MiPCT: Michigan’s “Model T” for Transforming Care

Diane Sayers, DO, Henry Ford Health System
Lisa Nicolaou, MSNI, BSN, Northern Physicians Organization
Karen Bennett, RN, BSN, Sparrow Medical Group
Cara Seguin, RN, MSN, Henry Ford Health System

Session Focus:

Three diverse practice organizations will share how they used the Michigan Primary Care Transformation CMS Demonstration Project to advance care management within their organizations.
Session Objectives:

- Identify ways to leverage the EMR to facilitate care management and clinician communication across the system.
- Apply effective strategies to engage your team.
- Optimize care management resources in a multi-payer environment.

Agenda:

- 1:00 - 1:30  Overview of MiPCT: Diane Sayers, DO
- 1:30 - 2:10  Small Practice Organization: West Point Primary Care, Lisa Nicolaou, MSNI, BSN
- 2:10 – 2:50  Medium Practice Organization: Sparrow Medical Group, Karen Bennett, RN, BSN
- 2:50 – 3:05 Break
- 3:05 – 4:00  Large Practice Organization: Henry Ford Medical Group, Cara Seguin, RN, MSN
- 4:00 – 4:30  Panel Discussion
CMS Multi-Payer Advanced Primary Care Practice (MAPCP) Demonstration:

- **Centers for Medicare & Medicaid Services** is participating in state-based PCMH demonstrations
- Assessing effect of different payment models
- CMS Demo Stipulations
  - Must include Commercial, Medicaid, Medicare patients
  - Must be budget neutral over 3 years of project
  - Must improve cost, quality, and patient experience
  - 8 states selected for participation, including Michigan
  - Michigan start date: January 1, 2012

What is MiPCT?

- The Michigan Primary Care Transformation Project (MiPCT) is a three-year multi-payer project aimed at improving health in the state, making care more affordable, and strengthening the patient-care team relationship by targeting funding for care coordination, practice transformation & incentives.

- MiPCT is state-wide in scope and is the largest Patient-Centered Medical Home (PCMH) project in the nation.

- Michigan is one of eight states participating (ME, MN, NY, NC, PA, RI, VT).

www.mipctdemo.org
Participants:

- 477 practices
- 36 POs
- 1,500 physicians
- 1 million patients
- 5 Payers
  - Medicare; Medicare Adv.
  - Medicaid managed care plans
  - BCBSM
  - Blue Care Network
  - Priority Health (7/13)

Michigan Primary Care Transformation

Attributed Beneficiaries as of September 2013 (n = 893,826)

Distribution of MiPCT Beneficiaries & Geographical Spread of Presenting Organizations:

- West Point Primary Care
- Sparrow Medical Group
- Henry Ford Medical Group
MiPCT Facts:

- Michigan suffers some of the highest rates of morbidity and mortality, particularly in preventable illness
- Four common traits of successful models for improvement in health care reduction of cost include:
  - The use of dedicated Care Managers
  - Expanded access to health practitioners
  - Data-driven analytic tools
  - The use of incentives to drive care transformation
- The above common traits are the foundation of the MiPCT model.

Michigan Primary Care Transformation Project
Advancing Population Management

**PCMH Services**

<table>
<thead>
<tr>
<th>Complex Care Management</th>
<th>Functional Tier 4</th>
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<tbody>
<tr>
<td>All Tier 1-2-3 services plus:</td>
<td></td>
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<tr>
<td>Home care team</td>
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<td>Comprehensive care plan</td>
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<td>Palliative and end-of-life care</td>
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<table>
<thead>
<tr>
<th>Care Management</th>
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<tbody>
<tr>
<td>Functional Tier 3</td>
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<tr>
<td>All Tier 1-2 services plus:</td>
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<tr>
<td>Planned visits to optimize chronic conditions</td>
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<tr>
<td>Self-management support</td>
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<tr>
<td>Patient education</td>
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<td>Advance directives</td>
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<tr>
<th>Transition Care</th>
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<tbody>
<tr>
<td>Functional Tier 2</td>
</tr>
<tr>
<td>All Tier 1 services plus:</td>
</tr>
<tr>
<td>Notification of admittance/discharge</td>
</tr>
<tr>
<td>COP and/or specialist follow-up</td>
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<tr>
<td>Medication reconciliation</td>
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</tbody>
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<thead>
<tr>
<th>Navigating the Medical Neighborhood</th>
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<tbody>
<tr>
<td>Functional Tier 1</td>
</tr>
<tr>
<td>Optimize relationships with specialists and hospitals</td>
</tr>
<tr>
<td>Coordinate referrals and tests</td>
</tr>
<tr>
<td>Link to community resources</td>
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</tbody>
</table>

