workshop series took place between May and July of 2017 and involved more than 150 participants. The attendees of the workshop series represented a broad spectrum of organizations throughout the state of Michigan from across the care continuum, including community-based organizations providing social services.

One positive takeaway from the workshop series was the passion of attendees to make a difference around coordination. Every attendee had an opportunity to make suggestions

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and share thoughts during workshop discussions and during reviews of this paper. Lively small and large group conversations collectively defined the “Coordination of Care” as:

Coordination of Care: 1. Monitoring a person’s goals, needs, and preferences. 2. Acting as the communication link between two or more participants concerned with a person’s health and wellness. 3. Organizing and facilitating care activities and promoting self-management by advocating for, empowering, and educating a person. 4. Ensuring safe, appropriate, non-duplicative, and effective integrated care.

Coordination of Care

Five infrastructure elements describe the coordination of care’s status quo. Each element and its current state are described below:

- **Service Delivery:** Care coordinators often exist within a hub-and-spoke relationship of service delivery. The person seeking services is the hub and service practitioners (e.g. clinicians, social service professionals, and peer supports) are the spokes. Duplication occurs often in this model due to lack of standard exchanges of information, fragmented reimbursement models, and lack of a “quarterback,” or lead care coordinator.
- **Regulations:** Managing and adhering to state health plan, state government, and national program policies regarding the coordination of care has become burdensome for care teams and community partners who are equally – if not more – important to a person’s health and wellness.
- **Reimbursement:** Michigan does not have a common way to pay for coordination of care services. As a result, there is a high level of variation across payment programs which can lead to a high probability of service delivery duplication among organizations seeking reimbursement.
- **Technology:** Technical systems can help facilitate the coordination of care information exchange and organize service delivery across organizations. However, end users need to more clearly define the most important data-sharing opportunities to develop. More application program interfaces must also be utilized to increase interoperability between different information systems.
- **Workflow:** The hand-off of information between two organizations is a critical moment in the coordination of care. Workshop participants identified the shared care plan as the most important item that needs to be communicated across organizations.

A Vision for the Coordination of Care

As defined by the Substance Abuse and Mental Health Services Administration (SAMHSA), the “Coordination of Care” addresses eight dimensions of wellness: emotional, environmental, financial, intellectual, occupational, physical, social, and spiritual. When the coordination is performed correctly, and when effective technology solutions that ease information exchange are in place, care coordinators should be responsible for connecting

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these individual elements of wellness and coordinating service providers responsible for helping an individual achieve wellness in these eight areas.

Next Steps

Michigan stakeholders need to create specific action items to realize its positive vision for the coordination of care. The workshop series produced key action items beyond defining “Coordination of Care.” The actions are:

- Develop criteria to identify communications among coordination of care “quarterbacks” and support teams
- Develop pilot demonstrations to test use cases:
 - Populate ACRS and Statewide Health Directory adoption by everyone doing coordination
 - Quality measure information related to receiving gap in care notifications
 - Use ICD-10 to track social determinants of health and link to quality measures
 - Standardization of screening and assessment tools
- Close loop referral tracking (Statewide Health Directory/ACRS)
- Align communication strategy with payers for coordination of care
 - Promote ICD-10 codes to track social determinants of health
 - Measure coordination return-on-investment at the population health level
 - Educate grant-funded care coordinators on how to submit \$0 claims

Authors

The Coordinating the Care Coordinators workshop series and this white paper were a collaborative effort led by the Michigan Primary Care Consortium with support from the Michigan Health Information Network Shared Services. The authors plan to use this white paper to help develop more detailed pilots and to inform key stakeholder groups like the HIT Commission.

About the Michigan Primary Care Consortium (MPCC)

The Michigan Primary Care Consortium is a nonprofit organization that facilitates knowledge exchange to help integrate care. Diversity is MPCC's core strength. MPCC members represent the following types of organizations: physician organizations, health plans, large employers, professional associations, state government, quality improvement organizations, community-based organizations, public health, and academic institutions. Learn more about MPCC's priorities and deliverables at www.mipcc.org.

MPCC joined with MiHIN to write this white paper because coordinating care coordinators is a significant issue for its diverse members. The workshop series helped members define solutions to common organizational issues that stem from systemic, statewide opportunities for improvement. MPCC plans to use the white paper's next steps to determine how to continue investing in coordinating care coordinators.

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About the Michigan Health Information Network Shared Services (MiHIN)

The Michigan Health Information Network Shared Services is Michigan's state-designated entity to improve health care quality, efficiency, and patient safety by sharing electronic health information statewide, and helping reduce costs for patients, practitioners, and payers. MiHIN is a nonprofit, public-private collaboration that includes stakeholders from the State of Michigan, health information exchanges that serve Michigan, health systems and practitioners, health plans/payers, pharmacies, and the Governor's Health Information Technology Commission.

MiHIN views its mission as aligned with the need for better coordination of care, since technology can help share information and build lines of communications between members of a care team.

Editors

The authors appreciate these individuals who thoroughly reviewed the white paper:

- Katherine Commey, MPH, Michigan Department of Health and Human Services
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- Steve Williams, Executive Director, Michigan Center for Clinical Systems Improvement

Introduction

Right now, fragmentation and silos inhibit optimal coordination of care throughout Michigan. This workshop and conference call series convened a broad community of individuals from across Michigan to frame a statewide approach that could make the coordination of care more transparent.

The aim of the *Coordinating the Care Coordinators* workshop series was to find opportunities to make care coordination more transparent in Michigan, with an emphasis on infrastructure. Infrastructure included aspects of service delivery, reimbursement, regulations, technology, and workflow related to care coordination.

Workshop attendees included representatives from:

- Associations (e.g. physicians, pharmacists, nurses, health centers)
- Community mental health agencies
- Community organizations (e.g. Area Agency on Aging, the Greater Detroit Area Health Council, Inc.)
- Grantmaking organizations
- Health information exchange organizations
- Health plans
- Health systems
- Home health
- Physician organizations
- Skilled nursing facilities
- State government representatives
- Training organizations (e.g. Michigan Care Management Resource Center, MPRO, Michigan Center for Clinical Systems Improvement, universities, Practice Transformation Institute)



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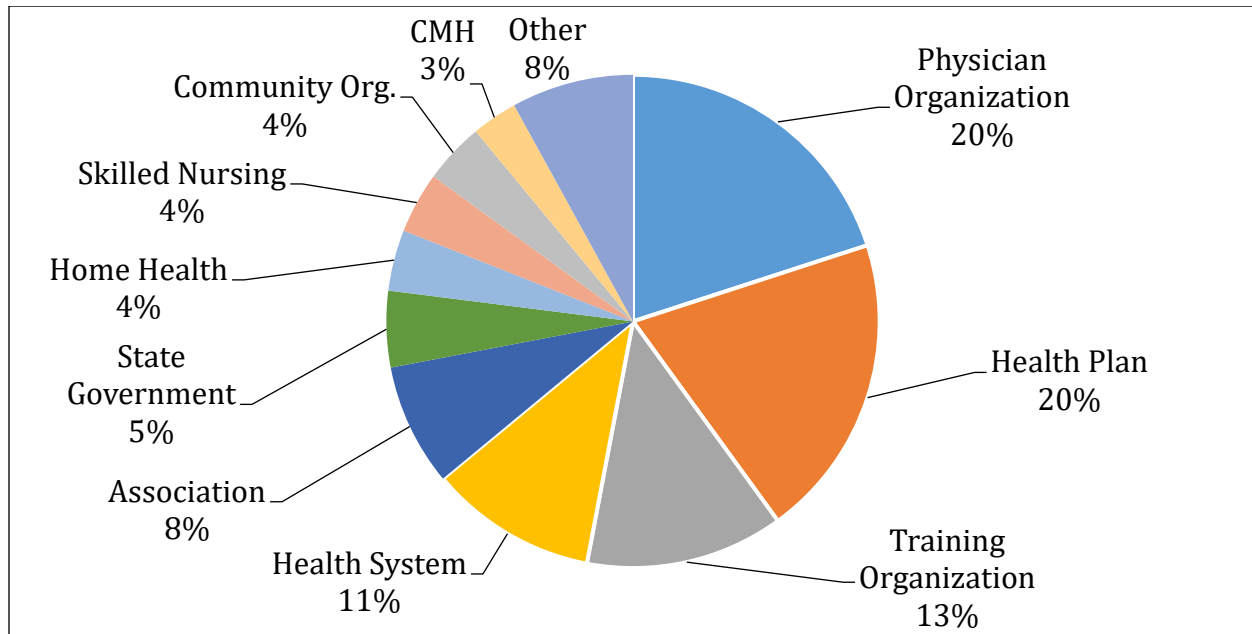


Figure 1. Workshop Participants

More information on attendees and their respective organizations can be found in Appendix B.

Please note, throughout this document “person” is an all-encompassing term, referring to: the patient (consumer), the individual receiving coordination of care assistance, or the beneficiary of a health plan. In other words, the “person” is the focus of attention for people providing care or overseeing the coordination of care services. Active engagement of the person in his or her health and wellness alongside coordination professionals was an important theme throughout the workshop series.

The targeted scope of payer populations and regulations include commercial and Medicare populations as well as Medicaid—both managed care and fee-for-service, as well as non-managed dual enrollees.

Information on each workshop can also be found in the appendices.

- Agendas for each of the workshops can be found in Appendix C.
- Appendix D details each workshop, discussing individual goals and results of the conversations and exercises.

The Coordination of Care Today Across Michigan

Today, care coordination guidelines are inconsistent and do not address many of the key elements that could optimize quality, efficiency, outcomes, and influence new payment directives. Adding to the lack of consistent care coordination guidelines is the absence of a universal job description that outlines roles and responsibilities.

At the workshops, the complexity of describing the status quo of such a broad cross-section of settings challenged participants. It took two workshops and two conference calls before attendees could agree on a general definition for “Care Coordination.” And this was after the attempt to define “Care Coordinator” was abandoned.

For more than a decade, two Michigan payers, Blue Cross Blue Shield of Michigan (BCBSM) and Priority Health, in collaboration (discussed more in detail below) with physician organizations have championed care coordination activities. BCBSM through the Physician Group Incentive Program (PGIP) spearheaded a pilot project to test various care coordination models with five physician organizations. Lessons learned through this pilot project contributed to the statewide expansion of provider delivered care management and influenced the Centers for Medicare and Medicaid Services (CMS) Innovation Center (CMMI) to award projects to Michigan, such as:

- Michigan Primary Care Transformation Project (MiPCT)
- State Innovation Model (SIM),
- Comprehensive Primary Care (CPC+)

Defining the Coordination of Care and Its Context

While there are ongoing efforts to promote team-based, interprofessional collaboration, there is not a universally accepted definition for the “Coordination of Care” in Michigan. Initial research revealed it is a broad term, an umbrella covering many different disciplines and needs. For example, emerging research is beginning to study ways nonprofit organizations participate in population health networks. Contributions from these community partners include: volunteering, feedback, expertise, connections/networking, and advocacy.¹

¹ Rachel Hogg-Graham, “An Examination of Nonprofit Organization Participation in Population Health Networks,” AcademyHealth (June 24, 2017), accessed August 7, 2017, <https://academyhealth.confex.com/academyhealth/2017ig/meetingapp.cgi/Paper/19621>

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Attendees worked together to define “Coordination of Care” as:

Coordination of Care: 1. Monitoring a person’s goals, needs, and preferences. 2. Acting as the communication link between two or more participants concerned with a person’s health and wellness. 3. Organizing and facilitating care activities and promoting self-management by advocating for, empowering, and educating a person. 4. Ensuring safe, appropriate, non-duplicative, and effective integrated care.

The coordination of care is not done to or for a person but in partnership with the person (person-centered), which results in many different variations of coordination. This made creating a common definition a challenge for workshop participants. The confusion around defining “Coordination of Care” is not a unique problem that is perplexing just Michigan. In a prominent report from the Agency for Healthcare Research and Quality, researchers found 40 different varieties of definitions.² The Institute for Healthcare Improvement (IHI) defines coordination as “a mechanism to assess the effectiveness of the care plan and make adjustments in order to avoid the need to deliver care in more expensive environments such as acute care facilities.”³

Beyond the definition of “Coordination of Care”, the length of time for a person’s relationship with various care coordinators can be very different (see Figure 2, below).

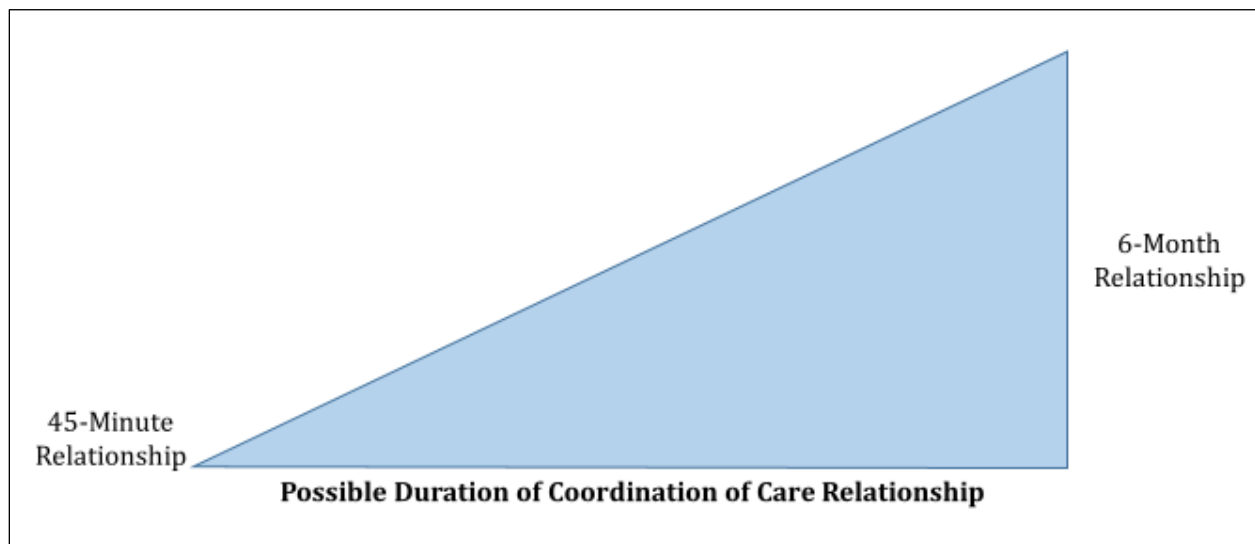


Figure 2. Coordination of Care Relationship Durations

² Kaveh G. Shojania, M.D., et al., *Closing the Quality Gap: A Critical Analysis of Quality Improvement Strategies, Volume 7*, Agency for Healthcare Research and Quality (Washington, D.C.: U.S. Department of Health and Human Services, 2007), 33

³ C. Craig, et al., *Care Coordination Model: Better Care at Lower Cost for People with Multiple Health and Social Needs*, (Cambridge: Institute for Healthcare Improvement, 2011), 3.

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Due to these variances, it can be difficult to determine what type of care coordinator a person needs at a particular point in time or based on their diagnosis, co-morbidities, and required level of service.

Communication Impacts on Coordination

It is common for people to have more than one physician or healthcare practitioner in their healthcare circle, or “care team.” People may also be accessing community-based services from several different organizations, such as food banks, transportation services, housing, and more.

These care and community team members need to be kept informed of a person’s status in order to with the individual and each other effectively to improve the person’s health and well-being. For many practitioners and professionals, the person (or caregiver/family member) is the only means to communicate any changes in a person’s needs and health status.

Current communication processes can create significant gaps in the sharing of information, such as:

- Appointment details
- Assessments
- Avoidable emergency department utilization
- Discharge and admission dates
- Eligibility for benefit programs
- Medications
- Mental health services
- Self-management education support
- Social determinants of health
- Treatment plans

If the person does not remember exactly what a previous practitioner said, misinterprets a diagnosis, or misunderstands a treatment regimen, then other care team members may be missing critical information. This lack of complete information may also limit the effectiveness of a care coordinator and a person’s effort to make decisions using a shared decision-making framework.

Additional consequences may include disjointed treatment plans, adverse medication reactions, and duplication of labs and other diagnostic tests. All of these complications may endanger the health and wellness of the person, cost the healthcare and social service organizations time and money, and impede an organization’s ability to deliver the highest level of service.

These communication challenges can lead to duplication. Many attendees at the workshop discussed the problem with duplication of paperwork and requests and how this impacts their work and their office. Duplication concerns are discussed more in detail below.

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Infrastructure

During the workshop series, five elements were introduced as crucial around the coordination of care. These elements define the infrastructure needed to strengthen the coordination. They were presented to the attendees as five corners of a star (Figure 3), with many discussions revealing how the elements are interconnected and need to be simultaneously addressed.

- **Service Delivery:** How a person receives the coordination of care, also referring to the people who are coordinating
- **Regulations:** Governing regulations from the state or national level that impact coordination of care and what can be shared among coordinators
- **Reimbursement:** Different funding opportunities available to support the coordination of care
- **Technology:** Technical solutions that assist in the exchange of information and oversight of a person's care
- **Workflow:** The coordination of care, including handoffs, communication and interaction between multiple coordinators, between care team members, and between coordinators and people

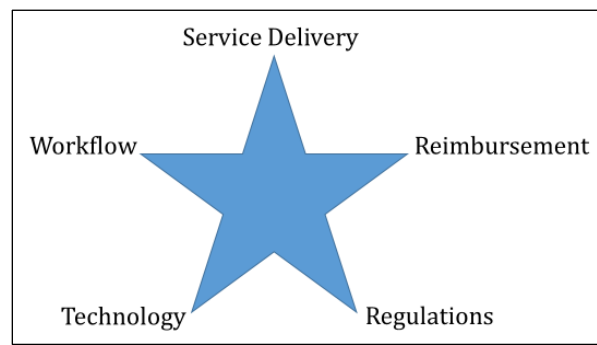


Figure 3. Infrastructure Needs

The status quo of each element is discussed more fully below.

Service Delivery

“Service Delivery” refers to how a person receives/interacts with care coordinators across a continuum of settings, including:

- Hospital
- Health plan
- Skilled nursing and rehabilitation
- Primary care
- Specialty care
- Behavioral health care
- Community
- Home (home care)

Also, service delivery refers to the individuals responsible for completing coordination of care activities. This can include many different types of individuals, such as a care manager, social worker, nurse, or even family member.

One image that resonated with attendees was describing the current service delivery using a hub and spoke relationship (as presented in Figure 4, below). However, this section does not attempt to define the ideal service delivery for coordination of care services. The goal

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here is to begin a dialogue about standards of practice to be further informed by community initiatives and end users.

The person appears in the middle (hub) and is surrounded by care team members (spokes). These care team members could be from within one agency or from different organizations and can include professionals based in the community.

