

Beaumont ACO

A Physician/Health System Partnership

Medicare Shared Savings Care Coordination Program

Medicare Shared Savings Program (MSSP) Overview

The Shared Savings Program is a volunteer (opt-in) program which is focused on Medicare parts A and B fee-for-service.

You as a Participant (Primary Care Provider, PCP)

As a participant in the Beaumont ACO's MSSP, your Medicare beneficiaries (patients) who are attributed to you are eligible for assistance within the MSSP-Advanced Illness Management (AIM) program. MSSP-AIM is a concept of beneficiary/family centered care delivered by our multidisciplinary team of health professionals adhering to evidenced-based best practice guidelines.

Targeted Population

Beneficiaries who need guidance and support for complex medical issues that may be compounded by social, economic, environmental and behavioral factors are the targeted population. Examples include but not limited to beneficiaries with changes in functional status and/or progression of conditions such as:

- Congestive Heart Failure (CHF)
- Chronic Obstructive Pulmonary Disease (COPD)
- End Stage Renal Disease
- Multiple co-morbidities

How Beneficiaries are identified for MSSP-AIM Care Coordination Services

- Direct referrals from healthcare team members, such as PCPs
- CMS utilization data and reports from EPIC EMR
- ADT (admission, discharge, transfer reports)

The BACO Care Coordination Services Include

- Transition of Care telephonic follow-up by a RN care coordinator within a few days of discharge from a hospitalization, emergency department visit or skilled nursing facility
- Skilled Nursing Liaison- RN Care Coordinator focusing on care in the SNF and transition post SNF
- Advanced Illness Management is face to face NP/RN care coordination visits, focusing on beneficiary/family centered care, PCP engagement and collaboration with other healthcare team members

The Process

- Identify individuals with more complex health issues
- Seek approval of the beneficiary to participate
- Conduct a person/family-centered assessment
- Collaborate with the PCP and health care team to develop a plan of care
- Execute and monitor the care coordination plan and beneficiary's self-directed care

Role of the PCP

Physician engagement is the key to success. The PCP remains the leader in treatment decisions. The team will support the goals of care as established by the beneficiary and his/her PCP.

For this program, we are asking that you take the lead in inviting your beneficiary to participate in care coordination. The biggest influence in their active participation is your support. The PCP's support includes:

- Schedule beneficiary (include family as appropriate) for office visit with you and a care coordinator
- Encourage the beneficiary's participation in MSSP-AIM
- Collaborate with the care manager in your plan of care

There is no charge or copay to the beneficiary or PCP for BACO MSSP Care Coordination program participation.

Contact Us:

Please contact Elizabeth Music by telephone (248.219.6178) or email (elizabeth.music@corewellhealth.org) to refer your patients for Care Coordination Services. Elizabeth will ensure your referral is forwarded to the appropriate RN Care Coordinator for follow up.

Name	Email	Phone	Team
Jessica Blake RN	jessica.blake@corewellhealth.org	248.389.2532	Advanced Illness Management
Marcelli Contreras NP	marcelli.contreras@corewellhealth.org	313.212.7273	Advanced Illness Management
Merleyn Fernandez-Fernando RN	merleyn.fernandezfernando@corewellhealth.org	313.204.8388	Advanced Illness Management
Karl Jacob RN	karl.jacob@corewellhealth.org	947.215.4725	Advanced Illness Management
Lynda Martenson RN	lynda.martenson@corewellhealth.org	248-665-6387	Advanced Illness Management
Shuab Miah RN	shuab.miah@corewellhealth.org	248.386.6661	Advanced Illness Management
Dawn Fiema RN	dawn.fiema@corewellhealth.org	313-310-8391	Skilled Nursing Liaison
Lubel Parent RN	lubel.parent@corewellhealth.org	248-386-6913	Skilled Nursing Liaison
Jennifer Hollins RN	jennifer.hollins@corewellhealth.org	313-244.9707	Transition of Care
Amy Mendez RN	amy.mendez@corewellhealth.org	313--409.6871	Transition of Care
Kathryn Smay RN	kathryn.smay@corewellhealth.org	947.522.0026	Director Care Coordination

Anyone on the team can receive your referral by either telephone or email. Our goal is to assist the beneficiary/family to effectively manage health conditions, improve overall health status, and decrease unnecessary costs through care coordination.