**Prepared Proactive Healthcare Team**
Engaging, Informing and Activating Patients

**PCMH Infrastructure**

<table>
<thead>
<tr>
<th>Health IT</th>
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</thead>
<tbody>
<tr>
<td>Registry / EHR registry functionality</td>
</tr>
<tr>
<td>Care management documentation</td>
</tr>
<tr>
<td>E-prescribing (optional)</td>
</tr>
<tr>
<td>Patient portal (advanced/optional)</td>
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<tr>
<td>Community portal/HIE (adv/optional)</td>
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<tr>
<td>Home monitoring (advanced/optional)</td>
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</tbody>
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<table>
<thead>
<tr>
<th>Patient Access</th>
</tr>
</thead>
<tbody>
<tr>
<td>24/7 access to decision-maker</td>
</tr>
<tr>
<td>30% open access slots</td>
</tr>
<tr>
<td>Extended hours</td>
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<tr>
<td>Group visits (advanced/optional)</td>
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<td>Electronic visits (advanced/optional)</td>
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<thead>
<tr>
<th>Infrastructure Support</th>
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<tbody>
<tr>
<td>PO/PHO and practice determine optimal balance of shared support</td>
</tr>
<tr>
<td>Patient risk assessment</td>
</tr>
<tr>
<td>Population stratification</td>
</tr>
<tr>
<td>Clinical metrics reporting</td>
</tr>
</tbody>
</table>

*denotes requirement by end of year 1
MiPCT Participants:

- Gain the ability to deliver more efficient, effective evidence-based patient care
- Contribute to improved community/population health
- Benefit from access to reports from a multi-payer database (CMS, Medicaid, and all participating commercial plans)
- Obtain access to Learning Collaboratives and/or coaching resources to help develop additional functionality in the areas of care management, care coordination, self-management support and linkages to community services

MiPCT Participants:

- Receive MiPCT financial and operational assistance to develop care management and care coordination models
- Receive incremental funds from CMS, Medicaid, and other commercial health plans
- Receive national recognition as a leader in development in the largest demonstration project in the nation
- Contribute to the development of evidence-based knowledge on a national level
Multi-Payer Claims Database:

- Collect data from multiple Payers and aggregate it together in one database
- Creates a more complete picture of a patient's information when they:
  - Receive benefits from multiple insurance carriers
  - Visit physicians from different Practices, Physician Organizations or Hospitals

- Phase 1 – claims data
- Phase 2 – claims and clinical data

MDC: MiPCT Dashboards

**Population Membership**
- Atributed members by Payer
- # of members by Risk Level
- # patients by Chronic Condition (Asthma, CKD, CHF, etc)

**Quality Measures**
- Screening and Test Rates
  - Diabetes tests, Cancer Screens, etc
  - Immunization Rates, Wellness Visits, etc.
- Comparison to Benchmarks

**Utilization Measures**
- Rates
  - ED Use, Admissions, Re-admissions, etc
  - Comparison to Benchmarks
2013-2014 MiPCT Priorities:

- Care managers fully integrated into practices
- Target PCMH interventions to patients from all participating payers
  - Distribute multi-payer lists and dashboards
  - Ensure care management for at risk members
  - Use registry for proactive population management
- Focus on efficient and effective health care
  - Avoid unnecessary services/hospitalizations
  - Assess practice utilization patterns
- Ensure adequate clinic access to meet demands

How will CMS define success?

IHI Triple Aim

The tie to budget neutrality and ROI
MiPCT Funding Model:

<table>
<thead>
<tr>
<th>Amount (pmpm)</th>
<th>Description</th>
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<tbody>
<tr>
<td>$0.26</td>
<td>Administrative Expenses</td>
</tr>
<tr>
<td>$3.00*, **</td>
<td>Care Management Support</td>
</tr>
<tr>
<td>$1.50*, **</td>
<td>Practice Transformation Reward</td>
</tr>
<tr>
<td>$3.00*, **</td>
<td>Performance Improvement</td>
</tr>
<tr>
<td>$7.76</td>
<td>Total Payment by non-Medicare Payers***</td>
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</table>

* Or equivalent
** Plans with existing payments toward MiPCT components may apply for and receive credits through review process
*** Medicare will pay additional $2.00 PMPM to cover additional services for the aging population

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Financial Investment, 2012:

<table>
<thead>
<tr>
<th>Description</th>
<th>“New” Money</th>
<th>Total</th>
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</thead>
<tbody>
<tr>
<td>Care Coordination</td>
<td>$35,577,697</td>
<td>$35,577,697</td>
</tr>
<tr>
<td>Practice Transformation</td>
<td>$8,739,951</td>
<td>$28,287,509</td>
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</tbody>
</table>

1. New money includes: Medicaid, Medicare, BCN g-code payments, BCBSM g-code + make whole payments
2. Total adds in: BCBSM Practice transformation (E&M uplift) of $19 million, but does not include incentive payments
Care Manager Models:

- **Moderate** Care Managers - Chronic disease management and self-management support.
- **Complex** Care Managers - Complex care coordination
- **Hybrid** Care Managers – Combination of moderate and complex care management.