Care team members are typically multi-disciplinary and provide services based on their scope of practice as a health plan case manager, nurse care manager, pharmacist, peer support specialist, behavioral health specialist, community health worker, primary care physician, etc.

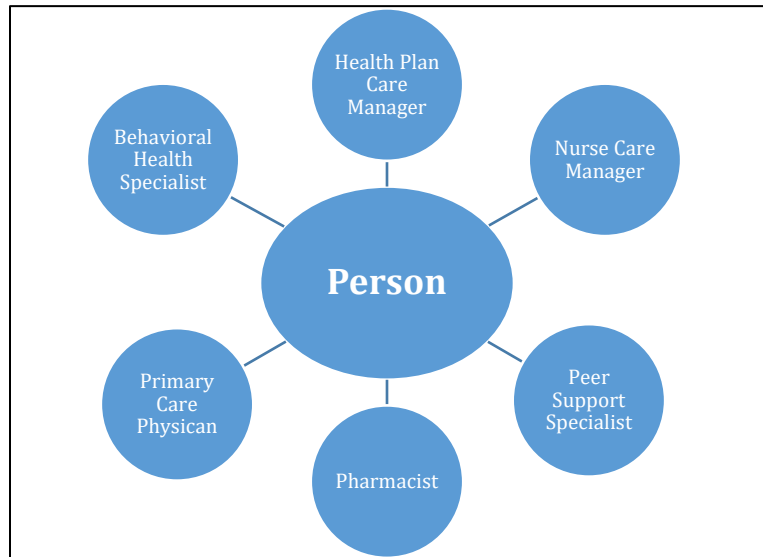


Figure 4. Example Care Team and Person Relationship

The person in this description is the center “hub” and is a key contributor to their own treatment plan and related efforts to enhance their quality of life. The care coordinator helps identify barriers to treatment that all team members can help manage. A major issue with the status quo is that there is not always a lead care coordinator, or “quarterback” who knows all of the “spokes” and what everyone is working on with the person. While there is a positive with the patient being at the center, it also places a burden on them to make sure everyone is informed. In many ways, this relationship structure assumes the patient (person) is capable of taking ownership of their health and social needs. The hope is for self-determination, but sadly, for some patients (especially those with complex conditions or elderly) that is not easily feasible.

How a person is aligned with a care coordinator (or multiple coordinators) is different based on needs, health plans, opportunities, conditions, and community. As noted by one community-based organization, their clients are determined at the time of this writing by who steps into the office, they are not selected or given by a health plan. In other words, if a person does not take that step, they might be missing opportunities for assistance or coordination of care in their area.

Health plans care a great deal about the success of care team relationships since health plans are often at full risk for the cost of care. This risk can make health plans reluctant to turn over members to another entity, unless there is a lot of oversight and documentation showing that the person is getting the attention necessary. Many times this oversight and multiple documentation demands can be overbearing for community-based organizations.

As one attendee noted from the Community Mental Health (CMH) perspective, there are circumstances that involve two leads who are working in partnership to get treatment

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coordinated for a person. The CMH system can be very complicated and hard to understand if a member is outside the mental health system, so having a lead within the system is helpful. The same can also be said for health systems and physical health systems, as having a lead within a specific system of care can be more efficient and help get care coordinated in a timelier fashion.

Defining the coordination of care leadership for different circumstances is an ongoing issue for virtually all workshop participants.

Duplication Concerns

Because of the wide variety in service delivery, care coordinators are in constant danger of duplicating work completed by other care coordinators.

For example, when a person is being discharged from a hospital, that person may end up having the same conversation with numerous individuals who each have a role in the person's care (health plan representative, primary care provider, specialist, hospital staff, etc.). This duplication was also mentioned by some attendees during a coordination of care game activity during Workshop #3 (discussed in more detail in Appendix D).

Duplication also occurs when organizational and funding source policies require care coordinators to solicit the same information from people during repetitive meetings, intake processes and related assessments required before service delivery so that the care coordinator assisting the person can be reimbursed for these services. Speaking with Upper Peninsula Commission for Area Progress (UPCAP), they described the level of duplication as "death by assessment." Everyone asks the same questions at multiple levels. This duplication adds to the frustration and dissatisfaction of the product by those it is designed to serve.

Regulations

The regulatory environment which shapes the coordination of care is complex. It can be described in two continuums: Public vs. Private and Payor vs. Provider (as presented in Figure 5, below). Even though there are regulations which apply equally to public and private sector (such as HIPAA or HiTECH, discussed below) these two dimensions in four combinations help to provide a framework for seeing how regulations impact the coordination of care.

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The regulation framework can be compared to that of a waterfall, with federal rules falling through federal agencies to state agencies and, finally to state rules. They are then implemented through vehicles such as contracts, defined benefits, population health policies, quality of practice and payment reform initiatives.

There are eleven agencies inside the US Department of Health and Human Services which regulate both private and public sector health care. Each sector is internally aligned, whether looking at existing policy or innovation efforts; however, the sectors are not always in alignment with each other and they lack a singular test of integration. This lack of alignment creates conflict and inefficiency in the field of practice.

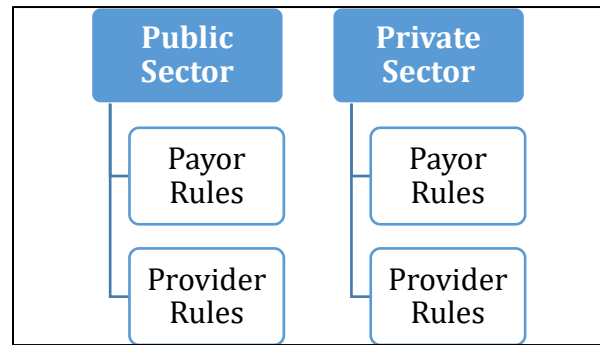


Figure 5. Regulation Continuums

Public Sector regulations – such as the Affordable Care Act, Social Security Act, Health Information Technology for Economic and Clinical Health Act (HiTech), Medicare Access and CHIP Reauthorization Act (MACRA) – all speak to the practice or requirement around the coordination of care.

At the federal level, entities such as CMS, which approves the state level Medicaid Plan, and the Substance Abuse and Mental Health Services Administration (SAMHSA) which funds innovation grants, are both highly involved in defining and innovating in the field of public sector coordination of care.

At the state level, the largest regulatory entity which addresses the coordination of care is the Michigan Department of Health and Human Services (MDHHS). The department authors and negotiates with CMS the terms of Medicaid State Plan and then contracts with managed health plans and prepaid-inpatient health plans for the implementation of the Medicaid benefit. Coordination of care is defined in the scope of work in those contracts and its detailed in the Medicaid Provider Manual.

Reimbursement

The utilization of care coordination or quality improvement incentives leads to improved patient satisfaction, improved quality of care, and a decrease in hospitalizations, emergency room visits, and overall cost. These results are especially true for high-risk patients with multiple chronic conditions.

David Dorr, “The impact of care coordination versus pay-for-performance incentives on utilization at 6 months: the ICCIS cluster randomized controlled trial,” *Care Management Plus*, 6.

There are many different funding sources available to assist with the coordination of care. Some funding is available through grants or charities aimed at helping a specific population

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(elderly, homeless, children in poverty, veterans, etc.). Sometimes funding is supplied via health plans, since the coordination of care can improve utilization and save health plans money, for example by cutting down the number of readmissions to a hospital.⁴ Despite these different funding sources, research indicates the level of direct reimbursement for the coordination of care may not be adequate; one study finds that reimbursement may cover only 21% of the costs of coordination to primary care offices.⁵

A decision to support the coordination of care, especially for more complicated conditions, can considerably reduce health plan costs. These decisions have become more evident as many practitioners begin to move away from more traditional fee-for-service care to more value-based care.⁶

Nationally, there is migration of payment to value-based payment with more of a shared-savings and quality improvement approach. Details of this approach can be found in the 2015 bi-partisan MACRA bill.⁷

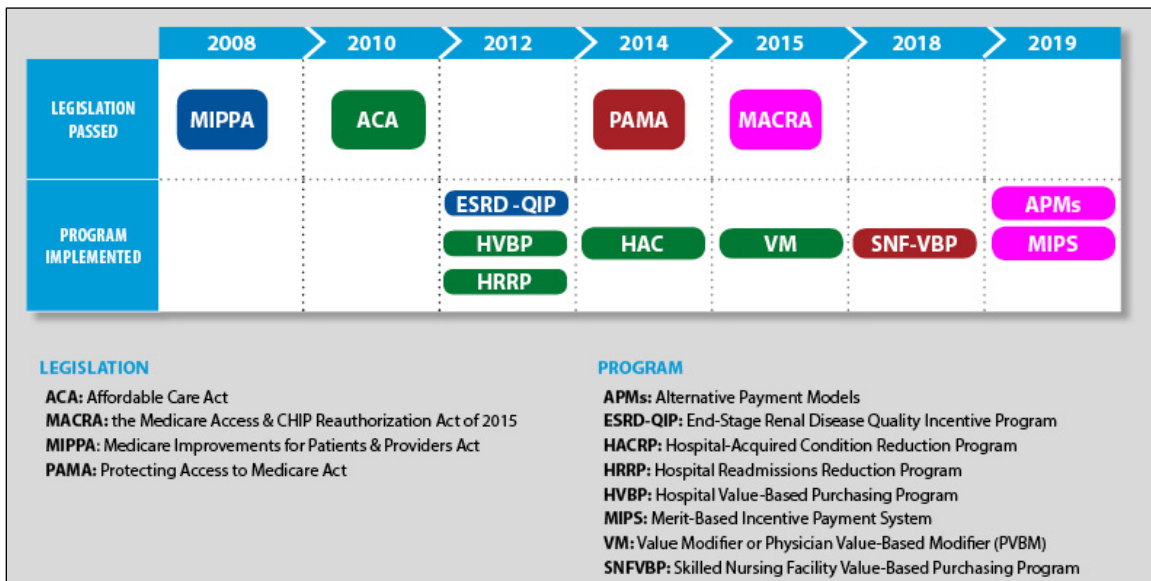


Figure 6. Value-Based Programs⁸

⁴ CG Wise, et al.. "Population-Based Medical and Disease Management: An Evaluation of Cost and Quality," *Disease Management* 2006;9(1):45-56.

⁵ JS Holtrop, et al., "Inadequate Reimbursement for Care Management to Primary Care Offices," *J Am Board Fam Med* 28 (2) (March 2015), 271-270, accessed August 7, 2017, <https://www.ncbi.nlm.nih.gov/pubmed/25748769>

⁶ Bruce Japsen, "Health Insurers Hire Thousands of Nurses to Coordinate Care," *Forbes* (September 25, 2015), accessed May 24, 2017, <https://www.forbes.com/sites/brucejapsen/2015/09/25/health-insurers-hire-thousands-of-nurses-amid-shift-to-value-based-care/#9222d976d9d7>

⁷ "MACRA," Centers for Medicare and Medicaid Services, accessed July 18, 2017, <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/MACRA-MIPS-and-APMs.html>

⁸ "What are the value-based programs?" Centers for Medicare and Medicaid Services, accessed July 18, 2017, <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Value-Based-Programs.html>

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This trend towards value-based payment will likely increase over time, as insurers will require more easily-manageable ways to track not only their savings, but whether the coordination of care is accomplishing its goals via person and practitioner satisfaction (in coordination with community-based organizations) to address a person's social determinants of health.

Additional reimbursement models being explored or utilized by health plans/payers include payment based on the use of CPT and G codes (an example is shared as Appendix E), or a per member-per month approach used by the State of Michigan Medicaid and Medicare.

Michigan-Specific Reimbursements

Coordination of care payment in Michigan has been driven by four significant initiatives:

- The State Innovation Model (SIM) Patient Centered Medical Home Initiative supported by CMS and the State of Michigan Medical Services Administration that began in 2017
- BCBSM Provider Delivered Care Management Initiative
- Michigan Primary Care Transformation (MIPCT) Project grant awarded by CMS in 2011
- The Comprehensive Primary Care Plus (CPC+) grant awarded by CMS in 2017

The MIPCT Project defines its model as:

... a three-year, multi-payer, state-wide project aimed at reforming primary care payment models and expanding the capabilities of patient-centered medical homes (PCMH) throughout the state. The selection of Michigan as one of eight states in the Multi-Payer Advanced Primary Care Practice Demonstration (MAPCP), sponsored by the Centers for Medicare and Medicaid (CMS), was the catalyst for bringing together Medicare, Michigan Medicaid Health Plans, Blue Cross Blue Shield of Michigan and Blue Care Network to improve upon the strong PCMH foundation in the state and create a uniform, sustainable primary care platform.⁹

The MiPCT payment model incorporated two payment approaches, one supported by the commercial payer partners, and the other supported by Medicare and the State of Michigan Medicaid. Commercial payer partners reimburse participating primary care practices/providers on a fee-for-service basis through the use of specified CPT and G codes (See Appendix E). Medicare and the State of Michigan Medicaid supported coordination of care through the provision of a per member-per month payment.

In the wake of the MiPCT demonstration project end (December 31, 2016), Michigan has experienced a number of methods to maintain or accelerate the possibilities for continued support of coordination of care services within a primary care setting. Subsequent to MIPCT, Blue Care Network (BCN) is no longer reimbursing for care management/coordination of care in the provider delivered models (discussed below). However, many

⁹ "Project Model," MiPCT Demonstration Project, accessed July 18, 2017, <https://mipct.org/about-us/project-model/>

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commercial payers and Medicaid Health Plans have continued to support the coordination of care through primarily fee-for-service reimbursement on a set of G and CPT codes, national and statewide programs have afforded alternative approaches to maintaining financial support to providers invested in the delivery of coordination of care services.

An example of national program support in the state of Michigan is the CPC+ program. Effective in 2017, CPC+ is one model that provides continued reimbursement for care management via shared savings and incentives based on quality metrics. The care management requirements for this program do not focus specifically on an individual service provider (not referencing, per se, a “care manager”), rather define a set of activities related to care management services. It appears more aligned with the Chronic Care Management (CCM) codes released in 2015 and updated in 2016, where care management is referencing activities associated with specific actions that could be performed by non-licensed individuals such as medical assistants.

This payment model is open to a set of primary care providers across the state that completed an application process and were deemed qualified for participation by CMS.

Similarly, the State Innovation Model is a cooperative agreement awarded to the State of Michigan by CMS. A main component of the SIM is focused on supporting advanced primary care capabilities through the Patient-Centered Medical Home (PCMH) Initiative. The PCMH Initiative utilized the foundation of the MiPCT demonstration to support primary care providers/practices either located in a SIM test region or previous MiPCT demonstration participant in the continued provision of care management and coordination services to their attributed Medicaid population. The payment model for the SIM PCMH Initiative mirrors the model previously used in the MiPCT demonstration, in which care management and coordination services are supported through a per member per month payment.

Practitioners that were not selected for participation in either CPC+ or the SIM PCMH Initiative rely on reimbursement through traditional contracting mechanisms with both commercial payers and Medicaid health plans. While many payers provide reimbursement for some care management services in fee-for-service reimbursement or capitated payment model, it is not consistent across payers

Reimbursement for coordination of care primarily covers services provided by care managers with a few codes to reimburse practitioners for oversight of care manager actions.

The Blue Cross Blue Shield of Michigan (BCBSM) Physician Group Incentive Program works to advance the coordination of care across Michigan with the Patient-Centered Medical Home (established in 2008) and Provider-Delivered Care Management (PDCM, first piloted in 2010, then linked to MiPCT in 2012). These programs have the shared goals of helping create both the financial and organizational infrastructure needed to implement care management consistently and effectively. This is accomplished through the following tactics:

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- Providing additional reimbursement to physicians who work with care managers to deliver services to chronically ill patients in the office setting
- Rewarding physician organizations with financial incentives for their efforts at helping practices develop care management capabilities
- Supporting the Care Management Resource Center in their efforts to train care managers around the state

Beginning April 1, 2012 BCBSM began accepting and paying claims for Provider Delivered Care Management services delivered by qualified Primary Care Physicians to patients in physician practices that are privileged by BCBSM to be reimbursed for these services... Provider Delivered Care Management refers to a comprehensive array of patient education, coordination and other support services delivered face-to-face and/or over the telephone by a variety of ancillary health care personnel who work collaboratively with the patient (and where indicated, the patient's family) in conjunction with the patient's personal physician. Services are performed within the context of an individualized care plan designed to help patients with chronic and complex care issues address medical, behavioral, and psychosocial needs such that the patient can be successful in meeting personal health care goals that contribute to optimal health outcomes and lower health care costs. The integration of PDCM services into the clinical practice setting is considered a key component of the patient centered medical home care model that BCBSM is fostering in its efforts to transform the way health care is delivered in Michigan.

"Provider Delivered Care Management Payment Policy and Billing Guidelines for Blue Cross Blue Shield of Michigan Commercial," Blue Cross Blue Shield of Michigan (August 2014), 1.

BCBSM continues to reimburse for the 12 care management codes associated with care management, through PDCM. The PDCM program expands upon the work of MiPCT by allowing Blue Cross Patient-Centered Medical Home Physicians the opportunity to bill for care management services using a trained care manager, and to potentially receive value-based reimbursement if the practice meets training and billing criteria.

There are some differences as to what level of licensure is required to function as a "care manager," and subsequently submit a claim for care management services. The national approach (CPC+) places the physician or advance practice provider as the responsible care coordinator, utilizing the services of others on the care team, often referred to as the qualified health professional (QHP); while BCBSM describes the main provider of care

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management as the "lead" care manager (RN, MSW, PA or NP); and Priority Health references the MIPCT guide, following BCBSM's definition.

In respect to the coordination of care reimbursement for services and practitioners external to the primary care provider/team, the process is very limited and time consuming.

Also, code 99487 related to chronic care management services¹⁰ requires the care team to track time spent communicating with the patient. If time accrues to more than 30 minutes, there is payment for the activity. If the time is less than 30 minutes, the code requirements are not met, and therefore there is no reimbursement for the time spent.

Technology

Care coordinators across the care continuum may draw on many different technical solutions for information sharing and to help with a person's assistance and oversight. These solutions can include electronic health records (EHRs), pharmacy systems used to track medications, and more general computer resources being used in an office (like Microsoft Word or Excel). While EHRs and health plan coordination of care applications have made contributions to information sharing and coordination of care, many organizations today still rely on fax for communication with other organizations with more limited use of email, and social media.

Since there are no guidelines defining which technology solutions that the coordination of care should use, care coordinators (as well as in-home care including family) use what is available to them. The differences can be stark. Large health systems and payers have a very organized and strategic approach to technology that supports the coordination of care; yet, some community-based organizations might not have access to EHRs or even reliable, modern computer applications.

One example of technology issues was shared by Dr. David Wingard of TrueNorth Services. TrueNorth is a community-based organization working with Spectrum; however, they do not have access to Spectrum's EHR systems. TrueNorth had to adapt a platform (SugarCRM) to collect a person's information. Since the technology does not communicate with Spectrum, the coordinators and contacts need to speak to each other, making sure both have the correct and current data.

