Care Management Expansion

The MSSP AIM program is expanding!

Beaumont ACO has been enrolled in the Medicare Shared Savings program since 2012. The Care Coordination program, also referred to as the MSSP-AIM, began soon after the initiation of MSSP. Most recently, new staff has been added to the MSSP-AIM program to allow an increase in the availability of care within the MSSP population to include Oakland and Macomb counties.

What is AIM?

The MSSP-AIM Care Coordination program is targeted to assist primary care physicians who participate in Beaumont ACO's MSSP with their medically complex Medicare beneficiaries (patients) who are attributed to them through the MSSP program.

MSSP-AIM is a concept of patient and family-centered care delivered by our multidisciplinary team of health professionals adhering to evidenced-based best practice guidelines. Identification of beneficiaries for care coordination can be identified thru:

- direct referrals from health care team members including PCPs
- utilizations data
- admission, data and transfer reports

MSSP-AIM Care Coordination has three components:

1. *Transition of Care telephonic* follow-up by an RN care coordinator within a few days of discharge from a hospitalization, emergency department visit or skilled nursing facility.
2. *Skilled Nursing Facility* liaison which includes oversight of beneficiaries while they are receiving sub-acute care. The RN care coordinator will coordinate the needs of beneficiary for discharge and transition from the skilled nursing facility.
3. *Advanced Illness Management* is face-to-face NP/RN care coordination visits, focusing on patient and family-centered care, PCP engagement and collaboration with other health care team members.

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 PCP.

For this program, the PCP is vital to take the lead to support the beneficiary to participate in care coordination. The PCP's guidance includes identification of appropriate beneficiaries and collaboration with the care coordinator to develop a plan of care.

Once the MSSP-AIM care coordinator has assessed the patient and their support systems, the care coordinator will execute and monitor the plan as developed with consulting with the PCP.

To enroll a beneficiary in the care coordination program, you may contact anyone on the team. Their contact information is as follows:

- Celeste Celis, RN, celeste.celis@beaumont.org, 313-586-5693
- Marcelli Contreras, NP, marcellijade.contreras@beaumont.org, 313-212-7273
- Trish Devine, RN, patricia.devine@beamont.org, 313-244-4711
- Dawn Fiema, RN, dawn.fiema@beaumont.org, 313-310-8391

- Merelyn Fernandez-Fernando, RN, merelyn.fernandezfernando@beaumont.org, 313-204-8388
- Jennifer Hollins, RN, jennifer.hollins@beaumont.org 313-791-4661
- Amy Mendez, RN, amy.mendez@beaumont.org 313-409-6871
- Shuab Miah, RN, shuab.miah@beaumont.org 248-386-6661
- Donna Mimikos, RN Director, donna.mimikos@beaumont.org 313-244-9302

Our goal

To assist the patient and family to effectively manage health conditions, improve overall health status and decrease unnecessary costs through care coordination.

There is no charge or copay to the beneficiary or PCP for MSSP - AIM program participation.