Care Management Continuum:

Primary Care Population Health Strategies

- **Registries**
- **Gaps in Care Outreach**
- **Planned Visits**
- **Self Management Support**
- **Medication Management**
- **Care Coordination**
- **Patient Education**
- **Patient Activation**
- **Complex Care Coordination**
- **Problem Solving**
- **Linking with Community Resources**
- **Empowerment and Education**
- **Transitional Care (post hosp/ED)**

1. Panel Management
2. Care Management for Chronic Dz
3. Complex Case Management for high risk/cost patients

Usual Care in Medical Home
New Potential for Medical Home to Transform Patient Health Outcomes

Distribution of MiPCT CM Roles: Nov. 2013

Care Manager Roles
Sample taken with N=420

- Hybrid 59% (248)
- Moderate 26% (109)
- Complex 15% (63)

Care Manager Survey:

- Conducted in May 2013
- 434 care managers asked to complete survey
- 53% completed the survey (n=228)
Care Manager Survey Results:

**Physician Interaction**

- Care Managers reported working with an average of 8.4 physicians
- On average, 83% of these physicians referred patients

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Care Manager Survey Results:

- Top 3 broad areas of challenge
  - **Care Manager Challenges**
    - Need for work flow processes
    - Need for practice team support/understanding of CM role
    - Time management
  - **Care Management Embedment**
    - Need for practice staff education on CM role and process workflows
    - CMs serving multiple practices or working as a CM part time
  - **Physician Engagement**
Care Manager Survey Results:

- Top 3 broad areas of success
  - Development of Process Improvement
    - Transition of Care
    - Using the MiPCT List
    - Reviewing the practice schedule regularly
  - Culture Change within the Practice
    - Physician engagement
    - Reviewing potential patients with the provider/use of huddles
    - Practice staff understanding of the CM role
  - Advanced/Improved IT Capabilities

Utilization and Cost Metrics:

MI and National Evaluations are Consistent

- Total PMPM Costs
  - Medicare Payments (National)
  - Utilization based standardized cost calculations across all participating payers (Michigan)
  - Additional analysis of cost categories
- Utilization
  - All-cause hospitalizations
  - Ambulatory care sensitive hospitalizations
  - All-cause ED visits
  - ‘Potentially preventable’ ED visits
What Does Sustainability Mean?

- To the Health Plan: Added value for their customers
- To the Practice: Maintaining and growing CM staffing, processes and roles
- To the PO: Payment reform for CM
- To the State and Patients: Servicing all patients, all payers

Sustainability Progress:

- Reduction of 4% in number of emergency room visits for MiPCT patients for ambulatory care-sensitive conditions from 2012 to 2013
- Addition of Priority Health brings payer participation from the largest plans in Michigan
- CMS Complex Care Management proposal
- Patient Advisory Council launched that offers the patient voices and input in program design and operations
- ROI PO Subgroup financial modeling
- ADT messaging and direct Care Manager member list distribution at no cost to POs
CMS Complex Care Management Post-Demo Payment Proposal:

- Good News! CMS Physician Fee Schedule included proposed codes for Complex Care Management
- Quarterly payment beginning 1/1/2015.

Large Scale Change from the Small Practice Perspective

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Northwestern Michigan: Traverse City Region

- Traverse City approximately 14,674
- Grand Traverse county 86,986
- Much larger catchment area
  - Large surrounding rural areas
- Munson Medical Center
  - Only Level II trauma center in northern ½ of state
  - Largest of 8 hospitals in system
  - 391-bed acute care facility

Northern Physicians Organization:

- Provider led Physician Organization
- No executive administrator for first 9 months of the MiPCT demonstration; PO led demonstration
- 6 eligible Primary Care Practices at the start of MiPCT were eligible to participate
  - 3 chose to participate
  - 2 practices left the PO within months of starting the demonstration
- 52 PCP practices currently / 18 are now PCMH designated
West Front Primary Care:

- 12 providers; 10 physicians; 2 NPs
- 51 employees currently
- Over course of 6 years practice rapidly expanded
- 2 person management team at beginning of MiPCT
- No prior Care Management services at practice
- Resignations received from both managers within 4 months of start of program

Only practice in PO and in catchment area participating in MiPCT

Where to start?

- Hired 2 care managers initially:
  - Hired directly by practice vs. through PO
  - Both held dual roles within the practice
  - One physician champion

- Assessment of current state of practice:
  - Culture
  - Communication
  - IT infrastructure
  - Current process flow
Culture & Communication:

- **Culture:** 12 independent practices under a single roof sharing staff
  
  **We learned:**
  - Change had been poorly managed in past;
  - Active and significant management was needed to proceed.

- **Communication:** What Communication???
  
  **We learned:**
  - Had to get staff members talking to start the changes in motion

IT Infrastructure:

- Group was considered an early adopter of EMR technology
- Training and support internally with minimal professional assistance
- Poor acceptance of EMR by older providers

**What we learned:**

IT development likely not going to happen in first few years of demonstration; find an alternative solution
Current Process:

- Minimal if any standardization
- Not repeatable
- Frustrating for staff

**What we learned:**
Care management would set the trend to standardize. Take our time and do it well.

In a Nutshell:

- Pretty common picture
- Struggling to keep up with patient needs
- Difficult to take time to plan for future

- MiPCT was *the* stimulating force to move in the right direction
- Start up funding was essential
Immediate Needs & Long Term Change:

Immediate Needs:
- Multidisciplinary project team
- Communication
- Documentation
- Process development

Long Term Change:
- Culture change
- Restructure of the organization
- IT development
- Quality improvement

Culture of Change:

“Don’t be afraid to fail. Don’t waste energy trying to cover up failure. Learn from your failures and go onto the next challenge. It’s OK to fail. If you’re not failing, you’re not growing.”