Workshop participants also acknowledged the role of EHR systems apart from health information exchange. Practitioners have invested in EHR systems that can track clinical health outcomes. Some participants feel that health information exchange and data interfaces should help facilitate the communication of these outcomes but avoid being overly prescriptive in how service delivery documentation is completed.

To help improve efforts around the coordination of care, public and private corporations have worked together to create portals, contact centers, directories and other technology

¹⁰ Department of Health and Human Services, "Chronic Care Management Services," Medicare Learning Network (December 2016), accessed July 18, 2017, <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf>

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solutions, all aimed at helping patients navigate a complex and dynamic healthcare system. More recently, these innovative solutions take advantage of resources outside of healthcare, recognizing that social determinants play a significant role in a person's health.

Some technology solutions discussed during the workshop series that can or currently do support better coordination of care efforts are described below.

CareConnect360

CareConnect360 is Michigan's state-sponsored, statewide care management web portal that provides claims data on individual and population levels, so care coordinators can better evaluate and manage programs to ultimately reduce costs and improve outcomes. The portal also supports the coordination of care efforts by facilitating information sharing across systems, including information on both behavioral and physical health. CareConnect360 can be seen as a partial look at a person's health information since it does not contain supplemental data or EHR data. At this time, only health plans and behavioral agencies have access to the portal. Funding for the portal comes from the state and Optum, the vendor responsible for building and maintaining the portal. CareConnect360 is one of the applications supported by MILogin.¹¹

Active Care Relationship Service® and Statewide Health Directory

MiHIN's Active Care Relationship Service® (ACRS®) helps link patients with their care team members by tracking which practitioners have "active care" relationships with patients. ACRS is a service used to ensure all care team members have access to a patient's health information.¹²

The Statewide Health Directory is a separate but complementary service that contains health professionals' demographics, contact information and electronic addresses, which are needed to route health information between practitioners in formats the practitioners can easily import into their systems and quickly use.¹³

By combining the ACRS and Statewide Health Directory services, practitioners can quickly identify each member of a patient's care team, find their up to date contact information, and the best way to reach them. Together, these shared services make it possible to keep the right people informed about a patient's health and transitions of care.

Michigan 2-1-1

Michigan 2-1-1 is a free service/resource that connects Michigan residents seeking assistance with local organizations that offer assistance through various programs and services.

¹¹ "What is MILogin," Michigan Department of Health and Human Services, accessed July 20, 2017, http://www.michigan.gov/mdhhs/0,5885,7-339-71551_2945_72165---,00.html

¹² "Active Care Relationship Service," MiHIN, accessed July 20, 2017, <https://mihin.org/acr/>

¹³ "Health Directory," MiHIN, accessed July 20, 2017, <https://mihin.org/health-provider-directory/>

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This public service is funded through the state, the Michigan Association of United Ways, and grants from corporations and philanthropy organizations.¹⁴ A planned integration with the Michigan Department of Health and Human Services' Integrated Service Delivery (ISD) will combine resources to further address the social determinants of health.

Integrated Service Delivery

Integrated Service Delivery is the Michigan Department of Health and Human Services' state-funded initiative to support person-focused care by better connecting people with the services they need to lead healthier lives. There are four different components to the initiative:

- MiBridges Portal¹⁵
- Universal Caseload Management
- Contact Center
- Supporting Services

ISD offers residents better online experiences through the MiBridges portal while also working behind the scenes for seamless coordination between information systems to get them what they need. Taken together, these new improvements maintain a person-centered focus to help better coordinate care for individuals.

Technology Concerns

During the workshops, technology and the different systems being used to oversee a person's health information came up repeatedly. For example, are EHR systems just recording symptoms or do they see the full picture needed to help make a person better after the practitioner appointment is over?

One attendee noted a concern that in some rural communities, care team members (both at the community and at the practitioner level) might not have access to technology that can access EHRs. This could definitely be troubling when a complicated health concern might involve specialists and hospitals outside a community. Organizations may also have different levels of health information exchange capabilities, which impacts their ability to provide coordination of care services.

A final concern is that existing admission, discharge, and transfer (ADT) information for mental health services are not available to primary care stakeholders.

Workflow

Coordination of care "workflow" is also broadly diverse and complicated to describe since it may include anything from an initial person's visit to an emergency room to a weekly visit with a community/social worker. Another aspect of workflow can center around the

¹⁴ "History of 2-1-1 in Michigan," Michigan 2-1-1, accessed July 20, 2017, <http://www.mi211.org/about-us/history-2-1-1-michigan>

¹⁵ "MiBridges," Michigan, accessed July 20, 2017, <https://www.mibridges.michigan.gov/access/>

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process of referrals and “hand offs” of a person’s information and follow-up between care coordinators at two different organizations or two different points on the care continuum.

In addition to variability in organizational settings where the coordination of care may occur, workshop participants also discerned that there is variation in workflow processes related to the coordination of care across those different settings. The triage and coordination of care interventions performed by hospitals, primary care practices, specialists, behavioral health teams, payers, community support systems and other coordination of care teams are often not well defined or standardized within each of these settings, and even less well coordinated across each of these settings.

This variation in the coordination of care settings, multiplied by the variation in workflow processes within and across these settings, clearly results in substantial variation in our current definition(s) and application of the coordination of care. In turn, this leads to duplication, re-work, limited coordination across settings, confusion for people, and great opportunities for improvement.

These widely variable workflows can also involve the coordination of care taking place between a person and a coordination professional since the person is being given direction in his/her care. Workshop participants also described the need for workflow standards of practice to accommodate the different types of relationships and resources available in different communities.

Workshop participants agreed that care coordinators need to be familiar with community resources and build relationships with members of the community to help provide better access to resources for people. Additionally, factors that impact a person’s quality of life, such as social and economic factors and their physical environment, contribute to 80% of a person’s overall health outcomes, making referrals to community resources aimed at improving quality of life even more important.¹⁶

On the technology side of workflow, electronic health records have taken on significant importance as well. Thanks to the work of national and state efforts to encourage EHR adoption, improvements in EHR features and interoperability, and health information exchanges and the statewide health information network, EHRs have become a touchstone to understand workflow taking place in practitioner settings across Michigan. This is especially true for Meaningful Use providers. As already noted, however, smaller community-based organizations may not have access to EHRs, or to high-functioning EHRs, which presents challenges when trying to coordinate services.

Other Concerns in Michigan Today

Over the course of the workshop series additional concerns were raised during the workshop series, including:

- Ratio of care coordinators to populations
- Matchmaking services

¹⁶ “Linking Clinical Delivery to Community Resources,” MetaStar (August 2016): 2-5

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- Education/Training
- Social determinants and their impact on a person's health
- Mental health codes in Michigan (and some of the changes that took place in 2017)

Each topic is described in more detail below.

Ratio of Care Coordinators to Populations

Many different factors can impact the coordination of care in a community. Anything from population demographics to regional medical needs can influence how much care management is needed in an area. Ratios of care managers to populations can vary widely due to these influencing factors, from one care coordinator for 75 people in areas that an organization considers high need, to one care coordinator for 5,000 people in areas with relatively young and healthy populations.

At this time there is no specific formula or plan that is universally used to decide acceptable ratios and universal standards to determine appropriate care manager allocation to a region. The definition of regions is also subjective, as workshop participants emphasized. Because of that, some areas may be vastly over-served and some may be challengingly under-served.

Identifying appropriate methods to determine these standard ratios would ensure that a population receives as much support as needed for care, especially in rural or underserved areas or in populations stretched over multiple different care organizations. Workshop participants suggested that future work by health plans, physician organizations, community-based organizations, and related entities should help determine how to establish acceptable ratios as part of some kind of coordination of care standards of practice.

One option that may merit additional research is the Case Management Society of America's Case Load Capacity Calculator (CLCC). According to its "About" page, the CLCC compares caseloads against a growing knowledge base that takes data from industry statistical research and surveys to set expected standard weekly cases and open cases for a case manager with a particular degree in a specific work setting.¹⁷

Matchmaking Services in Healthcare

It is not always easy for healthcare practitioners or community-based organization professionals to find services for a person and quickly determine if the person is eligible to receive those services. For example, if a person needs transportation assistance, home care, a specific support group, food assistance, or other such specialized services, practitioners and professionals do not have a standard resource to find and investigate this information.

With the 2-1-1 database (discussed earlier), Michigan has a resource that can assist with this need. The problem is that the resource is not utilized enough in the different communities across the state.

¹⁷ More information on the Case Management Society of America's Case Load Capacity Calculator is available at <http://clcc.cm-innovators.com/Home/About>

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Communication

A significant challenge impacting workflow at all points around the coordination of care is communication. This can involve communication from a healthcare practitioner to a person (or their family/caregiver), between practitioners or community service professionals, and between people and health plans. Each of these communication scenarios can critically impact a person's well-being and coordination around their health.

One attendee at the first workshop discussed how at her healthcare facility two different departments in the same building cannot share information or communicate about the same individual, essentially across the hall from each other. This problem arose because of two different issues: 1) different technologies being used for collecting and sharing a person's data, and 2) silos formed around different departments.

It would be ideal if information lived in one electronic platform that all team members shared, particularly within individual organizations. In order to communicate what needs to happen for a person the elements of treatment that need to be communicated are:

- Assessments
- Care plan/ health goals
- Progress notes
- Care team members and agencies including contact information
- Referrals (who, where, when, why)
- Upcoming appointments
- Medications

Based on workshop participant feedback, the shared care plan is the most important item that needs to be communicated across organizations.

The care plan allows all care team members to be informed and know all elements of care for a person. A shared care plan would also allow real time updates on what agencies are working on and what referrals are being made. Any changes to the plan would then be made if circumstances alter and could be updated by any team member. The "lead" coordinator (or quarterback) would be responsible to ensure that all elements of this shared care plan are being implemented.

If all agencies cannot have access to a shared plan then it is up to the "lead" coordinator to ensure communication of the plan to treatment team members.

Education/Training

There are many resources available today that could improve the coordination of care, but unfortunately those resources are often under-utilized or care coordinators are not aware of the resources. Keeping the community of health, social, and human service professionals updated and informed on these resources can be challenging in large part due to limited availability of time and funding.

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Working to improve understanding of what resources are available and how best to use those resources could be a major first step to improve the coordination of care across the state.

The issue with training care coordinators and care team members on available resources is complex. Training care teams is costly in both time and fees. In addition to fees, there is lost revenue for attendees who are not providing billable services.

This is compounded by limited funds to support training, to reinforce trained behaviors, and audit the appropriate application of training, let alone continued growth and development.

Training requirements also vary by payer. The Michigan Primary Care Transformation Project contracted with the Michigan Care Management Resource Center to develop and provide training recommendations for its program. The training recommendations were framed on the Geisinger Health System case management training program. This training program used the NCQA Case Management and the Case Management Society of America Case Management guidelines as a framework.

Some groups are also using the phrase “culture change” to denote the fundamental shift in education that is needed to prepare more individuals to complete coordination of care activities.¹⁸

Attendees described the need to continue facilitated, collaborative meetings like this workshop series where different service types of care coordinators can meet to discuss mutual concerns.

Better Understanding of Social Determinants of Health

Many factors outside the medical office can impact a person’s health and wellness. Social determinants of health (from the environment in a person’s home to community influences) account for as much as 80% of a person’s health outcomes.¹⁹ Some examples of social determinants include race, age, income, ethnicity, social supports, family status, housing and material insufficiency (food, clothes, diapers).

¹⁸ “Registered Nurses: Partners in Transforming Primary Care,” Josiah Macy Jr. Foundation, accessed August 7, 2017, http://macyfoundation.org/docs/macy_pubs/2016_Conference_Summary_FINAL.pdf

¹⁹ Lauren McGovern et al, “The Relative Contribution of Multiple Determinants to Health Outcome,” *Health Policy Brief* (August 21, 2014), accessed May 30, 2017, http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2014/rwjf415185

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Many social determinants are seen by the community-based organizations and their care coordinators, not the doctors.

What opportunities do we have to see and address societal problems before they become health issues for a person?

Recognizing that clinical care accounts for only 10 to 20 percent of health outcomes while social and environmental factors account for 50 to 60 percent of health outcomes, the State has focused efforts for the primary components of the State Innovation Model to continue developing and strengthening connections among providers of clinical care (e.g. physician offices, health systems, and behavioral health providers) and community-based organizations that address social determinants of health. Clinical-community linkages are emphasized heavily in the State's guidance for both Community Health Innovation Regions (CHIRs), and practices participating in the SIM PCMH Initiative.

One attendee brought up the use of International Classification of Diseases 10th Revision (ICD-10) codes being added to claims to help existing systems across the state capture information about social determinants of health. Research reveals a large discrepancy between the number of identifiable social determinants of health, a professional's ability to address them, and the actual documentation of the social factor with a billing and diagnosis code.²⁰

Physician organizations in Michigan like MedNetOne report they are currently meeting with several commercial and Medicaid payers to discuss plans to implement ICD-10 social determinant of health codes. Additionally, at least one Federally Qualified Health Center in Michigan is using ICD-10 to code for social determinants of health through the MI Care Team Project.

There are also opportunities to link data from ISD and CHAMPS (Community Health Automated Medicaid Processing System – the State of Michigan software application to enable reporting for Medicaid practitioners). Attendees also mentioned the need to add similar requirements for CHIRs (Community Health Innovation Regions) so there are common definitions across state systems related to social determinants.

Another important aspect of social determinants discussed during the workshop series is transportation. While it is a step forward that many payers are covering transportation costs individuals in need, many factors can impact usefulness of transportation services. Some of these impacts are social, from region capacity, the accessibility of transportation (and do they have the capability to transport different conditions), scheduling, etc.

New Mental Health Code Changes in Michigan

People with mental health complications are often the most complex people for coordinating care because these individuals can have greater difficulty following their

²⁰ Joy H. Lewis, "Community health center provider ability to identify, treat and account for the social determinants of health: a card study," BMC Family Practice (2016), accessed August 7, 2017, <https://bmcfampract.biomedcentral.com/articles/10.1186/s12875-016-0526-8>

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treatment plans for a myriad of different reasons. Issues these individuals (adults and children) may experience include:

- Intellectual and development disabilities (including autism spectrum disorder)
- Serious mental illness
- Severe emotional disturbance

One workshop participant noted that in 2015 the Community Mental Health Services Program served 244,962 Michigan residents.²¹

In the last year, some changes were enacted regarding laws governing the sharing of mental/behavioral health information:

- **Public Act 559 of 2014:** Updated in 2016 to allow mental health records to be shared for the purpose of payment, treatment and coordination of care.
- **New Final Rule for 42 CFR Part 2:** This revised rule instills new provisions for the exchange of health information related to mental health records and requires new levels of detail around the amount and kinds of information that can be shared.²²

While these changes will make sharing mental/behavioral health information easier, there is still a need for standards of practice (especially around forms to be completed for consent).

²¹ "Section 904 (2)(c) Part 1 Total CMHSP Costs by Service Category FY 2015," Michigan Department of Health and Human Services, accessed June 22, 2017, http://www.michigan.gov/documents/mdhhs/x-_904_2_c_Part_1_-_Statewide_Summary_533696_7.pdf

²² Phil Kurdunowicz, "Overview of Privacy Laws and Regulations (PowerPoint Presentation)," *Coordinating the Care Coordinators Workshop Series* (June 1, 2017).

A Vision for the Coordination of Care

A positive vision around the coordination of care includes infrastructure in place to help share information quickly, easily, and accurately.

The *Coordinating the Care Coordinators Workshop Series* represented a continued cultural shift that blurs the lines between the community and clinic. Until relatively recently, most people have understood a person's wellness as synonymous with their medical or physical health status. If a person is diagnosed with diabetes, they have always been expected to go to their medical provider for treatment.

Healthcare and community professionals are beginning to change their way of thinking to include mental, social, and financial wellbeing as part of a person's overall health. The evolution of the coordination of care (and the different titles, roles and activities associated with the topic) stems from a broad-based realization that even if a professional treats a person's diabetes, the person might still be struggling with significant depression, substance abuse, or the loss of income, which will directly impact that person's overall health.

This paradigm shift is also seen in the work of SAMHSA (Substance Abuse and Mental Health Services Administration) which lists eight dimensions of wellness. The dimensions include:

1. **Emotional:** Coping effectively with life and creating satisfying relationships
2. **Environmental:** Good health by occupying pleasant, stimulating environments that support well-being
3. **Financial:** Satisfaction with current and future financial situations
4. **Intellectual:** Recognizing creative abilities and finding ways to expand knowledge and skills
5. **Occupational:** Personal satisfaction and enrichment from one's work
6. **Physical:** Recognizing the need for physical activity, healthy foods, and sleep
7. **Social:** Developing a sense of connection, belonging, and a well-developed support system
8. **Spiritual:** Expanding a sense of purpose and meaning in life²³

Recognizing that a person's health spans many different fields and treatments is part of what makes the coordination of care so complex. Care coordinators try to connect these individual elements of wellness that have been kept separate for so long. An effective care coordinator should assume responsibility for coordinating overall care, providing support

²³ "The Eight Dimensions of Wellness," SAMHSA, accessed July 20, 2017, <https://www.samhsa.gov/wellness-initiative/eight-dimensions-wellness>

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for a person, working to build relationships among all members of a person's care team, and utilizing connectivity via electronic systems to achieve both accurate and timely flow of information.²⁴

As technology advances and this change in how we view health and wellness progresses, coordination of care is one vehicle for healthcare and community-based professionals to drive toward this preferred future that focuses on all eight dimensions of wellness.

Throughout the workshop series, attendees repeatedly emphasized that the coordination of care will result in not only better health outcomes for people, but also higher quality care at lower cost.

New Opportunities for Collaborations

Across the state, community-based organizations are seeking out opportunities to work with hospitals and health plans, helping to find opportunities to assist their patients. In many ways, this work is the next step forward for the coordination of care since it is part of the community where individuals live. When community-based organizations succeed in coordinating care in the local communities, it can help hospitals avoid readmissions and unnecessary expenses for the health plan. Community-based organizations offer flexible, creative solutions to many coordination of care challenges.

During the creation of the white paper, the authors spoke to two Northern Michigan community-based organizations TrueNorth Services²⁵ and UPCAP.²⁶

TrueNorth takes applications for the Michigan Energy Assistance Program (MEAP). Those applicants who screen into TrueNorth's Self-Sufficiency program are then offered the MiWay to Thrive program. A team of health care providers including a Community Health Worker then engages with the patient to facilitate primary care and health behaviors while TrueNorth's staff address social determinants of health and develop skills that move the patient toward self-sufficiency.

