ARVON CIN
A Physician / Corewell Health 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 ARVON CIN'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 ARVON CIN 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.

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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.

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.**

Name	Email	Phone	Team
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