- H. Stanley Judd

izquotes.com
Multidisciplinary Project Team:

- Critical to building better relationships
- Culture change
- All aspects of the practice represented
- Addressed one of our major threats for failure

Communication:

- Scope of change / transformation outlined
- How do the Care Managers communicate with providers
- Standardized documentation for communications
- Face to face very easy
- Huddles
Huddles:

Documentation:

- 90% of documentation needs exist in current EMR
- Cost prohibitive to develop templates
- System designed to document medical perspective
  - Single provider vs. team process; individual encounter vs. population focus
- Limited ability to extract information
- Worked within confines of EMR:
  - Searchability a main focus from the beginning
  - Analysis of process
- Registry – population view of patients

**How we chose to implement:**

- Focused on process and communication; What we could control
Documenting the Process:

- Created a shared understanding of what others do
- How will it change?
- All aspects of the practice understand where they fit in

**Benefit of Diagrams:**

- Repeatable process
- Training of new staff
- Dissection of the process – see where inefficiencies are

LEAN for Healthcare:

- Local resource for LEAN process
- PO sponsored initiative to increase efficiencies in CM process
- Meaningful analytics that could be captured the old fashioned way;
- Focused on process changes vs. clinical / physiologic changes
- Small practices perhaps a better fit
The Breakdown:
What we identified as a problem

Mapping a Solution:
Care Manager Liaison Role:

* See IHI Website for Handout

Will it work?

Quality Improvement in Practice Plan-Do-Study-Act

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<thead>
<tr>
<th>Quality Knowledge</th>
<th>Practice Improvement</th>
<th>Better Outcomes</th>
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How will I know if the change made a difference?

What is the clinical problem that I want to solve?

What change will I need to make?

What do I need to know? (e.g., How many patients are affected = "data collection")

What office systems are affected?
Transitions of Care:

- Started with MiPCT driven protocols
- CCM identifying, triaging and calling patients
  - 8-10 hours / week
  - 5 -10% of the patients would likely benefit from level of care that the CCM could provide

- How to adapt the process to fit our organization?

Who has the right skill level to do the work?

- Identified what skill set was needed
- Who in the practice met that skill set; who was the right choice for the job
- Defined the process
  - Triage pathway
  - Standardized measurement tools (LACE, Medication, Fall risk)
  - Role definition

- Result:
  - 8-10 hours / week to see patients
Summary: Challenges

- Access to a multidisciplinary team from the beginning
- Dual roles
- Ability to demonstrate ROI takes time/ Tracking the money coming in from a demonstration challenging
- Lack of standardization
- Use of IT systems as more than just a replacement for charting
- Eligibility

Eligibility:

Demonstration = scientific study
How do you have a scientific study where the control population cannot be reliably defined?

How can outcomes be measured without that control population?

Who can we treat?
Small Practices, Big Changes: Lessons Learned

- Strategies to engage team:
  - Manage the change actively
  - Focus on what you can control
  - Ensure multidisciplinary communication
  - Huddle, huddle, huddle

- Optimize CM resources in multiplayer environment:
  - Dual roles are not cost effective; just means neither job will be well done
  - Focus on process that allows your CM’s to maximize their time with patients
  - Clear goals for referral

- Effective use of EMR to implement CM services:
  - Don’t reinvent the wheel; collaborate
  - Involve the larger organizations (PO, PHO) to assist with the changes
  - IT systems are not just a more complex way to document

Perceived Benefits 2 years in:

“The changes that the demonstration brought to the practice were overdue and the program provided structure and a starting place. The financial start up money for a small organizations allows that transformation to begin.”

“We have stopped thinking of the EMR as a way to document and started thinking of the EMR as a tool to help us make decisions.”

-Dr. Nathan March, MiPCT Physician Champion
  West Front Primary Care
Thank you

Questions?
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Large Scale Change from the Medium Practice Perspective

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Sparrow Medical Group (SMG):

- Owned by Sparrow Health System caring for the Mid-Michigan Community
  - 4 acute care hospitals
    - Sparrow main is a 733-bed teaching hospital
    - 2 Rural hospitals
- Multispecialty physician practice organization
  - 11 Primary Care Offices (8 participating in MiPCT)
  - Actively engaged with Patient Centered Medical Home initiatives since 2009 (the first year Blue Cross and Blue Shield of Michigan formally designated patient centered medical homes)

Pre-MiPCT Care Management at SMG:

- Prior to the MiPCT project SMG offered Care Management to patients regardless of insurer
  - Services were on a much smaller scale
    - One Care Manager for 8 practices. Caseload of approximately 400 patients.
- Mostly moderate complexity and focused on patient and staff education (Hybrid Care Management)
- Extremely high patient, physician and staff satisfaction reported
Post-MiPCT Care Management at SMG:

- 6 Hybrid Care Managers (4.8 MiPCT funded) seeing patients in 8 practices by the end of year 1, 2012
- New practice opened in 2013, bringing supported practice total to 9 with 8 participating in MiPCT
- Care management for the non-MiPCT practice continued without compensation
- 3 Practices with 1 FTE Care Manager, 6 Practices share 3 FTE Care Managers (1 RN/2 practices)
- Existing Care Management relationships transferred to new Care Manager regardless of insurer
- Gradual shift from all patients/all payers to adding new patients to caseload as indicated by MiPCT participating payer groups

“Mining” for patients from Payer lists:

- Difficult transition from all payer/all patients to MiPCT eligible patients
- Office staff and physicians resistant to changing from the PCMH model of every patient regardless of payer
- List of attributed patients varies from month to month causing some confusion and distrust
- Payer’s attribution models rely on claims data which is often outdated
- Gradual acceptance of the need to focus on the demo project’s payer mix
Almost two years into the project:

- Patient, physician and staff satisfaction remains very high.
  