Community-based organizations, like these are part of the community and see the social determinants of health first hand that impact a person because they are in the home. While a person may have a primary care provider that they might see from time to time, an organization like TrueNorth and UPCAP will have a more personal day-to-day relationship. As noted by Dr. David Wingard from TrueNorth, they are dealing with immediate needs of their clients, not long-term goals. TrueNorth uses EQ-5D for determining coordination of care needs.²⁷

²⁴ Group Health's MacColl Institute for Healthcare Innovation, "Reducing Care Fragmentation: A Toolkit for Coordinating Care," The Commonwealth Fund (2011), 2-5.

²⁵ "Home Page," TrueNorth Services, accessed August 31, 2017, <http://www.truenorthservices.org/>

²⁶ "Home Page," Upper Peninsula Commission for Area Progress, accessed September 6, 2017, <http://upcap.org/>

²⁷ More information on EQ-5D can be found at <https://en.wikipedia.org/wiki/EQ-5D>

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Even though (as noted in Technology) TrueNorth does not share the same technology as Spectrum, they are able to work around that, focusing on communication between the organization about their shared patient. TrueNorth is also investigating options to get their platform into local physician offices to make sure the community voice is part of the practice's relationship with the patient.

Unlike TrueNorth, the Upper Peninsula Commission for Area Progress (UPCAP) gets their candidates directly from the health plans who are contracted with them. They are forwarded the name of members most in need. While the health plan is at risk if the coordination is not successful, having the community-based organization on board helps them since it gives them "boots on the ground." They, like other community-based organizations, are working first hand with the social determinants of health present in the house and neighborhood. Also, another difference is that with technology, while UPCAP is not using the same EHR as the health plans, they can upload their data right to the health plans via the Upper Peninsula Health Plan's Altruista data system developed specifically for the MI Health Link program.²⁸

UPCAP also uses 2-1-1 to find local opportunities, and welcome the outreach of this service to primary care providers and physician offices.

The TrueNorth team includes social workers certified as community health workers. They also assist in community mental health needs but do not provide treatment directly. Staff might recognize untreated mental health issues and refer. Opportunities showcased by these two organizations reveals what is possible when the clinic is meaningfully linked with community organizations.

Thoughts From the Frontline

The following is the perspective on the future of the coordination of care from an attendee with coordination experience:

Care coordination, as we've discussed and defined it over the past few months, is representative of a current culture shift. Up until relatively recently, most people have understood a person's wellness as synonymous with their medical or physical health status. If a person is diagnosed with diabetes, they have always been expected to go to their medical doctor and get treated for it. Now, however, people are beginning to change their way of thinking to include mental, social, and financial wellbeing as part of a person's overall health. Care coordinators are a result of people realizing that even if you treat a person's diabetes, they might still be struggling with

²⁸ UPCAP contacts with the Upper Peninsula Health Plan to conduct level 1 assessments as well as level 2 assessments for "Community Well" members needing personal care assistance and for individuals needing long-term supports and services through the MI Health Link "C-Waiver". They conduct the face-to-face assessments required by MI Health Link and for the Community Well and C-Waiver, develop a portion of the care plan and purchase the services on behalf of the health plan. Their assessments are uploaded into UPHP's Altruista Data System. UPHIE is UPHP's secure network for sharing information between the various entities who work with UPHP enrolled members.

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significant depression, substance abuse, or the loss of income, which has an impact on their overall health.

But culture and policy shifts are slow. There are still many individuals who look at someone with depression and think, “Pull yourself together. Get over it” but would never say that to someone with asthma.

Recognizing that a person’s health spans across many different fields and treatments is part of what makes care coordination so complex. Care coordinators are, in many cases, the only person in a patient’s care team who tries to connect these individual elements of wellness that have been kept separate for so long. Policymakers and payers must support care coordination and integrated care in order to achieve this attitude shift, and complete the extraordinary amount of work it will take, on an infrastructure level, to allow for cross-field communication and integration.

As technology advances and this change in our way of viewing health and wellness progresses, care coordination is the future. Throughout the workshop series, participants mentioned again and again that care coordination will result in not only better health outcomes for patients, but also reduced cost on our entire healthcare system.

Next Steps

“The Institute of Medicine (IOM) identified care coordination as one of 20 national priorities for action to improve quality along its six dimensions of making care safe, effective, patient centered, timely, efficient, and equitable... Care coordination interventions are particularly attractive in that they have the potential to improve both efficiency and quality.”

Kaveh G. Shojania, et al., “Closing the Quality Gap: A Critical Analysis of Quality Improvement Strategies.” (Rockford, MD: U.S. Department of Health and Human Services, 2007).

Michigan stakeholders need to create specific action items to realize the workshop series participants’ positive vision around the coordination of care. The workshop series produced key action items beyond defining “Coordination of Care.” The actions are:

- Develop criteria to identify communications among coordination of care “quarterbacks” and support teams
- Develop pilot demonstrations to test use cases:
 - Populate ACRS and Statewide Health Directory adoption by everyone doing coordination of care
 - Quality measure information related to receiving gap in care notifications
 - Use ICD-10 to track social determinants of health and link to quality measures
 - Standardization of screening and assessment tools
- Close loop referral tracking (Statewide Health Directory/ACRS)
- Align communication strategy with payers for coordination of care
 - Promote ICD-10 codes to track social determinants of health
 - Measure coordination of care return-on-investment at the population health level
 - Educate grant-funded care coordinators on how to submit \$0 claims

Workshop participants brainstormed a myriad of related action items. The list includes actions to:

- Develop standards of practice to coordinator care coordinators
- Develop criteria to help determine what type of care coordinator should be the lead care coordinator during particular time periods or situations
- Utilize matchmaker technologies (e.g. 2-1-1 database) to help care/service providers connect people with eligible services and available resources. This can be accomplished via an outreach effort, incentives, or other opportunities.
 - Includes capacity to close linkage with referring organization once service/care has been completed
- Build upon the Consolidated Clinical Documentation Architecture (C-CDA) by creating a standard care summary document and making its use more pervasive across various EHR systems and service provider types

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- Build a list of how health plans and different state and federal demonstration programs oversee coordination of care functions and pay for some, all or none of the functions.
- Understand the relationship between how the coordination of care services are delivered through different models and how the services are paid for, including per-member/per-month, incentives, fees for services, and related value-based reimbursement models
- Explore opportunities and tools that can be developed to identify common fields applicable across the care/service continuum to summarize an interaction
 - Systematically communicate in a timely manner (less than 30 days) to the person's other care/service providers
- Create statewide education and training guidelines supported by payers and funders across the state. The guidelines should also take into consideration some national programs operating in the state (e.g. Ryan White Care) as well as coordination of care standards published by different profession-specific groups (e.g. American Academy of Ambulatory Care Nursing).
- Certify and track training for healthcare and community staff, including use of technologies and understanding of resources available in the community
- Establish monthly emails or mailings updating offices on resources available and best practices
- Better educate care coordinators around different social determinants of health. These educational efforts could be developed in partnership with groups like Michigan Care Management Resource Center, Michigan Center for Clinical Systems Improvement, MPRO, Practice Transformation Institute, and others
- Build an accessible, common screening tool for social determinants of health that a care coordinator can use to help develop the proper coordination for a person.
- Create a one-pager or brochure detailing implementation changes and subsequent issues around those changes

The Michigan Primary Care Consortium plans to consult with experts from across the coordination of care spectrum to further develop and prioritize these action items in partnership with MiHIN and other groups that express an interest in continuing to build Michigan's coordination of care infrastructure.

The prospective projects and potential uses cases described below offer additional detail to guide future action. One goal of the forum is to continue developing priority actions with more specificity in order to solicit support and test each proposed action's capacity to strengthen the coordination of care.

Linking Social Determinants of Health Services to Healthcare Delivery Systems for Greater Sustainability

During the *Coordinating the Care Coordinators* workshop series, two unique and related opportunities surfaced that will help better position community-based services to align with more traditional care delivery and payment systems.

The first opportunity occurs when a community organization receives grant funding from a third party, such as a foundation, to provide community services expected to positively

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impact the long-term health of an individual. Frequently, the granting agency provides resources with the expectation that the community organization will demonstrate the value of a community service or services to reduce long-term costs of care (e.g. emergency department utilization or hospital readmissions). The granting agency hope is often that ultimately the funded program will develop a sustainability model once this value proposition has been more fully established and that the funded program will transition away from reliance on grant funds to resources from the traditional care delivery system.

One of the reasons this transition often fails is because these community-based services only rarely turn in claims to health plans for such services. Another reason this approach may fail is because the agency does not have a complete data set that reflects all of a person's utilization, and/or the agency cannot demonstrate the actual impacts of its activities on overall cost and health improvement.

Data is the life blood for health plans to measure the cost of care and to utilize analytics to determine and assess the effectiveness of new services to improve quality or reduce the cost of care. Sometimes under community-based programs the traditional services often paid for by a health plan are instead covered by the grant or special community program so no claims are submitted. This results in further unintended consequences because the health plan typically has some data about the individual who received the community services, but remains blind to any additional services rendered.

This lack of transparency can lead to a scenario where, from a data perspective, the community program does not demonstrate a return on investment and worse may appear to have resulted in lower quality of care due to missing data.

The second and related opportunity is the potential for community-based services to leverage the ICD-10 as a mechanism to link traditional health care delivery infrastructure to the provision of community-based services.

The reason these two opportunities are related is that all claims that are now sent to health plans utilize ICD-10 codes to record traditional health care conditions. However, unlike ICD-9, ICD-10 has numerous codes for social services and social determinant conditions. Health plans and practitioners were required to use ICD-10 starting in 2016. Therefore every entity producing or paying claims is only recently beginning to use ICD-10.

The existing claims submission process can fully accommodate use of ICD-10 codes.

The broad adoption of ICD-10 codes to uniformly represent social determinants of health and the submission of claims during periods when the “normal” payer of record might not be reimbursing for certain health services offers a unique opportunity to link the traditional health delivery system and community programs. To harness this opportunity, a statewide plan to assess the challenges for community-based organizations to send zero dollar claims to health plans and the effort required to broadly incorporate the use of ICD 10 codes into information systems will first be necessary.

This action will ensure that the data is captured in a way that allows greater transparency and will facilitate data comparisons and analysis between traditional health delivery and social determinants service provision.

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ACRS Adoption by Everyone Doing the Coordination of Care

Listing the active care relationships of anyone engaged in a care team is an early opportunity that surfaced through the workshop series. The follow-up would be to build on this capability and to determine how to register individuals who are not licensed or not already sending in updates related to active care relationships.

Once these care providers are registered and updating their active care relationships, they can be tracked in the Statewide Health Directory and observable through a View ACRS option in multiple applications across the state (e.g. Salesforce, CC360, ISD, HIEs, etc.).

Quality Measure Information (QMI) Use Case Gap-In-Care Sharing

Another opportunity surfacing through workshop discussion was the opportunity to share gaps in care identified through Michigan's Quality Measure Information use case with care coordinators.

The follow up action is to ensure that once all those performing the coordination of care are sending active care relationships, the organizations with which they work can receive the appropriate gaps in care notifications.

ICD-10 Social Determinants Linked Quality Measures

Building on the Quality Measure Information use case opportunity, the need to have reusable assessment tools and linkage tracking led to another potential opportunity to explore: to create an electronic quality measure/s that triggered off of an ICD code (Z59.0 Homelessness). The ICD-10 might be used to trigger inclusion of an individual in a measure linked to best practices associated with addressing appropriate care and coordination efforts.

Standardization of Screening and Assessment Tools

Many groups engaged in the coordination of care have proprietary screening and assessment tools. One action item that surfaced was making these assessments reusable and their results shareable through standard electronic shared services (e.g. Application Program Interfaces). This would allow multiple groups to share a common assessment.

Closed Loop Referral Tracking

Many groups surfaced their desire to know when referrals had been followed up on, once a recommendation had been made to link a person in need to another group such as a community service.

Conclusion

One key success was the level of participation and passion for the subject with participants from across the state. Each workshop enjoyed significant attendance and generated substantial, energetic dialogue. As noted previously (and listed in the appendices) the attendees and speakers represented a diverse group from around the state and these multiple voices together made sure that many different perspectives were involved and heard. Any successes from this effort began with these passionate stakeholders and will continue to drive efforts after completion of this white paper.

A central result of the workshop series was a definition of “Coordination of Care” that can be presented to the State of Michigan and the HIT Commission.

Coordination of Care : 1. Monitoring a person’s goals, needs, and preferences. 2. Acting as the communication link between two or more participants concerned with a person’s health and wellness. 3. Organizing and facilitating care activities and promoting self-management by advocating for, empowering, and educating a person. 4. Ensuring safe, appropriate, non-duplicative, and effective integrated care.

If the definition is accepted, Michigan will be better able to align functions, titles and other roles around the coordination of care. In time this could lead to broader consensus on different coordination of care titles, roles and responsibilities across organizations. Right now, a “case manager” in one organization may mean something very different than in another organization.

The other immediate next steps based on the workshop series findings include:

- Develop criteria to identify communications among coordination of care “quarterbacks” and support teams
- Develop pilot demonstrations to test use cases:
 - Populate ACRS and Statewide Health Directory adoption by everyone doing the coordination of care
 - Quality measure information related to receiving gap in care notifications
 - Use ICD-10 to track social determinants of health and link to quality measures
 - Standardization of screening and assessment tools
- Close loop referral tracking (Statewide Health Directory/ACRS)
- Align communication strategy with payers for the coordination of care
 - Promote ICD-10 codes to track social determinants of health
 - Measure coordination of care return-on-investment at the population health level
 - Educate grant-funded care coordinators on how to submit \$0 claims

Glossary

This glossary was created for the sole purpose of assisting in the reading of this white paper. Unless otherwise noted, these terms should not be considered official definitions. They were created by the authors, created by their respective organizations, or collected from other resources (when noted). If you have any questions about these definitions, please contact the authors at caremanagers@mihin.org.

Active Care Relationship (ACR). (1) for Health Providers, a patient who has been seen by a provider within the past 24 months, or is considered part of the health providers' active patient population they are responsible for managing, unless notice of termination of that treatment relationship has been provided to the statewide health information network (HIN); (2) for payers, an eligible member of a Health Plan; (3) an active relationship between a patient and a health provider for the purpose of Treatment, Payment and/or healthcare operations consistent with the requirements set forth in HIPAA; (4) a relationship with a health provider asserted by a consumer and approved by such Health Provider; or (5) any person or trusted data sharing organization (TDSO) authorized to receive Message Content under an Exhibit which specifies that an ACR may be generated by sending or receiving Message Content under that Exhibit. ACR records are stored by HIN in the ACRS.

Active Care Relationship Service® (ACRS®). The HIN Infrastructure Service that contains records for those TDSOs, their participating organizations Participants or any Health Providers who have an Active Care Relationship with a patient.

Admission, Discharge, Transfer (ADT). An event that occurs when a patient is admitted to, discharged from or transferred from one care setting to another care setting or to the patient's home. For example, an ADT event occurs when a patient is discharged from a hospital. An ADT event also occurs when a patient arrives in a care setting such as a health clinic or hospital.

Care Team. The list of persons or organizations having an Active Care Relationship for a single given patient.

Caregiver. An individual such as a health professional, social worker, or family member who assists in the identification, prevention or treatment of an illness or disability.

Community-Based Organization. Typically nonprofits, these organizations work at a local level assisting in coordination of care (many times seeing the social determinants

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first hand); they are not usually associated with official healthcare organizations (including health plan).²⁹

Community Health Automated Medicaid Processing System (CHAMPS). Michigan's system for processing Medicaid expenses via MiLogin.

Coordination of Care. (1) Monitoring a person's goals, needs, and preferences. (2) Acting as the communication link between two or more participants concerned with a person's health and wellness. (3) Organizing and facilitating care activities and promoting self-management by advocating for, empowering, and educating a person. (4) Ensuring safe, appropriate, nonduplicative, and effective integrated care.

Electronic Health Record (EHR). A digital version of a patient's paper medical chart.

Fee-For-Service Care. "A method in which physicians and other health care providers are paid for each service performed. Examples of services include tests and office visits."³⁰

Gaps in Care ("Care Gaps" or "Gaps in Coverage"). The discrepancy between recommended best practice medical care and the care that is actually provided. Health plans determine care that is actually provided based on a combination of claims and quality information received from health providers.

Gaps in Care Report. Quality measure performance data, often listing individual patients and any missing services, designed to be actionable to health providers such that they can improve quality scores and patient care.

Health Directory. The statewide shared service established by HIN that contains contact information on health providers, electronic addresses, end points, and electronic service information (ESI), as a resource for authorized users to obtain contact information and to securely exchange Health Information.

Health Information. Any information, including genetic information, whether oral or recorded in any form or medium, that (1) is created or received by a Health Provider, public health authority, employer, life insurer, school or university, or healthcare clearinghouse; and (2) relates to the past, present, or future physical or mental health or condition of an individual; the provision of healthcare to an individual; or the past, present, or future payment for the provision of healthcare to an individual.

Health Plan. An individual or group health plan that provides, or pays the cost of medical care (as "group health plan" and "medical care" are defined in section 2791(a)(2) of the Public Health Service Act, 42 U.S.C. 300gg-91(a)(2)). Health Plan further includes those entities defined as a health plan under HIPAA, 45 C.F.R. 160.103.

²⁹ "CBOs – Introductions," Nonprofit organizations, accessed August 23, 2017, <http://eder671nonprofit.pbworks.com/w/page/18541471/CBOs%20-%20Introduction>

³⁰ "Fee For Service," HealthCare.gov, accessed August 24, 2017, <https://www.healthcare.gov/glossary/fee-for-service/>

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Health Professional. (1) any individual licensed, registered, or certified under applicable Federal or State laws or regulations to provide healthcare services; (2) any individual holding a non-clinical position within or associated with an organization that provides or coordinates healthcare or healthcare related services; and (3) any individual who contributes to the gathering, recording, processing, analysis or communication of Health Information. Examples include, but are not limited to, physicians, physician assistants, nurse practitioners, nurses, medical assistants, home health professionals, administrative assistants, care managers, care coordinators, receptionists and clerks.

Health Provider. Facilities/Hospitals, Health Professionals, Health Plans, Caregivers, Pharmacists/Other Qualified Professionals or any other person or organization involved in providing healthcare.

Health Provider Information. Information about Health Providers, including name, contact information, organization(s), title(s), position(s), Health Plan network participation, ESI, End Points, Person Records, Organization Records, any related Affiliations, a National Provider Identifier (NPI) and other associated information as appropriate and as required by the Statewide Health Directory.

HIN Infrastructure Service. Certain services that are shared by numerous Use Cases. HIN Infrastructure Services include, but are not limited to, Active Care Relationship Service, Statewide Health Directory, Statewide Consumer Directory, and the Medical Information DIrect GATEway (MIDIGATE®).

HIN Services. The HIN Infrastructure Services and additional services and functionality provided by HIN allowing the participating organizations to send, receive, find, or use information to or from HIN as further set forth in an Exhibit.