  “My life is better and my patients are receiving better care. You can’t ask for more than that.” Susan Caldwell, MD Family Practice at SMG DeWitt

- Success remains difficult to measure as there is no true before and after data set

- It’s very difficult to follow the money trail—too many different payment models

- IT tools have improved communication enabled better patient tracking/reporting

- Attribution and eligibility are still challenges

Sparrow Health System EMR:

- Uses EPIC

- Ambulatory practices live since August, 2010

- Hospital live since December, 2012
Transitions of Care Post Hospital Go live:

- Primary Care Physician and RN Care Manager receive notification in “real time” of patient admission/ED visit and follow the inpatient/ED course
- Allows Care Manager to coordinate with inpatient case managers PRIOR to discharge
- Able to run reports and monitor in real time:
  - Inpatient stay/ED visits
  - Elective surgery/Procedures
  - Sparrow Urgent Care clinic
Identifying MiPCT Patients in EPIC:
- Created “MiPCT Eligible” problem using a dummy code
- Clearly visible on the problem list
- Can create an overview indicating when the case was opened and complex or moderate level
- IT automated monthly import of MiPCT “problem”

Tracking Care Management Case Load:
- Chief complaint section of navigator - facilitates tracking of discrete data
  - Ambulatory Complex OR Moderate Care Management
  - Distinguish from Inpatient Case Management
- Problem list – adding problem “MiPCT Eligible”
- Episode create/link
Clinical Documentation Tools:

- Initial contact create a MiPCT episode
- Follow up visits link today’s note to the episode
- Able to see all care facilitator activity/notes in one defined printable report
- Deactivate episode when patient discharged from care facilitator caseload

Chart Review

<table>
<thead>
<tr>
<th>Data N.</th>
<th>Status</th>
<th>Data Received</th>
<th>Type</th>
<th>Episode</th>
</tr>
</thead>
<tbody>
<tr>
<td>10/26/2012</td>
<td>Active</td>
<td></td>
<td>MiPCT</td>
<td>Complex</td>
</tr>
</tbody>
</table>

{PHONE/OFFICE:20353} visit for Case Management
{New / Annual:22394} Assessment

Diagnoses:
1. Diabetes mellitus

Reason for Referral: {REASON FOR REFERRAL:22272}
Source/Contact: {CFSOURCE:22273}
Consent: {CFCONSENT:22274}

Patient reported greatest concern at this time:

Hospitalization/ED Summary:
{Hospitalization / ED Summary:22395}:"Patient has not been hospitalized or treated at an ED.

Care Team:
Patient Care Team:
Sparrow Ambulatory Physician, MD as PCP - General (Family Medicine)
Diane McLeod, RN as Amb Care Facilitator (Family Medicine)

Home Health/Therapies:
{Home Health Therapies:22396}:"Not indicated at this time."
**Communication/Follow up Tools:**

- Send in-basket messages to Sparrow PCP/Specialists
- Send in-basket reminders to yourself and future date them, i.e. “call the patient for a status report”
- Patient portal: MySparrow
  - Secure email from/to patient
  - Patient flow sheet glucose and blood pressure
- Route documentation

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**REVIEW OF SYSTEMS**

**Patient/Other Reports:**

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**General:**

- Activity change: \{YES **/NO:20554\}
- Exercise: \{EXERCISE:20290\}
- Fever
  - \{Fever / Denies:22405\}

**Hearing:**

- \{HEARING:20476::"Denies pre\}

**Nutrition:**

- \{YES **/NO:20554\}

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**SmartLists allow you to select multiple options without having to type every word**
Complex Case Study:

- Problem List – “MiPCT Eligible” provider referred patient
- PCP requested RN Care Manager work with 91 y/o male due to HgbA1c of 9.1 (last result 7.8)
- RN Called patient to introduce herself. Patient reported he was not feeling “so good”
- Glucose in the past 3 days had been in the 400’s
- RN Scheduled care management and PCP visit

Findings:

- Glucose in clinic was 425
- Lantus vial empty – he thought he had at least one week of insulin left
- Novolog: giving incorrectly only at breakfast
- Glucose testing: only fasting
- Hard of Hearing: often cannot hear the phone
- Lives alone: no life line/did not carry cell phone
Actions:

- Scheduled PCP visit that day
- Determined he had previously been seen by Sparrow Endocrine specialty
- Electronic communication with Sparrow Endocrine to coordinate care and receive suggested insulin dose changes
- Facilitated sooner Endocrine follow up apt
- Communicated with patient’s son
- Home care referral

Actions – cont’d:

- Son agreed to family home care insulin teaching
- RN Care Manager accompanied patient and son to Endocrine appointment the following week
- Weekly calls to patient and son
- Patient chose to continue to live independently
- Son visited patient at least every other day and called twice a day
All was going well for a while........

Two Months Later:
- RN Care Manager accompanied patient and son to Diabetes Center appointment
- Glucose running in the 500’s (RN had just called patient 3 days ago –was told levels were 200)
- Insulin vial empty again!
- Insulin dose increased and patient sent home with new dose and monitoring instructions
- Another home care referral
- Family re-educated regarding medication safety and adherence
The EMR Advantage for Care Transitions:

- Next day the RN received an electronic alert - patient had been seen at Sparrow ED
- Able to follow up immediately with family and facilitate a PCP visit
- Home care updated
- Patient was firm that he wanted to continue to live alone independently
- The family explored alternative living options and had a plan in place

Fast Forward

ONE MONTH LATER...
RN Received an Epic Electronic Alert:

- Patient was currently in the ED - hypoglycemia
- Notes indicated the plan was to send patient home
- RN facilitated doctor –to-doctor call and discussed “the rest of the story”
- Patient was admitted to monitor hypo/hyperglycemia episodes and address safety concerns
- Social work involved
- Care Manager and inpatient Case Manager communicated

Currently:

- Patient continues to live at home alone
- Son checks on him twice a day: before and after work
- Patient now carries a cell phone with him
- Home care has just discharged him
What have we learned?

- Leverage IT/EMR resources
  - Communication vastly improved between all involved in patient’s care and in “real” time
  - Assigning unique electronic patient identifiers (“MiPCT eligible problem”) and reason for visit (Ambulatory Moderate or Complex Care Management) enabled MiPCT specific registry functionality and care management tracking/reporting
- Maintain open and honest communication between the provider organization, the offices and the care managers
  - Understand frustrations while supporting change efforts
  - Share resources
- Success is measured one patient at a time and looks different for each
- A single payment model would be ideal

Thank You

Questions?
Karen Bennett, RN, BSN
Sr. Quality Specialist
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Break Time

Large Practice Organization Perspectives:

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Director, Clinical Care Design
Henry Ford Health System
Detroit, MI
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Outline:

- Henry Ford Health System and Henry Ford Medical Group overview
- HFMG Care Management Journey
- Leveraging the EMR
- Team engagement
- Sustainability/Return On Investment - the delivery system perspective - Exercise

Henry Ford Health System (HFHS):

Core Services:
- Four acute med/surg and two behavioral health hospitals
- Henry Ford Medical Group
  - 30 Medical Centers
  - 1200 physicians & scientists
- 2200 private physicians
- 1500 MD & DO physician trainees
- Health Alliance Plan

Post-acute services:
- 2 Skilled nursing facilities
- Home Health Care
- Outpatient Dialysis
- Home Products
- Retail Pharmacies
- Vision Centers

Other Statistics:
- Over 23,000 employees
- Over 200 care delivery sites
- 102,000 admissions, 2200 beds
- 418,000 ED visits
- 3.2 million office visits
- 88,000 surgeries
Henry Ford Health System
Patient-centered Team Care SM

Extended Hours
Advanced Access
Same Day
Appointments
24/7 Access
Self-Care
Kiosk / Web Access
Health Assessments
Preventive Care Scheduling
Poly-pharmacy Management

Palliative Care
Home Care for Frail Elderly
Skilled Nursing Facility
Care Coordination
“Ambulatory Intensivist”
Complex Chronic Disease Care
“Population Management”

Palliative Care
Home Care for Frail Elderly
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“Ambulatory Intensivist”
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“Population Management”

Virtual Visits
E-Visits (G Code)
Preventive Care Reminders
Panel Managers

Population Management
Preventive Care Reminders
Panel Managers

Mid-level Provider Visits
Stable Disease Follow-up
Minor Organ/Care Preventive Care

Extended Hours
Same Day Appointments
24/7 Access

Clinical Practice Guidelines (CPG)
Chronic Disease Management

PCTC Team Members:

- Mid-Level Providers
- RN Care Managers
- Panel Managers
- Clinical Pharmacists
- Behavioral Health Nurse Practitioners
- 250 PCPs/+residents/medical students
- Program Managers

- ~950 Specialty Physicians
- Clinic Service Representatives (CSRs)
- Medical Assistants
- Clinic Registered Nurses
- Home Infusion/Home Health Care Nurses
- Anticoagulation Nurses
- Diabetes Educators & Dieticians
Our Care Management Story:

1. **2007-2009** Piloted CM in 2 Primary Care clinics (Taylor, Detroit Campus K-15)
   - Disease Management/Moderate CM (DM and CHF)
   - DCC depression screening

2. **2010-2011** Spread CM to 4 PC sites (35%)-Taylor, Detroit Campus K-15, Sterling Hts, Fairlane
   - CM Expanded from 2-8 CDs (CAD, COPD, Dep, HTN, asthma, CKD)
   - Patient Satisfaction; IMPACT training - PST

3. **2012-2013** Primary Care Standards, Access, Rapid Spread
   - CM Spread to 21 sites (~85%)
   - Part of System Strategic Plan and Performance Goals, Epic Dashboards
   - MIPCT Transitions of Care- added Complex Case Management- Hybrid Model

2012 - 2013 System Spread of Case Management: (From 4 sites to 21 sites- 24 CMs)

Expanded from 35% of Chronic Disease Population Covered - to now > 85%
Primary Care
Chronic Disease Management:

- 25 Ambulatory Care Sites Across 3 Regions/ 4 Counties
- Supported by Center for Clinical Care Design
- Patient Centered Medical Home
- Physician Group Incentive Program
- Organized Systems of Care
- Michigan Primary Care Transformation Project