Infrastructure. In the context of this white paper, this refers to five elements that need to be in place in order to support and strengthen the statewide coordination of care; the elements are: service delivery, regulations, reimbursement, technology and workflow.

Integrated Service Delivery. Michigan Department of Health and Human Services state-funded initiative to support person-focused care by better connecting people with the services they need to live healthier lives. It has four components: MiBridges Portal, Universal Caseload Management, Contact Center, and Supporting Services.

Meaningful Use (MU). Using certified EHR technology to improve quality, safety and efficiency of healthcare, and to reduce health disparities as further contemplated by Title XIII of the American Recovery and Reinvestment Act of 2009.

Patient Data. Any data about a patient or a consumer that is electronically filed in a participating organization or organization's participant's systems or repositories. The data may contain Protected Health Information, Personal Credit Information or Personally Identifiable Information.

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Person (People). “Human, individual.”³¹ In the context of this white paper, person is defined as an individual (consumer, patient, etc.) who may or may not need medical attention or care assistance.

Pilot Activity. The activities set forth in the applicable Exhibit and typically includes sharing Message Content through early trials of a new use case that is still being defined and is still under development and which may include participating organization’s feedback to HIN to assist in finalizing a Use Case and Use Case Exhibit upon conclusion of the Pilot Activity.

Regulations. One of the five infrastructure elements of the coordination of care. Governing regulations from the state or national level that impact coordination and what information can be shared among the coordinators

Reimbursement. One of the five infrastructure elements of the coordination of care, related to different funding opportunities available to support the coordination of care.

Risk Stratification. “... a tool for identifying—and predicting—which patients are at high risk—or likely to be at high risk—and prioritizing the management of their care in order to prevent worse outcomes...”³²

Service Delivery. One of the five infrastructure elements around the coordination of care. It refers to how a person receives/interacts with care coordinators across a continuum of settings.

Social Determinants of Health. “The social determinants of health are the conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels.”³³

Specially Protected Information. Health information that is protected beyond the scope of HIPAA such as under 42 CFR Part 2, the state mental health code or other state or federal privacy laws.

State Innovation Model. “The State Innovation Model (SIM) focuses on the development and testing of multi-payer health care payment and service delivery models in order to achieve better coordination of care, lower costs, and improved health outcomes for Michiganders. MDHHS will work with stakeholders to develop and test these models

³¹ “Person,” Merriam-Webster, accessed August 24, 2017, <https://www.merriam-webster.com/dictionary/person>

³² Predict, Prioritize, Prevent,” *Issue Brief* 2, no 2 (Grand Junction, CO: Colorado Beacon 2013), accessed August 24, 2017, <https://www.rmhpcommunity.org/sites/default/files/resource/Vol.%20%20Issue%20%20Predict,%20Prioritize,%20Prevent.pdf>

³³ “What are social determinants of health?” World Health Organization, accessed August 23, 2017, http://www.who.int/social_determinants/sdh_definition/en/

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in the five pilot regions in Michigan: Jackson County; Muskegon County; Genesee County; Northern Region; and the Washtenaw and Livingston counties area.”³⁴

Statewide Consumer Directory (SCD). A HIN Infrastructure Service that helps organizations provide tools to consumers, which allow the consumers to manage how their personal Health Information can be shared and used. The Statewide Consumer Directory is essentially a Software Development Kit (SDK) with a robust set of APIs (application programming interfaces) that can be used by Consumer-Facing Applications that enable consumers to take an active role in viewing and editing their preferences for how their Health Information is shared.

Technology. One of the five infrastructure elements around the coordination of care, refers to technical solutions that assist in the exchange of information and oversight of a person’s care.

Transitions of Care. The movement of a patient from one setting of care (e.g., hospital, ambulatory primary care practice, ambulatory specialty care practice, long-term care, rehabilitation facility) to another setting of care and can include transfers within a healthcare organization.

Use Case. (1) a Use Case Agreement previously executed by PO; or (2) the Use Case Summary, Use Case Exhibit and a Use Case Implementation Guide that participating organizations or TDSO must follow to share specific Message Content with the HIN.

Value-Based Care. “In value-based models, doctors and hospitals are paid for helping keep people healthy and for improving the health of those who have chronic conditions in an evidence-based, cost-effective way.”³⁵

Workflow. One of the five infrastructure elements around the coordination of care that refers to the coordination of the care, including handoffs, communication and interaction between multiple coordinators and between coordinators and people.

³⁴ “MDHHS / Doing Business With MDHHS / Health Care Providers / State Innovation Model,” Michigan Department of Health and Human Services, accessed August 24, 2017, http://www.michigan.gov/mdhhs/0,5885,7-339-71551_2945_64491---,00.html

³⁵ “Value-based care: better care, better health, lower costs,” aetna, accessed August 24, 2017, <https://news.aetna.com/2015/01/value-based-care-better-care-better-health-lower-costs/>

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Appendix A: Literature Review

During the Workshop series, a literature review was done of the material listed in the Bibliography. The results of that review are below, helping direct readers to other source material that can be explored for more information on this expansive and growing topic.

“Patient Care Coordination Program” ABF Home Health Services, LLC

This program allows ABF Home Health Services to view ahead and meet the needs of their patients through quick and practical care. ABF receives a referral and then physically approaches the person to address the person’s needs once discharged. To determine these needs, ABF’s Home Health Coordinator will walk the person through a short questionnaire. Within 24-48 hours of admission to home care services, the person will be contacted by the Patient Care Coordinator, who will facilitate the process of care for the person. Nearing the end of their care, the Patient Care Coordinator schedules the person a final survey call to recap on any concerns and the Patient Care Coordinator will verify post homecare physician follow up appointments.

Roles of the Patient Care Coordinator include:

- Confirming upcoming physician appointments
- Availability for transportation. If there are issues, the Patient Care Coordinator will provide a list of resources to the person (Transportation companies and contact numbers)
- Medication compliance
- Upcoming visits from the staff
- Overall comprehension of the ER plan

“ACM Certification Login” American Case Management Association

This website is the information page regarding the ACM Certification exam. This exam is specifically designed for health delivery system and transition of care case management professionals. The exam is available to registered nurses and social workers, but there are some additional prerequisites that must be met before the individual is eligible. Registered nurses must possess a valid nursing license; social workers must have a minimum of a bachelor’s degree from an accredited school of social work or a valid social work license. In addition, all applicants must have at least one year of full-time, supervised, paid work experience employed as a case manager, or in a role that falls within the standards of practice as a case manager by a health delivery system.

Unique aspects of this certification:

- This exam directly addresses case management in health delivery systems
- Evaluates the heart of case management knowledge
- Harnesses clinical simulation testing methodology to assess competency beyond knowledge

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“Risk-Stratified Care Management and Coordination” American Academy of Family Physicians

This document is a guide to assist with identifying major risk factors within the population. Along with identifying risk factors this document moves further into the stages and categorization of each risk. Further into the document an example case is provided to demonstrate the breakdown and formulation of a care plan for several different categories that are listed.

“The Value of Nursing Care Coordination” American Nurses Association

This white paper summarizes the need and value of nurses within the process of the coordination of care. This paper advocates for the enhancement of RN’s education by incorporating the coordination of care as well as team-based care which allows nursing organizations and nurse leaders to implement nurse-led coordination of care models.

“Bright Spots in Care Management in Medicare Advantage” Tyler Barreto, Robert Graham Center and Better Medicare Alliance

This document addresses the prevalent issues caused by the flaws in our health care and relates these issues to lack of care management. Listed in this document are many different resources and programs where other organizations implemented some care management. Their findings are listed as well. These reports examine care management under the Medicare Advantage and it is stressed to identify the essential elements in the successful models displayed.

IHl Innovation Series white paper: Care Coordination Model: Better Care at Lower Cost for People with Multiple Health and Social Needs

The Institute for Healthcare Improvement’s white paper on the coordination of care focused on supporting individuals with multiple health and social needs and understanding how to provide better care with lower healthcare costs. When developing a coordination of care program, the authors found that it is most important to “foster an ongoing relationship with the individual at the center of his or her own care plan. This requires a relationship focused on learning about the needs of the individual, such as life and health goals; past treatment experiences and preferences; and the strengths and resources of the individual as well as the barriers they face.” (p.1) The authors also noted the importance of creating partnerships with community-based social service providers, including housing services, churches, and behavioral health centers.

The white paper stated that the needs of patients are often not complex, but making the connections to, and communicating with, multiple care providers to target each component of an individual’s unique care plan can be complex. The researchers reported that “Communities where health care and housing providers have partnered together have seen dramatic improvements in health, costs, and patient experience, including increased engagement in preventive care, increased management with self-care, higher self-reported health status, and dramatic decreases in individuals’ health care costs.” (p. 2)

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The authors noted that the most common and effective way to implement better coordination of care is to hold monthly care conferences with all members of the patient's care team. "Multidisciplinary, multi-agency collaboration at all levels is key to successful integration efforts with people with multiple overlapping health and social needs." (p. 20)

"Care management of Patients With Complex Health Care Needs" Thomas Bodenheimer et al., Robert Wood Johnson Foundation

This report breaks down the large task defining care management and the role it plays with people with complex health care needs. Many examples of complex health care needs are given to illustrate the difficulty of defining a care manager's role within this process and goes on to address the implications of this plan and show where progress can be made.

"Improving Access to Primary Care" Bright.md

This paper highlights on the issue that we are approaching a crisis-level shortage of primary care providers. This can be observed by the 2014 average wait time for a primary care appointment, which was 19 days. Because of this crisis it is imperative that we avoid over-burdening clinicians. Currently, we are burning out our clinicians, and it is believed that to address this situation, the addition of a digital care team member could increase a person's access to health care as well as lessen the burden that is put on clinicians.

- "Reconciling medications, updating the patient's medical history, and providing patient education are examples of tasks that non-physician caregivers can manage at a lower cost, and often, with better outcomes."
- "New technologies and competitive pressures, access to primary care services no longer needs to be restricted to the traditional realm of in-patient visits at a physician's office"

"Standards of Practice for Case Management" Case Management Society of America

This document aims to define case management, provide case management practice settings, list the components of the process. The evolution of the standards for case management is displayed to illustrate the progress and trend that these standards are moving towards. Concluding the document are the present standards that are expected within case management.

Case Management – Translated

This page is a resource to access the definition of case management. This definition is translated to English, Spanish, German, Italian, Arabic, Indonesian, Russian and Japanese. The definition is as follows:

- "Case Managers work with people to get the health care and other community services they need, when they need them, and for the best value."

"Chronic Care Management Services" Centers for Medicare and Medicaid Services

This document assists Centers for Medicare and Medicaid Services (CMS) with determining a person's eligibility for Chronic Care Management Services. To qualify, people must have

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multiple (two or more) chronic conditions expected to last 12 months or until the death of the person, as well as a significant risk of death, functional decline, or decompensation. This service highlights various functions provided, such as:

- Structured recording of a person's health information
- Comprehensive care plan
- Access to care and care continuity
- Comprehensive care management
- Traditional care management

The Impact of Care Coordination Versus Pay-for-Performance Incentives on Utilization at 6 Months: The ICCIS Cluster Randomized Trial

This paper follows an example process of a woman age 75 who has diabetes, systolic hypertension, mild congestive heart failure, arthritis and recent diagnosis of dementia. Methods for the plan of care are displayed. This care case is used to reinforce the method of incenting care managers for coordination of care (education, outreach, coaching). It is estimated that hospital bed-days may be reduced if care managers are incented towards coordination of care.

“Care Management: Implications for Medical Practice, Health Policy, and Health Services Research” David Dorr, Care Management Plus

This document is a summary of an investigation into successful strategies for the implementation and proactive of care management. A total of 12 investigations were held all with the goal of developing care management programs in differing clinical, geographic, and administrative context. Each study provided a summary of their findings, as well as shared themes and case studies.

“Burnout Among Health Care Professionals: A Call to Explore and Address This Unrecognized Threat to Safe, High-Quality Care” Lotte Dyrbye et al.,

This article is an overall summary of the widespread burnout of all health care professionals, and moves further into addressing the issues that can arise if burnout within the medical field is not addressed. The origination of burnout is speculated as well, and many work-related factors are brought into consideration.

“Complex Care Management Toolkit” Timothy Farrell, et al., Agency for Healthcare Research and Quality

This toolkit is a guide to improving and implementing a complex care management program for individuals with several chronic conditions, limited functional status and psychosocial needs. This is a summary of ideas for improving a current program and or implementing a new one. The beginning suggestions for improving a current program are some of the following:

- Develop an initial algorithm or set of criteria to identify candidates for your high-risk/complex care program
- Stratify them into different levels of interventions and outreach intensity

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- Refine your identification and risk stratification approaches
- Re-assess people enrolled in your complex care program on an ongoing basis
- Consider at a high-level how your complex care program will be structured
- Develop levels within your complex care program that carry based on severity of illness

“Community-Based Case Management for Uninsured Patients with Chronic Diseases: Effects on Acute Care Utilizations Costs” Alison Glendenning-Napoli, et al., Professional Case Management

This paper is a study done to examine the effects of community-based case management program on acute health care utilization costs in uninsured patients with 1 or more chronic diseases. The setting for this practice was in a large regional academic medical center the provides health care services to a great amount of the surrounding population.

“Caring for High-Need, High-Cost Patients: What Makes for a Successful Program?” Clemens S. Hong, et al., The Commonwealth Fund

The goal of this paper is to promote a high-performance health care system. A large objective in health care is to improve care to control costs. Many suggestions are given in this document, as well as reviewing what makes a complex care management program effective. This is stressing the areas of improvement for these care management programs and provides a thorough list of actions to make improvements.

“Improving Chronic Illness Care”

This article summarizes their use of the chronic care model and how it has helped transform clinical practices to improve the healthcare they provide. MacColl Center for Health Care Innovations is still currently building onto ideas that the chronic care model provided. This site also expands upon the roll of the MacColl Center and its continued movement towards improving chronic care.

“Community Health Center Provider Ability to Identify, Treat and Account for the Social Determinants of Health: A Card Study” Joy Lewis

This study discusses the social determinants of health, and defines them as “conditions that shape the overall health of an individual on a continuous basis” (page 1). This definition is a prevalent driver in the later defined methods of identifying a person’s social determinants of health

“How Health Care and Community-Based Human Services Organizations are Partnering for Better Health Outcomes” Quiana Lewis

This article is an informative overview of a collaboration that has recently begun between community-based providers of human services and health care organizations. The purpose of this collaboration is to identify the crucial social and clinical determinants of health. This movement understands the importance of factors such as housing, transportation and other social determinants and aims to highlight the importance of these factors.

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“Effective Care for High-Need Patients” Peter Long

Currently, “the top 1 percent of patients account for more than 20 percent of health care expenditures” (page 19). This document displays the need for high-needs patients to receive more efficient, cost-friendly services. The key characteristics of high-need patients are listed to help further identify these patients within a population.

“Bridging the Gap: Identifying and Addressing Social Determinants of Health” Mathematica

Accountable Health Communities (AHC) are working alongside Centers for Medicare and Medicaid Services (CpriMS) to close the gap between clinical care and community services such as stable housing, food security, and protection from interpersonal violence. Implementation of the AHC Model will assist CMS in determining the effect of addressing health-related social needs among Medicare and Medicaid beneficiaries.

“Linking Clinical Delivery to Community Resources” Metastar

This document addresses the social determinants of health, some of which are the environmental conditions of where people are regularly present. These determinants affect a large amount of health, quality-of-life, and functioning outcomes. By addressing these issues, this study can propose some possible improvements, such as:

- Expanding screening and referral through and health, community, or social service entry point
- Linking and coordinating clinical settings and community resources

“Physician Burnout is a Public Health Crisis: A Message to Our Fellow Health Care CEOs” John Noseworthy et al.

This article addresses the increasing percentage of physician burnout within the U.S health care system. This widespread epidemic is an early sign of the increasing malpractice risk, readmission rates and many more indirect factors. Direct effects include physicians retiring early, or less than full time work. These results can sum up to an incredibly large cost for replacement, training, and an early warning of dysfunction in our health system.

“Patient Advisory Council Care Plan Sessions: Executive Summary” Michigan Center for Clinical Systems Improvement

The purpose of this document is to deepen the understanding of patient perspective related to the patient-centered care plan. Mi-CCSI has pushed to engage patients in the work of the organization, and to do so, the staff formed a patient advisory council to develop a care plan based on patient input. This includes patient feedback as well as a list of pros, cons and findings. Additional templates are included in the document.

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“Reducing Care Fragmentation Executive Summary: A Toolkit for Coordinating Care” The Commonwealth Fund

This is an overview of complex toolkit aimed to improve coordination of care by transforming the methods in which person referrals and transitions are managed. The toolkit begins with two-person cases that describe what coordination of care means and moves into a coordination of care model. This toolkit illustrates real-world situations of improved coordination of care by following five diverse case studies ranging from family care networks to regionally integrated health systems delivering comprehensive care.

“Make the Clinician Burnout Epidemic a National Priority” Andrew Shin

This article communicates the steady increase of clinician burnout within previous years. Burnout within the health care system poses a massive threat towards the improvement of high-quality reporting, better patient experience, improved population health and lower costs. A large contribution to this burnout is “work compression” where clinicians, and other health care professionals, are driven to do the same amount of work in less time.

“Closing the Quality Gap: A Critical Analysis of Quality Improvement Strategies” Kaveh G. Shojania et al., U.S. Department of Health and Human Services

This is a research paper considering the numerous amounts of coordination of care programs that are in progress right now. Many of these programs have not been evaluated, but of these programs, over 40 definitions of coordination of care were identified. This found knowledge is an excellent resource in determining the wide variety of approaches that coordination of care offers.

“Cambridge Health Alliance Model of Team-Based Care Implementation Guide and Toolkit” Somava Stout, et al., Cambridge Health Alliance

This paper addresses several flaws within the infrastructure for primary care, as well as objectives to overcome these issues. The article states that on average, adults are only receiving 54.9% of recommended care and this joins with the observation that the absence of primary care leads to dramatic worsening of population health outcomes, mortality, and increased costs. Currently, we are in a major primary care workforce crisis which reinforces the crucial fact that the infrastructure must be strengthened to increase the efficiency of health care. The proposed solutions are as follows:

- Developing a team model of care that sustainably meet the needs for acute, preventative, and chronic care. This is done by clearly defining the roles, responsibilities and workflows of care. A plethora of defined roles and methods are defined as well (Page 7-12).
- Engaging competent members of the communities that are served to increase impact on improving health. Having the community members appropriately trained.
- Reinforcing basic health literacy as well as a basic understanding of how the health care system works.
- Addressing mental, physical, and social issues in an integrated way.

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- Care management for both routine and complex people, who have needs in several areas.
- Care Team: To provide safe, timely, effective, efficient, equitable, person-centered care* in a systematic way.

“Services for Social Determinants of Health Delivered in Primary Care Settings: Measurement and Prevalence” Joshua Vest et al.

This study is aimed to identify patients in need of multiple social determinants services in primary care settings. The population studied consisted of 84,317 adult patients and it was found that half of these adults needed at least one social determinants service. The detailed findings have more depth and can display the need for social determinants services.

What is Care Coordination?

This document is a prime reference that includes many organization’s diversified understanding of defining the coordination of care. The following definitions:

- ***Agency for healthcare Research and Quality (AHRQ)***: The deliberate organization of client’s care activities among two or more participants (including the client/support system) involved in the client’s care to facilitate the appropriate delivery of healthcare services.
- ***Accountable Care Organizations (ACOs)***: The organization of clients’ care, treatments, and services across several healthcare practitioners and settings.

Appendix B: Attendees and Speakers of Workshop Series

Attendees List

First Name	Last Name	Organization
Jennifer	Allen	Blue Cross Complete
Lisa	Allen	MAG
Kim	Bachelder	Michigan Department of Health and Human Services
Dara	Barrera	Michigan State Medical Society
Tracy	Barger	Covenant HealthCare
Diane	Bechel-Marriott	University of Michigan Clinical Values Institute
Suzanne	Beckman	Healthwest
Marie	Beisel	Michigan Care Management Resource Center
Amanda	Berg	Covenant HealthCare
Phillip	Bergquist	Michigan Department of Health and Human Services
Debbie	Bernstein	Livingston Physician Organization
Michelle	Berryman	Medilodge Group
Peggy	Best	Oakland Physician Network Services
Sarah	Blackstock	ABF Home Health Services
Rebecca	Blake	Michigan State Medical Society
Maureen	Braun	IHA
Katie	Brown	MPRO
Kimberly	Brown	Affinia Health Network
Margaret	Brown	Henry Ford Allegiance Health
Karen	Bunio	Total Health Care
Linda	Burghardt	Area Agencies on Aging Association of Michigan
June	Castonguay	Michigan Primary Care Consortium
Becky	Cienki	Michigan Health Endowment Fund
Mary Lynn	Clark	McLaren Health Plan
Ruth	Clark	Integrated Health Partners
Clifford	Combs	Ascension
Katherine	Commey	Michigan Department of Health and Human Services
Connie	Conklin	Livingston County Community Mental Health
Kathryn	Correll	MedNetOne
Rachel	Cotton	Genesys PHO
Becky	Cross	Ascension
Debra	Darling	Michigan State University – Honors College
Maria	Diedo	DMC PHO

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First Name	Last Name	Organization
Katie	Commey	MDHHS
Ann	Donnelly	Genesys PHO
Kathy	Dontje	MSU College of Nursing
Barbara	Dusenberry	Priority Health
Nora	Errickson	University of Michigan
Tami	Farnum	Community Action Agency
Samantha	Fell	Lakeland Care Network
Maura	Fulton	University of Michigan
Yvonne	Gibson	DMC Primary Care Physicians PC
Monica	Geldres	Western Wayne Family Health Centers
Kyleen	Gray	Van Buren Community Mental Health
Mary	Graham	Great Lakes Health Connect
Julia	Griffith	Blue Cross Complete of Michigan
Heidi	Gustine	Area Agency on Aging of Northwest Michigan
Joanne	Gutowsky	CJ Systems, Inc
Brandie	Hagaman	Washtenaw County Community Mental Health
Michelle	Hall	Molina Healthcare
Maria	Han	University of Michigan Health System Faculty Group
Krista	Haven	Ingham Community Health Centers
Lynn	Hendges	MDHHS
Denise	Hershey	Michigan State University – Honors College
Christina	Hildreth	Metro Health Hospital
Patricia	Hill	Covenant HealthCare
Kelsey	Hoffman	Sparrow Care Network
Priscilla	Hohmann	Michigan Community Health Worker Alliance
Paige	Horton	Lakeshore Regional Entity
Terri	Howell	Greater Macomb PHO
Jenifer	Hughes	Oakland Southfield Physicians
Simmi	Isaac	Michigan Primary Care Association
Victoria	Kamal	Beaumont
Denise	Klieman	Physician HealthCare Network, PC
Melissa	Krishner	Olympia Medical Services
Joan	Ilardo	MSU College of Human Medicine
Leanne	Kellogg	Allegan County Community Mental Health
Susan	Kelly	Ascension
Mike	Klinkman	Jackson Health Network
Phil	Kurdunowicz	MDHHS
Andrew	Kurecka	MedNetOne Health Solutions

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First Name	Last Name	Organization
Mark	Lazar	MedNetOne
Anne	Levandoski	Upper Peninsula Health Plan
Elizabeth	Lipscomb	Ascension MI Borgess Health
Cheyl	Logan	McLaren Health Plan
Kara	Lorenz	Region 2 Area Agency on Aging
Rosalie	Lummus	Molina Healthcare
Lori	Lynn	Metro Health Hospital
Jean	Malouin	Blue Cross Blue Shield of Michigan
Joleen	Martin	ABF Home Health Services
Mindy	Matthews	Spectrum Health
Lynda	Meade	MPCA
Joann	Meilinger	Bronson
Karen	Meyerson	Priority Health
Keven	Mosley-Koehler	Henry Ford Allegiance Health
Kara	Lorenz	Region 2 Area Agency on Aging
Eric	Liu	Michigan Pharmacists Association
Jean	Malouin	Michigan Care Management Resource Center & BCBSM
Diane	Marriott	University of Michigan
Joleen	Martin	ABF Home Health Services
Lisa	Mason	Greater Detroit Area Health Council
Mindy	Matthews	Spectrum Health
Ewa	Matuszewski	MedNetOne Health Solutions & MOA
Lynda	Meade	MPCA
Joanne	Meilinger	Bronson
Anavia	Mitchell	Olympia Medical
Ewa	Matuszewski	MedNetOne
Amber	Monahan	Lenawee Community Mental Health Authority
Drew	Murray	Michigan Primary Care Consortium
David	Neff	MDHHS
Anita	Nesby-Flowers	Total Health Care
Tawana	Nettles-Robinson	Trinity
Diane	Nielsen	Northern Lower Michigan Area Health Education Center
Lori	Noyer	Ingham Health Plan Corp
Kim	Nuyen	Ascension
Maureen	O'Flynn-Manzitti	CJ Systems, Inc.
Tom	Page	United Way Michigan
Roger	Panella	GDAHc
Michelle	Pardee	University of Michigan, School of Nursing

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First Name	Last Name	Organization
Gloria	Pizzo	MPRO
Jennie	Pollak	Lifeways CMH
Sallie	Prins	Priority Health
Angel	Reese	MOKA
Caitlin	Rogell-Jones	Ingham Health Plan Corp
Jackie	Rosenblatt	MPRO
Stacie	Rublein	Lakeshore Regional Entity
Susan	Ryan	Total Health Care
Michelle	Schotzko	Michigan State University – Honors College
Amy	Schultz	Jackson Health Network
Julie	Ryan	The WellBridge Group
Gretchen	Schattilly	Covenant Healthcare
Bob	Schlueter	Area Agency on Aging of NW MI
Rebecca	Schreier	Green Tree Pediatrics
Sharon	Schultz	Health Alliance Plan
Kevin	Shinaberry	Sanofi Aventis U.S.
Michael	Slavin	Covenant Healthcare Foundation
Angela	Smith-Hietikko	Centra Wellness Network
Mary	Spicketts	Aetna
Jackie	Sproat	State of Michigan
Colleen	Sproul	Saginaw County Community Mental Health Authority
Uriel	Stephens	Easterseals 55ichigan
Melissa	Stone	Genesys PHO
Tiffany	Stone	Michigan Association of Health Plans
April	Stopczynski	Michigan Dental Association
Kimmie	Symon	Physician HealthCare Network
Kathryn	Szewczuk	Lenawee Community Mental Health Authority
Cameron	Tigges	Wayne State University Physicians Group
Tricia	Thomas	Grand Valley State University
Linda	Tilot	Saginaw County Community Mental Health Authority
Whitney	Tompkins	Lifeways CMH
Aarti	Toth	Ciena Healthcare Management
Tiffany	Turner	Huron Valley Physicians Association
Meghan	Vanderstelt	MDHHS
Sue	Vos	Michigan Center for Clinical Systems Improvement
Christine	Wade	Ciena Healthcare Management
Nancy	Wallace	SWMBH
Marianna	Webb	DMC PHO

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First Name	Last Name	Organization
Jason	Werner	MDHHS
Marie	Wendt	Great Lakes OSC
Julie	Wetherby	Region 2 Area Agency on Aging
Ericca	Withlow	Ascension
Joshua	Williams	Allegiance Health
Steve	Williams	Michigan Center for Clinical Systems Improvement
Martha	Wligikes	
Chris	Wise	HAP Midwest Health Plan
Martha	York	Region 2 Area Agency on Aging
Latonia	Young	Physician HealthCare Network
Lori	Zeman	MedNetOne
Angela	Zell	Michigan State University

Speakers List

Workshop #1

- Lori Zeman, MedNetOne Health Solutions and Practice Transformation Institute
- Jean Malouin, Blue Cross Blue Shield of Michigan
- Mindy Matthews, CPHQ, Spectrum Health
- Suzanne Beckeman, HealthWest
- Aarti Toth, Ciena Healthcare
- Michael Klinkman, Jackson Health Network

Workshop #2

- Phillip Bergquist, Michigan Department of Health and Human Services
- Tom Page, Michigan 2-1-1
- Jeanne McNeil, Optum
- Meghan Vanderstelt, Michigan Department of Health and Human Services
- Marty Woodruff, MiHIN
- Julie Griffith, Blue Cross Complete of Michigan
- Jeff Livesay, MiHIN
- Phil Kurdunowicz, Michigan Department of Health and Human Services

Workshop #3

- Colleen Sproul, Saginaw County Community Mental Health Authority
- Debra Darling, Michigan State University College of Human Medicine Institute for Health Policy
- Matthew Hamburg, LMSW, Area Agency on Aging of Northwest Michigan
- Barbara Robbins, Area Agency on Aging of Northwest Michigan
- Sue Vos, Michigan Center for Clinical Systems Improvement
- Elyse Berry, Molina Healthcare of Michigan
- Julie Griffith, Blue Cross Complete of Michigan

Appendix C: Workshop Agendas

Workshop #1

9:30 AM Welcome & Description of Roles (Drew Murray and Tim Pletcher)

- Primer on MPCC and current state of care coordination
- Goals for today's workshop
- Review today's agenda

10:00 AM Tabletop Exercise #1

- What is a care coordinator/care manager?
- What are the functions of a care coordinator/care manager?

10:45 AM Short Break

11:00 AM Real World Examples

- Three groups present “here is what we do, what’s our model, what do we call a care manager, what we think we do well, where our big challenges are”
 - Lori Zeman, PhD, MedNetOne Health Solutions
 - Jean Malouin, MD, MPH, Blue Cross Blue Shield of Michigan
 - Mindy Matthews, MSN, RN, CPHQ, Spectrum Health

12:00 PM Lunch

12:30 PM Real World Examples

- Three groups present “here is what we do, what’s our model, what do we call a care manager, what we think we do well, where our big challenges are”
 - Suzanne Beckeman, RN, HealthWest
 - Aarti Toth, RN, BSN, OTR/L, MOT, Ciena Healthcare
 - Michael Klinkman, MD, MS, Jackson Health Network

1:30 PM Short Break

1:45 PM Tabletop Exercise #2

- Identification of key Personas and common scenarios
- How can we improve the current state of care coordination?

2:45 PM Summarization of the Major Areas of Focus for Improvement

- Review as a group the major Persona scenarios and potential solutions

3:15 PM Summary of Next Steps (Drew Murray and Tim Pletcher)

3:30 PM Adjourn

The Coordination of Care in Michigan

Workshop #2

9:30 AM Welcome & Review Charge – Drew Murray

- Highlight workshop series goals objectives and feedback from past events
- Feedback from participants on Workshop #1 and Call #1
- Outline today's agenda

10:00 AM Tabletop Exercise #1 – Tim Pletcher

- Walk-through the list of care coordinator functions and definition
- Describe your current technology system infrastructure and how you use it to coordinate care/services for your patients
- List ways you wish your infrastructure worked, especially during hand-offs

10:45 AM Short Break

11:00 AM Technology System Presentations on their Current and Desired Future State – Drew Murray

- Integrated Service Delivery Portal – Phillip Bergquist, MDHHS
- Michigan 2-1-1 – Tom Page, MNPL, Michigan 2-1-1
- CareConnect360 – Jeanne McNeil, MBA, Optum, and Meghan Vanderstelt, MDHHS
- Active Care Relationship Service and Health Directory – Marty Woodruff, MiHIN

12:00 PM Lunch

12:30 PM Tabletop Exercise #2 – Tim Pletcher

- Describe the opportunities for coordinating with other coordinators across the continuum that offer the most value
- List gaps in current communication processes and technical systems that prevent these types of communication from occurring

1:30 PM Short Break

1:45 PM Program Eligibility, Privacy/Security, and Mental Health Code Presentations – Drew Murray

- Communicating Health Plan Program/Service Eligibility to Patients, Clinicians, and Community-Based Service Providers – Julie Griffith, LLP, LPC, Blue Cross Complete of Michigan
- Standard Consent and Related Privacy/Security Issues – Jeff Livesay, MiHIN
- Implications of Mental Health Code Changes – Phil Kurdunowicz, MHSA, MDHHS

2:45 PM Major Areas of Focus for Improvement – Tim Pletcher

3:15 PM Summary of Next Steps – Drew Murray

3:30 PM Adjourn

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Workshop #3

9:30 AM Welcome & Description of Roles (Drew Murray)

- Highlight workshop series goals/objectives and participant feedback
- Outline today's agenda

10:00 AM Tabletop Exercise #1 (Is there a need for a Quarterback?)

- Who should take the lead? When?
- What should the quarterback share?

10:45 AM Short Break

11:00 AM Peer, Peer, Public Health, and Community-Based Organizations Models of Care Coordination

- Colleen Sproul, LMSW, MSA, Saginaw County Community Mental Health Authority
- Debra Darling, RN, BSN, CCP, Michigan State University College of Human Medicine Institute for Health Policy
- Barbara Robbins, RN, BA, CDE & Matthew Hamburg, LMSW, Area Agency on Aging of Northwest Michigan

12:00 PM Lunch

12:30 PM Real World Examples (Tim Pletcher)

- Continue persona and sequential intercept discussion
- Reflection on highs and lows of the workshop series

1:30 PM Short Break

1:45 PM Care Management Reimbursement (Sue Vos)

- Sue Vos, BSN, CCM, RN, Michigan Center for Clinical Systems Improvement
- Elyse Berry, FHFMA, Molina Healthcare of Michigan
- Julie Griffith, BSW, MA, LLP, LPC, Blue Cross Complete of Michigan

3:00 PM Major Areas of Focus for Improvement (Tim Pletcher)

- Review Financial Pieces

3:15 PM Summary of Next Steps (Drew Murray)

3:30 PM Adjourn

Appendix D: The Coordinating the Care Coordinators Workshops

Workshop #1 – May 11, 2017

This first workshop focused on current barriers to the coordination of care and identifying a common definition of what coordination across the care continuum and in community settings.

Much of the conversation was focused on current coordination of care activities and what can be improved to meet the needs of different Michigan communities.

Goals

- Begin to establish clear definition of care coordinator/care manager
- Determine agreed-upon functions of care coordinator/care manager
- Understand real-world examples and challenges
- Highlight statewide priorities with stories
- Discuss and document statewide infrastructure needs and potential solutions
- Identify agenda items for next workshop

Synonyms for Care Coordinators

1. Health (Coach, Educator, Specialists, Professional)
2. Wrap Around/Independent Facilitator
3. Navigator
4. Care (Transition Coordinator, Guide, Foster, Team Coordinator)
5. Liaison
6. (Health, Care, Process, Transition, Complex Case, Benefits, Communication, Risk, Linkage, Panel, Community) Manager
7. Community Health Workers
8. Discharge Planner
9. Advocates
10. Patient Leader
11. Family Educator
12. Provider Support
13. Social Worker
14. Interdisciplinary Team
15. Recovery/Translator Coach
16. Person-Centered Planner
17. Jack of all Trades

Functions of a Care Coordinator

- Empower, educate, advocate, facilitate, improve management and quality of life

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- A clinical/nonclinical person connecting to resources to facilitate, organize, and maximize efficiency to prevent duplication of resources, improve person outcome, improve healthcare experience, and deliver whole person care
- Somebody who connects people to care
- A person who navigates person to healthier outcomes
- Health literacy included in definition
- Professional facilitating and empowering person and continues to care for quality of life
- Person-centered closing of gaps in care
- Elements in definition: facilitates communication, maximizes resources, improves quality of life, best outcomes, assessment, patient-family centered, physical psychosocial medical care, support independence and empower individual autonomy, helps with person goals, educate in health literacy, team based care, community based whole life wellness, social determinants, integration of all care, self-management for person, managing person community preferences, safe effective appropriate care, use individual instead of person, promote clear understanding to all involved, patient understanding of quality and cost, linking consulting and monitoring, communicates patient preferences to right people
- Addressing physical, social, cultural, environment and financial patient aspects
- Allows appropriate communication to care partners
- Manages proxy access to individual in question
- Responsible for patient/family centered collaboration of care across the continuum. Developing a treatment process including assessment of the patient's physical, psychical, medical and social needs through communication, resulting in best outcomes for the patient and family
- Successful navigation of the health care system
- Minor conditions
- Outreach for gaps in care
- Make referrals and relationship building
- Make a plan
- Engage and motivate people
- Risk stratification and root cause analysis
- Facilitating care and navigation of insurance policies and health plans
- Advocates and mediators
- Innovation
- Shared decision making and consulting
- Documentation review and prevent duplication
- Efficiency of care
- Transportation

Top Twelve Functions of a Care Coordinator

- Linking community/team coordination resources
- Assessing barriers and needs
- Support and problem solving
- Preventing readmission and duplication
- Prepare for high self-management

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- Identify patient complexities
- Empower patient
- Guidance to optimal, collaborative care planning
- Educator and communicator
- Care planning and monitoring/integration of patient
- Management – follow ups, mental health, self-management of diseases, privacy
- Medication reconciliation

Who is impacted by the coordination of care?