6 Diabetes Care Centers
- Medical Nutrition Therapy
- Diabetes in Active Control Program
- Diabetes Self Management Program

Integrated Depression Care
- Regional Psych Nurse Practitioners
- PCPs Practices Screening and Managing Depression

Ambulatory Case Management
- 24 Nurse Case Managers across 21 sites
- Panel Managers - 10

Supported by Center for Clinical Care Design

Team Engagement:

- Challenges:
  - Changes in Care Management Model
  - Change from all payer model to limited payer attributed model
  - Rapid spread of CM from 4 sites to 21 sites
  - Clinics in wide geographic distribution
  - Rapid hiring and training process
  - CM connection to other CM’s and to their assigned clinic
  - Heavy workload, focus shifts, attribution that doesn’t always make sense
Anticipating Hurdles:

1. Spread big in short amount of time
2. Potential to lose existing buy-in with new focus
3. New role for sites - new processes; potential for fragmentation
4. System communication and buy-in important
5. Merging the new team with the existing team

Hire the Right People and Plan for Success:

- Human Resources advanced screening questions
- Transparency of model, project details, salary range known PRIOR to interview
- Candidate preference for top 3 sites to work
- Strong problem solving, organizational, planning and computer skills
- Initial screen done centrally for abilities and overall recommendation, 2nd interview by site leadership to ensure "right fit" for both the site and the candidate
Team Meeting Essentials:

- **Patient Story**: case review, group input, recognition, problem solve, reinforce strategies
- **MiPCT updates**: webinars summaries by Clinical Lead, 3 take-aways for the team!
- **Input**: collaborative algorithms, documentation guidelines, defining site champion role to support self-management
- **Ongoing education**: Disease management, tips, tools & resources, Community partnerships
- **System collaborations**: CM Programs, Pharmacy, Home Health Care, Self-Health Centers
- **Focus on quality**: system initiatives, dashboard performance

Driving System Support

- **Spreading the Word…**
  - System meeting updates – Board Meetings, Quality Forum
  - Medical Group Newsletters*
  - MiPCT internal newsletters
  - Visibility on Primary Care Homepage
  - CM updates at site staff meetings
  - Regional updates
  - Transparency of challenges- share feedback and progress with system leadership
Communicate – Communicate:

- Huddles
- Collaborative Protocols
- Standing Orders
- Medication titration protocols
- Coordinated D/C follow-up expectations
- CM meeting minutes and patient feedback is shared monthly with site leadership
- MiPCT standing time at all 3 Regional Meetings

Overcoming Challenges With Communication:

- Established project time line - Gantt chart
- Initiative part of system strategic plan
- Monthly Steering Committee meetings - include Human Resources, Nursing Leadership and Finance
- Conference calls with sites; orientation weekly e-updates, site visits; regular presentations at staff meetings
- Communication - system case management council; What's Up? Calls to CMs
Recognition:

- Celebrations at CM monthly all day meetings: birthdays, achieving goal milestones
- Received Focus on People Awards last 2 years
- "WOW" awards & system employee recognition
- Share positive patient feedback surveys with CM, site leadership, up to CEO level, Board of Trustees
- Team building at each meeting and other events (e.g. luncheons, Tigers baseball game)

The Best Recipe for Spread?

Recipe: Team Care

Serves: The Patient

1. Combine 1-Physician leader and an open site team with a zesty focus.
2. Add 1 cup support, each from Human Resources, Finance & Quality.
3. Blend in generous portions of Communication, "sift" in a dash of frustration, and top with 2 heaping tablespoons of patience.
4. Taste and share outcomes.
5. Modify until recipe perfected!
Key Changes to Customer Engagement:

- System-level approach to customer engagement
- Service training on AIDET (Acknowledge, Introduce, Duration, Explain, and Thank you) mandatory for all employees
- Re-introduced team member standards and rolled out leadership expectations
- Team engagement in performance goal setting

“The Henry Ford Experience” 7 Pillars of Performance:

Mission
To improve people’s lives through excellence in the science and art of health care and healing.

Vision
Transforming lives and communities through health and wellness – one person at a time.

People | Service | Quality & Safety | Growth | Research & Education | Community | Finance

December 8, 2013

Strategic Plan: 2012-2014

This Strategic Plan presents Henry Ford Health System’s mission, vision, values, core competencies, and strategic advantages and challenges. This document also identifies Henry Ford Health System’s key strategic objectives for 2012 as well as strategic initiatives and performance measures for the next three years.
Standardization:

- Roles and responsibilities of Case Manager
- Primary Care Development Team - input from all sites and regions
- Learning Collaborative Meetings - include Pillar Awards to acknowledge PI initiatives related to standardization
- Use of standing orders to limit interruptions and reinforce population segmentation and risk stratification approach
- PCMH standardization - “30 standards”

Designing Effective Hand-Over:

Identify opportunities for hand over and collaboration between:

- Inpatient Case Management
- Ambulatory Case Management
- Clinic nurses
- Home Health Care
- E-Home Care
- HAP case management
- Pharmacy – Medication Therapy Management Program
- Diabetes Educators & Dieticians
- Psych Nurse Practitioners
MiPCT Health Information Exchange:

State of Michigan

MiHiN

PO #1
PO #2
PO #3
PO #4
PO #5
PO #6
PO #7

HFHS

MHC

GLHIE

Beacon

PO #8
PO #9
PO #10
PO #11
PO #12
PO #13
PO #14

Ingenium

The Power of IT-Driven Transformation: 2012-2013 Screening Trends

<table>
<thead>
<tr>
<th></th>
<th>Pre-Epic</th>
<th>Post-Epic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Duration</td>
<td>4 years</td>
<td>5 months</td>
</tr>
<tr>
<td>Total patients screened</td>
<td>40,074</td>
<td>49,269</td>
</tr>
<tr>
<td>Mean no. patients screened per month</td>
<td>835</td>
<td>9,854</td>
</tr>
<tr>
<td>Mean no. new depression cases identified per month</td>
<td>131</td>
<td>393</td>
</tr>
</tbody>
</table>
Depression Screening in CM:

Customized with permission to include suicide intent/plan, mania, bi-polar

Custom CM Navigator Built in EMR
Chronic Disease Sections:

- Diabetes
- Hypertension
- Coronary Artery Disease
- COPD
- Chronic Kidney Disease
- Depression
- Asthma
- Heart Failure
Charge Capture for G-codes:

Putting it altogether with PATIENT STORIES
Early HFMG CM Outcomes:

- Utilization Impact after enrollment
  - 46% ↓ # pts admitted to hospital
  - 26% ↓ overall # admissions

What did we learn?

- 24% ↓ # pts with ED visits
- 32% ↓ overall # ED visits

- Excluded patients < 3 months enrollment interval
- N = 422

- 62% monthly discharges have follow up within 7-14 days; 14% no show rate
- 88% follow-up rate for appointments made by CM
- Received Focus on People Award - System Award for Service
  - 93% Satisfaction Scores on Top Box Score
  - Likelihood to Recommend

Utilization Reductions:

<table>
<thead>
<tr>
<th>Metric</th>
<th>Population Description</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>ED Utilization</td>
<td>Overall HFMG MiPCT rate – snapshot taken at 6 months</td>
<td>9.08% decrease</td>
</tr>
<tr>
<td>ED Utilization(2011-2012)</td>
<td>Overall HFMG MiPCT rate at 12 months</td>
<td>1.36% decrease</td>
</tr>
<tr>
<td>Inpatient hospitalizations</td>
<td>MiPCT Case Managed Patients only* who completed CM program</td>
<td>26% decrease</td>
</tr>
<tr>
<td>ED utilization</td>
<td>MiPCT Case Managed Patients only* who completed CM program</td>
<td>32% decrease</td>
</tr>
</tbody>
</table>
Developing Analyses Templates:

Are you my ROI?

Billing for CM Services:

<table>
<thead>
<tr>
<th>Code</th>
<th>Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>G9001</td>
<td>Initial Assessment</td>
</tr>
<tr>
<td>G9002</td>
<td>Individual face-to-face visit (per encounter)</td>
</tr>
<tr>
<td>G9007</td>
<td>Coordinated care fee, scheduled team conference</td>
</tr>
<tr>
<td>G9008</td>
<td>Physician coordinated care oversight services</td>
</tr>
<tr>
<td>98961</td>
<td>Group visit (2-4 patients) 30 minutes</td>
</tr>
<tr>
<td>98962</td>
<td>Group visit (5-8 patients) 30 minutes</td>
</tr>
<tr>
<td>98966</td>
<td>Telephone discussion 5-10 minutes</td>
</tr>
<tr>
<td>98967</td>
<td>Telephone discussion 11-20 minutes</td>
</tr>
<tr>
<td>98968</td>
<td>Telephone discussion 21+ minutes</td>
</tr>
<tr>
<td>99487</td>
<td>Complex chronic care coordination, first hour</td>
</tr>
<tr>
<td>+99489</td>
<td>Complex chronic care coordination, additional 30 minutes</td>
</tr>
<tr>
<td>99495</td>
<td>Moderate complexity transitions of care</td>
</tr>
<tr>
<td>99496</td>
<td>High complexity transitions of care</td>
</tr>
</tbody>
</table>
Return on Investment Models:

**Million dollar question:**

*What does it take to effectively manage moderate & complex patients?*

---

**G-Code Billing ROI Model:**

'Plug and play' model that allows the user to enter their data. Model will assist in determining:

- Viability of case management with all-payer G-code billing model
- Determining the difference between complex and moderate episodes of care
- The number of visits/types of visits needed for each type of episode of care
- How case managers' time is spent
- Where to focus/re-focus efforts to produce a viable G-code billing model
Utilization ROI Model:

‘Plug and play’ model that allows the user to enter their data. Model will assist in determining:

- Effect of case management on:
  - Admissions
  - Readmissions and
  - ED utilization
- Utilization rates
- Cost savings associated with reduced utilization
- Percentage change (as used with MiPCT incentives)
- Statistical significance of reduction in ED visits

In Summary:

- Several approaches to care management being proven
- Importance of team buy-in: What's in it for them? Balance influx of change
- Strategic alignment/transitions; anticipate hurdles
- Share patient stories daily
- Leverage technology to facilitate processes; Use of MiPCT resources
- Use quality improvement tools to establish efficiency
- Communicate progress and outcomes- Patient/Provider Satisfaction, Clinical, Efficiency & Utilization
- Value in networking and learning approaches to build the ultimate model
Thank you

Questions?
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