During the first workshop, attendees were asked to share examples of scenarios when the coordination of care impacted the healthcare results of people. Some examples include:

- A mother with substance use disorder delivers a baby. The newborn will be hospitalized through the withdrawal and both mom and baby need extensive follow up.
- A person is discharged from a facility and practitioners are not contacted. Person does not receive follow up which results in readmission.
- A person arrives at the emergency department for acute care, but is diagnosed with a cognitive disorder and multiple morbidities. Person has limited support and relies on disability income and public transportation.
- A person has a primary care doctor and a psychologist who need to work together to develop a cohesive plan while avoiding duplication of work.
- A 62-year-old, post-stroke female receives initial rehabilitation, but no follow-up care after leaving facility. Person has complex conditions including mental illness. Two years post-release, she is seeking follow-up care. She has regressed in mobility and overall health.
- A diabetic person with no access to healthy food, transportation, or medical care.

Workshop #2 – June 1, 2017

The second workshop took a detailed look at the current state around the coordination of care. This information included technology systems, laws and regulations, and the process health plans use to alert people about the services they are eligible to receive. One of the other chief aims was learning more about the functions and roles around the coordination of care (discussed in more detail in the next section). This was accomplished through a series of tabletop exercises.

The first draft of the white paper was also shared among the attendees at the workshop.

Goals

- Review progress from Workshop #1 and Call #1
- Discuss healthcare information technology, legal, and workflow infrastructure needs and possible solutions
- Detail the personas and scenarios that attendees believe will be impacted the most by future technology system developments

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Responsibilities in the Coordination of Care

To help understand how the previously mentioned categories work together or “hand off” responsibilities, in Workshop #2, the attendees were asked to fill in the following grid.

	Clinical	Administrative	Community	Individual/ Peer
Clinical				
Administrative				
Community				
Individual/Peer				

The results of these exercises will be discussed in the sections below.

Level of Professional Training

During Workshop #2, the attendees reviewed the 22 function in relation to training that maybe needed for the coordination of care to take place. The results are presented in the following table.

Functions	License	Degree	Training Certificate	On-the-Job Training	None
Linking community/team coordination resources			•	•	
Assessing barriers and needs	•		•	•	
Support and problem solving	•	•	•	•	
Preventing readmission and duplication			•		
Prepare for high self-management			•	•	•
Identify patient complexities					
Empower patient				•	
Guidance to optimal, collaborative care planning					
Educator and communicator	•	•		•	•
Care planning and monitoring/integration of patient	•	•	•	•	•
Management – follow ups, mental health, self-management of diseases, privacy					

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Functions	License	Degree	Training Certificate	On-the-Job Training	None
Medication Reconciliation	•	•			
Outreach for gaps in care			•	•	
Make referrals and relationship building			•	•	
Engage and motivate the patient			•	•	•
Risk stratification and root cause analysis	•	•			
Facilitating care and navigation of insurance policies and health plans			•		
Advocates and mediators			•	•	•
Shared decision making and consulting	•	•	•	•	•
Documentation review and prevent duplication	•	•	•	•	
Efficiency of care					
Transportation			•		

The following findings were of note:

- Only 3 functions of the 22 were seen by the attendees as only possible with proper license or degree. They were medication reconciliation, risk stratification and root cause analysis.
- Shared decision making and care plan monitoring were both seen as functions individuals without advanced training could complete
- Empower person was the one function that was seen by the attendees as needing only on-the-job training to know how to accomplish. In other words, this is viewed as something that a coordinator must learn through experience. Possibly this is because every person and situation is considered unique by the attendees.
- Four functions were not linked to any specific educational or training requirements: identify patient complexities; guidance to optimal, collaborative care planning; management—follow-ups, mental health, self-management of disease, privacy; and efficiency of care. It is uncertain if this means that anyone in the role of a care coordinator could do them or if more information was needed for an answer.

One takeaway from this exercise is that it is not obviously clear what specific educational or training requirements are necessary for the different aspects around the coordination of care, and many in the field must simply work with what is given to them regardless of the education they had prior to the role.

Different Roles

To better understand how the functions are done by different members of a care team, one useful direction was to break down the roles by four titles. While not completely mutually exclusive given the current lack of standard terminology in Michigan, the roles seek to

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make the types of activities completed by different kinds of care coordinators more transparent. The four roles were:

- Care Manager (Clinical)
- Case Manager (Administrative)
- Community Health Worker (Community)
- Health Coach (Individual/Peer)

During Workshop #2, attendees were asked to break these roles down based on the functions listed above. The initial response was around the definition of these roles, causing some confusion because these titles might mean something different to a different region or office. Also, some organizations might require a license to perform a certain role/title, while others might not require it. The preliminary results are presented in the following table.

Functions	Care Manager	Case Manager	Community Health Worker	Health Coach
Linking community/team coordination resources	•	•	•	•
Assessing barriers and needs	•	•	•	•
Support and problem solving	•	•	•	•
Preventing readmission and duplication	•	•	•	•
Prepare for high self-management	•		•	
Identify patient complexities	•	•	•	
Empower person	•	•	•	•
Guidance to optimal, collaborative care planning	•	•		
Educator and communicator	•	•	•	•
Care planning and monitoring/integration of patient	•	•	•	
Management – follow ups, mental health, self-management of diseases, privacy	•	•	•	
Medication reconciliation	•			
Outreach for gaps in care	•	•	•	•
Make referrals and relationship building	•	•	•	•
Engage and motivate the patient	•	•	•	•
Risk stratification and root cause analysis	•	•		•
Facilitating care and navigation of insurance policies and health plans	•	•	•	•
Advocates and mediators	•	•	•	•
Shared decision making and consulting	•	•	•	•
Documentation review and prevent duplication	•	•		•

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Functions	Care Manager	Case Manager	Community Health Worker	Health Coach
Efficiency of care	•	•	•	•
Transportation	•	•	•	•

The following points are of consideration:

- Care Managers are definitively viewed by the attendees as being responsible for all of the 22 coordination of care functions listed. Of note, they were the only one seen capable of doing medication reconciliation.
- Health Coaches are seen more as supportive, connected to the majority of functions related to advocacy and support; linking the person to the help and resources available in their region.
- Case Managers were seen as very similar to Care Managers, with two distinct differences, medication reconciliation and high self-management preparation (which did not fall under Case Managers).

Different Health Statuses

At Workshop #2, attendees were asked to review the functions in relation to different aspects of health statuses. The hope was to see what are priorities based on the person and their condition. It is not a complete list, certainly, but enough to get a conversation started on the need for coordination and priorities across the healthcare spectrum. This list was created by the National Academy of Medicine.³⁶

The options for healthcare status included:

- Non-elderly disabled
- Advancing illness
- Frail elderly
- Major complex chronic
- Multiple chronic
- Children with complex needs

The attendees rated the priority level of each function by status on a scale of 1 to 5 (highest). The results were then broken down into three categories (as listed in the key below the table). The results were then broken down into three categories (as listed in the key below the table).

³⁶ “Models of Care for High-Need Patients: Workshop 2,” National Academy of Medicine (2016), accessed June 27, 2017, <https://nam.edu/event/workshop-on-high-need-patients-2/>

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Functions	Non-Elderly Disabled	Advancing Illness	Frail Elderly	Major Complex Chronic	Multiple Chronic	Children With Complex Needs
Linking community/team coordination resources	●	●	●	●	●	●
Assessing barriers and needs	●	●	●	●	●	●
Support and problem solving	●	●	●	●	●	●
Preventing readmission and duplication	●	●	●	●	●	●
Prepare for high self-management	●	●	●	●	●	●
Identify patient complexities	●	●	●	●	●	●
Empower person	●	●	●	●	●	●
Guidance to optimal, collaborative care planning	●	●	●	●	●	●
Educator and communicator	●	●	●	●	●	●
Care planning and monitoring/integration of patient	●	●	●	●	●	●
Management – follow ups, mental health, self-management of diseases, privacy	●	●	●	●	●	●
Medication reconciliation	●	●	●	●	●	●
Outreach for gaps in care	●	●	●	●	●	●
Make referrals and relationship building	●	●	●	●	●	●
Engage and motivate the patient	●	●	●	●	●	●
Risk stratification and root cause analysis	●	●	●	●	●	●
Facilitating care and navigation of insurance policies and health plans	●	●	●	●	●	●
Advocates and mediators	●	●	●	●	●	●
Shared decision making and consulting	●	●	●	●	●	●
Documentation review and prevent duplication	●	●	●	●	●	●
Efficiency of care	●	●	●	●	●	●
Transportation	●	●	●	●	●	●

Key: ● = Top Priority ● = Medium Priority ● = Low Priority

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The following are some interesting insights from this exercise:

- **Nothing** is considered a low priority by the attendees. Each function was designated as a top or medium priority. This attempt at prioritization challenged attendees and some report that there was a significant amount of discussion and some confusion around this exercise. The difficulty may relate to one workshop participant's comment that some care coordinators across different organizations feel "they are responsible for everything all the time."
- There are four functions that were considered medium priorities by the attendees: make referrals and relationship building; risk stratification and root cause analysis; and documentation review and prevent duplications.
- Both advancing illness and frail elderly were considered a lower priority for helping achieve high self-management.

Different Health Situations

The attendees were asked to rate the priority of a function based on various situations on a scale of 1 to 5 (highest). The results were then broken down into three categories (as listed in the key below the table). The hope was to find moments when a function were of higher priority based on a situation.³⁷

The situations highlighted were:

- Recovery from acute injury or surgery
- Conditions requiring intensive therapy
- Chronic addiction-related impairment
- Long-term mobility impairment
- Long-term cognitive impairment
- Needs at the end of life

The table below shows the results of that exercise.

Functions	Recovery From Acute Injury or Surgery	Condition Requiring Intensive Therapy	Chronic Addiction-Related Impairment	Long-Term Mobility Impairment	Long-Term Cognitive Impairment	Needs at the End of Life
Linking community/team coordination resources	●	●	●	●	●	●
Assessing barriers and needs	●	●	●	●	●	●
Support and problem solving	●	●	●	●	●	●
Preventing readmission and duplication	●	●	●	●	●	●
Prepare for high self-management	●	●	●	●	●	●
Identify patient complexities	●	●	●	●	●	●

³⁷ Ibid.

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Functions	Recovery From Acute Injury or Surgery	Condition Requiring Intensive Therapy	Chronic Addiction-Related Impairment	Long-Term Mobility Impairment	Long-Term Cognitive Impairment	Needs at the End of Life
Empower patient	●	●	●	●	●	●
Guidance to optimal, collaborative care planning	●	●	●	●	●	●
Educator and communicator	●	●	●	●	●	●
Care planning and monitoring/integration of patient	●	●	●	●	●	●
Management – follow ups, mental health, self-management of diseases, privacy	●	●	●	●	●	●
Medication Reconciliation	●	●	●	●	●	●
Outreach for gaps in care	●	●	●	●	●	●
Make referrals and relationship building	●	●	●	●	●	●
Engage and motivate the patient	●	●	●	●	●	●
Risk stratification and root cause analysis	●	●	●	●	●	●
Facilitating care and navigation of insurance policies and health plans	●	●	●	●	●	●
Advocates and mediators	●	●	●	●	●	●
Shared decision making and consulting	●	●	●	●	●	●
Documentation review and prevent duplication	●	●	●	●	●	●
Efficiency of care	●	●	●	●	●	●
Transportation	●	●	●	●	●	●

Key: ● = Top Priority ● = Medium Priority ● = Low Priority

Findings include:

- From the viewpoint of most attendees at the workshop, every situation is a priority and they rarely see a difference between the needs of one function and another based on the person's need.
- There was only one listing that was given a “low priority.” It was outreach for gaps in care related to needs at the end of life.
 - Outreach for gaps in care was one of the very few functions that was seen as either a “medium” or “low” priority.
- The one function that participants rated a “medium” priority across the board was “risk stratification and root cause analysis.”

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While reflecting on the health status and health situation groups created by the National Academy of Medicine, workshop participants confirmed the need to more clearly describe and track population health metrics for specific types of individuals. Example groups of individuals include: intellectual and developmental disabilities, adults with serious mental illness, and children with severe emotional disturbance. Some workshop participants felt that tracking metrics for specific population health groups could help justify additional public investment and private investment in the coordination of care infrastructure.

Handoffs and Communication

During Workshop #2, attendees were asked to identify handoff and communication possibilities between the different types of care coordinators. The results of the exercise available are presented in the tables below. The terms in the left column are the creation of the respondents.

Treatment (T) in the table “generally means the provision, coordination, or management of health care and related services.”³⁸ Other references in this table are Administrative (Ad), Community (Co), and Individual/Peer (In).

This first table refers to handoffs and communications when they are referenced more than once. They are in order of number references.

Handoffs & Communications	Clinical				Behavioral Health	Social Work	Administrative				Community				Individual/Peer			
	T	Ad	Co	In			T	Ad	Co	In	T	Ad	Co	In	T	Ad	Co	In
Notes	•	•	•		•	•	•				•				•			
Referrals	•	•			•	•					•	•	•					
Diagnosis	•				•	•	•				•						•	
Prescriptions	•			•	•	•	•				•							
Care Summaries/ Treatment Plans	•				•	•					•						•	
Gaps in Care		•						•	•				•					
Individual Outcomes			•						•				•				•	
Authorizations		•					•			•								
Claims/ Bills/ Payment Denials		•					•											
Health Ins Info/ Benefits							•			•								
Quality Reporting		•					•											
Enrollment Info										•				•				
Discharge Summaries											•				•			
Resources Available																•	•	

³⁸ “Uses and Disclosures for Treatment, Payment, and Health Care Operations,” HHS.gov, accessed June 20, 2017, <https://www.hhs.gov/hipaa/for-professionals/privacy/guidance/disclosures-treatment-payment-health-care-operations/index.html>

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- The most popular form of handoff and communications was notes, which appeared eight different time in the results. It is not clear precisely what the attendees were referring to as “notes,” it could possibly be a general term for multiple different forms of communication quickly being shared between offices and healthcare practitioners.
 - There is also a good chance that “notes” might include exchanges that other respondents separated out, for example care summaries, treatments, reporting, etc. In other words, “notes” might reflect a larger spectrum of handoffs and communications than is shown here.
- Not surprisingly, the second most popular response was referrals; since they are, by definition, shared among different healthcare offices.
- Diagnosis, prescriptions, and care summaries are the next three most prominent among different health care offices and service provider, which again is not surprising since they are each about coordinating care and treating the person.
- Participants listed health insurance and claims/bills were both only listed twice. At least, in the way of benefits, it looks like a possible missed opportunity for both the person and the care coordinator to use this information to improve communication during handoffs.

Other handoffs/communications were only listed once. They are collected in the table below.

Handoffs & Communications	Clinical				Behavioral Health	Social Work	Administrative				Community				Individual/Peer			
	T	Ad	Co	In			T	Ad	Co	In	T	Ad	Co	In	T	Ad	Co	In
Participation Summary			●															
Care Plan			●															
G9001 Code		●																
Home Maint. Results				●														
Health History				●														
Consent				●														
Access							●											
Understand Bundle							●											
Simplified Payment Structure							●											
Measure/Metrics								●										
Utilization Reports								●										
Attribution List								●										
History of Previous Services								●										
Pilot Prog Info									●									
Linkage to Programs									●									
Assessments										●								

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Handoffs & Communications	Clinical				Behavioral Health	Social Work	Administrative				Community				Individual/Peer			
	T	Ad	Co	In			T	Ad	Co	In	T	Ad	Co	In	T	Ad	Co	In
Portal Info										●								
Follow-up Reports											●							
Health Education												●						
Geo. Similarities & Shared Org. Needs													●					
Assessments														●				
Caregiver Support															●			
Self-Management															●			
Value & Needs of Person															●			
Accurate Member Profile																●		
Appt Reminders																	●	
Marketing Materials																	●	
Emotional Support																		●

There are a few surprises in this table, especially of note:

- Consent
- Assessments
- Caregiver support
- Access
- Follow-up reports
- Health history
- Health education

Some of these could be argued to be missed opportunities. Better coordination of care and support could possibly be more attainable if many of these were across the board, including emotional support, self-management, appointment reminders, and caregiver support.

Technology

During Workshop #2, attendees shared the types of technology used to complete coordination of care activities. They are presented in the table below. Please note, the responses in the left column are the creation of the attendees (listed in alphabetical order).

Technology	Clinical				Behavioral Health	Social Work	Administrative				Community				Individual/Peer			
	T	Ad	Co	In			T	Ad	Co	In	T	Ad	Co	In	T	Ad	Co	In
ADT	●				●	●	●				●							
Call Centers																	●	
CC Platform			●															
CCD	●				●	●	●											
Direct Secure Messaging	●				●	●	●				●							

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Technology	Clinical				Behavioral Health	Social Work	Administrative				Community				Individual/Peer			
	T	Ad	Co	In	T	T	T	Ad	Co	In	T	Ad	Co	In	T	Ad	Co	In
EHRs	•				•	•												
Email	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Fax	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Hardcopy	•				•	•				•				•	•	•	•	•
HIE	•				•	•	•											
Phone	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Portals	•	•			•	•				•								
Registry	•				•	•												
Social Media														•				•
Text		•					•								•			•
Translator Ser.															•			
Webinars		•																
Websites	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•

There are some findings worth noting:

- The first is the surprising resilience and prevalence in the use of the fax machine or other scanning tools. It is still considered by the attendees as a go-to option in offices across Michigan. With some electronic fax machines offices have the capability to upload directly to an EHR.
- Two more recent technology communication options were as pervasive as the fax machine: websites and email.
 - One noteworthy finding is that Direct Secure Messaging is not as pervasive as email, despite being a more secure form of email. Direct Secure Messaging may be considered something more related to clinical communication, and as not seen as an option for other communications even though it has that capability.
 - While websites are considered useful, some of the functions that can be done with it (webinars and social media) are not considered very useful.
- Phone was the fourth option that was selected across the spectrum, yet, some of the capabilities with it (including text and call centers) did not have much of a reaction from the attendees.

A significant finding is the relatively lower level of use of the more advanced types of health information technology, including health information exchanges, electronic health records, CCD (Continuity of Care Document), and admission, discharge, transfer (ADT) notifications. These results lend to an argument that there may need to be a greater outreach in the healthcare and coordination of care communities on the capabilities of these advances and others for helping coordinate care. It also may reflect the substantial and multiple barriers to implementing new technology into the coordination of care workflow: cost, training, technical support, constant change in technology, privacy concerns, implementation issues, connectivity capacity, etc. More work is also needed to understand how to integrate health information exchange capacity into the community since many of these capabilities are not currently available for many community-based organizations.

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Workshop #3 – June 29, 2017

The aim of the third workshop was to bring everything that was discussed previously together while finding the next steps for making the coordination of care in Michigan more effective, efficient, and easier-to-manage. The conversation hit many important topics from reimbursements to different models around the coordination of care. The meeting also had a two-part tabletop exercise using three personas created by MiHIN to showcase how coordination might occur in different situations.

The second draft of the white paper was shared at the end of the day, a more finalized draft was planned for the next conference call (July 11). A final version will be shared with participants and other key stakeholders (e.g. HIT Commission).

Goals

- Review progress from previous workshop and conference call
- Discuss the prioritization of specific pilot projects based on:
 - Personas and the quarterback issue
- Learn and share about the different reimbursement models and their impact on how the coordination of care services are delivered
- Discuss progress of the white paper

“Let’s Coordinate!”

There are many different players in the coordination of care. In the first two workshop events, the attendees focused on the experience and the needs of the coordination of care professionals (from the specialist to the community-based worker to the health plan and social service provider), but that is only one aspect; missing in that is the person attempting to address their own health and social care needs.

In Workshop #3, attendees took part in a “game” over the two tabletop exercises. The game, entitled “Let’s Coordinate!”, took three different and unique case study personas (fake, but realistic individuals) created by the MiHIN team, introduced a new event, and then the attendees figured out different coordination paths for the person. The results of that exercise are discussed below.

Personas

MiHIN’s personas are a new standard of richly and deeply populated synthetic people that can interact with technology solutions at all stages of development. These personas represent a combination of simulated clinical test data and detailed insights into person behaviors, derived from studies conducted with real people and doctors. Through these personas, MiHIN can see the technological impact on a “real” life.

The stories associated with each persona’s background and conditions allow an exploration of the impact of use cases and services on these different stakeholder groups, for example: how admission, discharge, and transfer notifications can help a doctor in an intensive care unit or the mother of a child with a complex condition who normally would have to spend time notifying a care team of an event.

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Personas allow MiHIN to plan, test, and depict use cases with that complexity and personal touch in mind.

The three MiHIN personas that were shared with the attendees are introduced below.

Alice Vargas



Alice Vargas's life after returning from a tour in Afghanistan has not been easy. While there, she was caught in an explosion which cost her half of her right leg. Everyone in her life (from friends to family) tries to be supportive, but none of it seems to help.

Alice is suffering from post-traumatic stress disorder (PTSD). Her doctor at the Veterans Affairs hospital and psychologist at the local community mental health clinic have tried different treatments, with disappointing results. Now Alice copes by smoking more than a pack a day and drinking more than she used to. She will try anything to calm her nerves and help her forget the terrors of war.

Alice has also been diagnosed with Hepatitis C. She has undergone several rounds of therapy but continues to relapse. Her doctors have determined she is resistant to anti-viral therapies, so she has given consent to participate in the Veterans4Research Program for any clinical trials for which she is eligible.

Alice made a clean break from the military and enrolled in the Integrated Disability Evaluation System to help her get a normal 9-to-5 job at the local post office. She loves the daily structure of the tasks in her job since it reminds her of the military, but because of her injury she feels very different from those around her. That was a feeling she never experienced in the military. Sometimes she wonders if she will ever feel whole again.

Janie Barnes



Janie Barnes has done a lot of growing up over the last year. As a young single mother of a four-month old, every day is a mixed blessing of challenges and surprises.

Janie had her daughter Daisy during the end of her junior year in high school. Janie is determined to make a difference for her daughter, which means getting the best grades possible while being the best mom she can be.

The father (a college freshman) hopes to marry Janie when she graduates from high school and wants to be a good dad, but that doesn't help Janie now, especially with him living on campus a few

hours away.

Janie's asthma further complicates her life with nightly asthma attacks that affect her sleep. She could take corticosteroids, but she is nervous about taking medications since she is still breastfeeding Daisy. She does have some inhalers that she uses when her breathing gets bad, but she's still nervous the inhalers could impact her daughter.

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Janie doesn't have a regular doctor (and doesn't think she has the time for one). She has visited a doctor for prenatal and post-partum care, but her daughter and their future comes first and there are just so many hours in a day.

There are moments each day when Janie wants to cry with the frustration of it all... and then Daisy smiles and everything is possible again.

Millie Bryant



For most of her life, Millie Bryant has never thought much about her health. There was always enough to do with her family and farm. Life was very busy then. Doctor visits were usually postponed or missed without a second thought... until reality finally caught up with her.

It began with problems around obesity, which led to diabetes and increasing issues with mobility, especially with her hips and knees. Now 72 years old, Millie is battling an increasing number of health problems and everything regarding her healthcare feels hard. From getting to the doctor's office to finding the food for her special diet and managing her medications, Millie needs help.

Recently, Millie was admitted to the local emergency room with chest pains. She was diagnosed with coronary artery disease which led to congestive heart failure. Millie received a stent placement.

Adding to the complications, neither Millie nor her husband can drive, and they struggle to make ends meet financially. Their son oversees their finances, which helps with some of the stress, but Millie never feels comfortable contacting him because she feels like she's bothering him. Her son recommended they sign up for Meals on Wheels so at least their food was handled; but Millie and her husband did not feel comfortable doing that.

Millie is not sure what tomorrow will bring, but she and her husband share the dream that someday life might return to what it once was.

The Coordination of Care "Game"

The objective of "Let's Coordinate!" was to chart the most realistic and comprehensive network of relationships across the care and community continuum (practitioners, care coordinators, social service organizations) for one of the personas. Each persona also had particular pathways, including their health status (HS), programs and social determinants (SD).

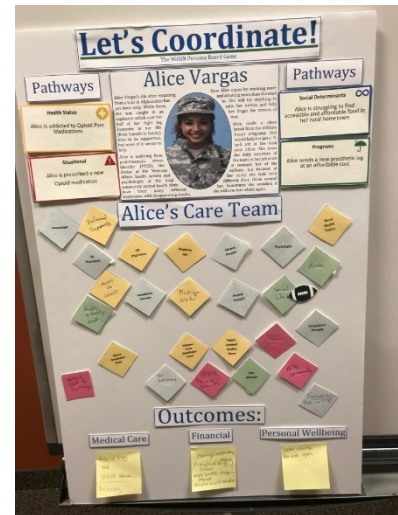
Each group of the attendees was given one persona and asked to identify and map the practitioners, care coordinators, and organizations that would lead to the best possible outcome for the persona. The goal was to agree upon the coordination "quarterback(s)" that help manage each persona's care team on the course of care. The following sections present the results of the workshop groups' deliberations.

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Alice's Journey

Pathway included right leg amputation (HS), Post-Traumatic Stress Disorder (HS), anxiety (HS), tobacco and alcohol use (HS), having a difficult time following her treatment plan due to health illiteracy (SD), and participating in mental health counseling program (programs).

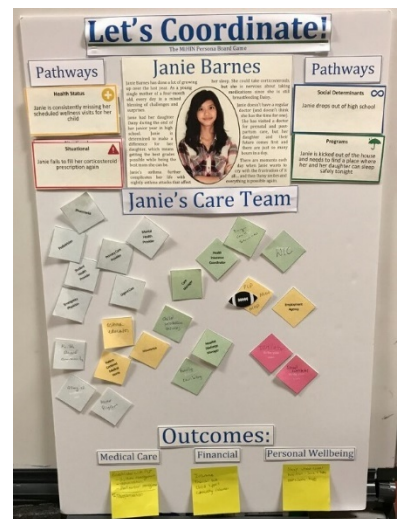
- **Quarterbacks:** Case manager, care manager/care coordinator, and primary care physician
 - It was noted by the group that Alice was also a co-coordinator through much of her experience.
- **Care Team:** Dialysis clinic, VA pharmacy, community mental health, alcohol rehabilitation center, tobacco cessation program, person-centered medical home, VA health systems, PACE site, prosthetic lab, insurance, POW, PT/OT clinic, substance abuse rehabilitation center, physical therapist, primary care physician, VA pharmacist, general practitioner, dentist, tobacco cessation provider, psychologist, mental health practitioner, prosthetist, massage therapist, rehabilitation counselor, pharmacist, gynecologist, peer support, family and friends
- **Outcomes:**
 - *Medical Care:* Prosthetic leg, Hep C controlled, involved in peer group, quit drinking and smoking
 - *Financial:* Work/income and health insurance
 - *Personal Wellbeing:* Anxiety and PTSD-controlled, eating healthy/nutrition available, and transportation



Janie's Journey

Pathway included asthma (HS), regularly missing scheduled wellness visits (HS), dropped out of high school (SD), family does not speak English (SD), and kicked out of the house and needs a safe place for the night (programs).

- **Quarterbacks:** Maternal Infant Health Program and PCP
- **Care Team:** Pharmacist, pediatrician, student health provider, emergency physician, primary care provider, urgent care, mental health provider, faith-based community, asthma educator, insurance, care manager, health insurance coordinator, hospital discharge manager, day care services, person-centered medical home, school counselor, WIC, translator, employment agency, family counseling, mentor program, child protective services, and allergist.



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■ **Outcomes:**

- *Medical Care:* Established with PCP, asthma is managed, immunizations, medication management, and transportation
- *Financial:* Insurance, financial aid, child support, community resources, and income
- *Personal Wellbeing:* Housing, keeping her child, mental health support, and education

Millie's Journey

Pathway included frailty (HS), lack of transportation for groceries (SD), and home improvements needed for mobility (program).

■ **Quarterbacks:** Person-centered medical home care manager; individual and/or family member

■ **Care Team:** Insurance, pharmacist, rural health center, in-home care, transport company, person navigator, mental health provider, optometrist, person-centered medical home, care manager, cardiologist, hospital discharge manager, endocrinologist, primary care provider, general acute care provider, home care, Millie and her family, rehabilitation counselor, health educator, case manager, public health nurses, and dentist

■ **Outcomes:**

- *Medical Care:* Medication management and support with mobility
- *Financial:* Additional financial aid/benefits
- *Personal Wellbeing:* Work with mental health counselor to accept life stage, feel empowered, access to transportation, and safe home/living environment

How the Stories End and the Findings

At the end of Let's Coordinate!, there were some general conclusions that the attendees could draw from the experience. For example, many could agree that funding sources generally drive the entire critical path around the coordination of care. Being able to be bill for a service, impacts the care coordinator and that person. If a healthcare worker is not being paid for the care they deliver, they will probably hand off the person to another care coordinator. Workshop participants shared that lack of payment prevents their organization from providing some desired coordination of care services. So it matters where services can be billed since that funding source drives the entire critical path.

Another important conclusion was that every office needs a billing/coding specialist. Without that resource, both the office and the person are losing opportunities.

It was noted that care coordination is a complicated strategy game, lining up the funding with the needs of the person; then hoping that the alignment is best for both the care coordinator and the person.

Some other findings that were discussed by the attendees are listed below:

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■ **The Individual's Experience:**

- The more complex an individual's scenario is, the bigger the care team is and the greater the need for good coordination of care
- Care coordinators need to pay attention to the social determinants and incorporate these needs into the person's treatment plan
- A person cannot achieve physical health without also having personal wellness needs met
- Every person is unique and needs a unique care team and care plan
- It was noted that participants at health systems are seeing a lot younger people (20-30s) with heart failure or COPD, in part as a result of social determinant of health factors

■ **Reimbursement:**

- Reimbursement needs to cover the cost of any service and if the finances are not there, there could be gaps in service.
- Higher risk people may receive more coordination services and present more reimbursement opportunities for the service provider
- Reimbursement depends on whether or not the person has insurance and the type of payer they have. This coverage impacts the coordination and what kind of coordination they will receive.
- It can also be impacted by the type of organization (government funded, private, public, through the hospital)
 - ◆ Hospitals are based primarily on readmissions, incentives, and how well they give a diagnosis
 - ◆ It could be said that hospitals want people to leave as soon as they are able and they want to avoid readmission

■ **Community**

- Community programs are based on grants, if they are not funded then they cannot support a person

■ **Mental Health**

- The claim was made that community mental health does not have codes to reimburse, but this may be a function of their contractual obligations with their funders.
- There is a need for good collaboration among physical health care and behavioral health care

■ **Health Plan**

- Healthcare plans like to be the "quarterback" because they want to manage payments related to the coordination of care services.

■ **Others**

- Pharmacies have huge copays if people do not have the benefits
- Specialists can sometimes get extra dollars if they are doing outreach.
- The "quarterback" changes throughout the care plan; and everyone on the care team should know who the quarterback is.

Appendix E: Multi-Payer G and CPT Care Codes

The attached PDF document is a general description of the codes and payment methods that are used in Michigan to pay for care management services delivered in the provider setting.

The attached document (which can be viewed via Adobe Acrobat by clicking on the paperclip image) is a general description of the codes and payment methods that are used in Michigan to pay for care management services delivered in the provider setting. Note payment and processing of the codes varies based on product and payer.

Check with the specific payer with questions regarding payment levels or other questions related to documentation or other billing details. Because policies and payment levels change over time, it is best to use a payer's website as the source of truth.

Appendix F: Public Comment Responses

Between September 11 and October 13, the Coordinating the Care Coordinators White Paper was made available for public review. It was shared with attendees from the workshop series, as well as other healthcare, community, and business leaders. Their unedited responses are included below.

Becky Cienki, Michigan Health Endowment Fund

I commend the authors and contributors for their leadership in tackling such an important and complex opportunity for health improvement. The recommendations described in this paper will help to improve health outcomes by advancing team-based and person-centered care inclusive of community-based services, all while reducing duplication and low-value activities.

Joanne Gutowsky, CJ Systems, Inc.

- While the next steps are a critical (or key) component to improve aspects of care coordination, it is not the sole solution to our systemwide challenge.
- There have been several others in care coordination activities (HAP, as an example). This document references the example of Blue Cross Blue Shield of Michigan and Priority Health. So as not to anger or to alienate others in the industry this needs to be noted.
- The MiPCT demonstration project was a continuance of efforts started on the Improving Performance in Practice (IPIP) concept.
- The payment model (discussed in Reimbursement) offers our communities the opportunity to provide the best care at the best cost.
- It should be noted that bridges do exist throughout healthcare's siloed systems and that needs to be identified and removed to improve our statewide challenge.
- There is an opportunity to more aggressively market the 2-1-1 database. Advertising it might add value.
- In order to maximize the effectiveness of a shared care plan, a standardized template with defined components would best facilitate this effort.
- As drivers in transformative health care, leaders should be asking "What opportunities do we see and address these societal problems before they become health issues for a person? What can we do to change it?"
- When there are no claims submitted, there is a "false" condition of \$0 being associated with the effort.
- The report "Closing the Quality Gap" should have been used as a starting page for striving to define care coordination.
- If root cause analysis is not viewed as important by the workshop attendees, how are we to improve?

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Anne Levandoski, Upper Peninsula Health Plan

During this time of care coordination proliferation, this white paper and the Coordinating the Coordinator workshops have provided the first steps of what will hopefully be an ongoing collaboration to streamline processes, improve the sharing of actionable information, and facilitate communication between care coordinators. All these activities are essential to assure that individuals receive optimal care coordination services and that care coordination becomes a sustainable service without repetitive assessments and duplicative processes. In the future, it will be crucial to bring the voice of the consumers of care coordination services into these discussions to determine how best to meet their needs and prevent care coordination fatigue.

Diane Nielsen, Northern Lower Area Health Education Center

I would consider the paper a great success because such a diverse group of individuals and agencies provided their honest feedback. I believe that the project will be successful moving forward as long as the emphasis of "care coordination will result in not only better health outcomes for people, but also higher quality care at lower cost" remains a priority.

Beth Roszatycki, Michigan Health Improvement Alliance (MiHIA)

MiHIA's mission and vision is centered around sustained system change to address the Quadruple Aim. Care coordination has the ability to improve outcomes, experience, quality, lower the cost of care and aid in improving provider well-being. It is critical that we focus on how healthcare delivery can move into addressing social determinants of health, pilot and build financing mechanism, and utilize technology to achieve greater success. Current practice patterns and flow may need to be re-evaluated, as well as payment models; fostering non-traditional relationships and incorporating a multi-disciplinary/multi-sector approach will also need to be included in future strategies

Michael Talley, South East Michigan Health Information Exchange

The paper is a nice piece of work and I have no issues with the technology approach or how it is discussed. But having read "Hobbes", "Kant", "Locke", and "Rousseau" from my college days at State, there is a real "philosophical" approach and issue inherent in what the participants discussed and what they didn't discuss. Some do not wish to discuss philosophy, but I think it's important to how we live as individuals and the paper notes that some felt that the work is not focused on the "patient", but the "individual". I like that view best.

In the definition, there is the use of the word "empower". Normally I see that word used in instances discussing "social justice", "equality", and as the SAMHSA list of bullet points shows, the "emotional" and the "spiritual". The paper even discusses "societal" environments and while I am aware that many in Michigan, such as myself, growing up there. I'm not sure that "care coordination" can do much in providing "social justice" and given income differences and education, there shall be those who use the system for effectively than others. The care coordination system will be more "efficient" in outcomes, but for those who have the understanding of the system, there is an inherent advantage.

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For me, the word "empower" means, (and Hobbes said "words have meaning".) that the person has the "authority" and the "power" to do something. I read the section on "BCBS", but in that instance of "payment" and such, who has the authority, BCBS or the "individual"? I suppose "he who pays the piper, calls the tune", will be the result, but what if the individual for their own moral and virtue reasons, decides NOT to move down a path recommended by the "Care Coordinators"? Can they "force" the individual? At the moment, that is not clear and perhaps is not the purview of this paper or the participants? The paper discusses "communication" with the individual but somewhere along the way, we are going to have to define the "roles and responsibilities" as the paper correctly outlines and notes and I agree that "active engagement" of the individual is a necessary "value", but there shall be the nagging question of what is the role of the individual in their healthcare? I shall admit that I have not been "sick" since I was 4 years old and that due to my "social advantage", I have jogged from 14 to 55 and now ride a Mountain Bike 5 miles every day, in Summer and the dead of Winter. Some men get no exercise and take no responsibility for doing it can have heart attacks at 50, shoveling the snow. I drink water and juices and gave up "Pop" decades ago, eat vegetables and fruits, meat from time to time, but more salads and since I have a knowledge of chemistry, I tend to eat that which is necessary for cellular health, my heart and other vital organs. Someone not having my "social advantage" would not realize that as one grows "older", as I have, one has to "change" and "adapt" an individuals "diet". Is this information the role of the "care coordinators" and will the individual follow it? The recent reports on "obesity" in America, which came out yesterday, suggests, they shall not. Can the individual be "forced"? I think not.

The system described is great for me, but there is an undercurrent in the paper of what to do about those who in society don't have my advantage or my "privilege" as some might say.

I read the sentence of "investing in care coordinators" and I'm not sure what that means or who or what will pay for it? I suspect the individual by their insurance purchases of government agencies, will find that useful, but I shall note I bought a new pair of glasses in February and got my annual check up by my Doctor at "New York Presbyterian", and the woman who asked about "payment" in both instances was surprised I handed over my "Debit Card". How does "care coordinator" work for someone such as me as what do I care about "BCBS"? Others with social advantage such as "Taylor Swift", Members of Congress, Officers of Fortune 500 companies and those active in maintaining their health will have I think, better "outcomes" by the use of this system, which I support. What I don't support are those individuals being "vilified" by some, who might not see it as "fair".

You folks did a good job and it is much appreciated and let's see how it all works out! Go for it!