M4: Care Management in the PCMH:

Results from a 2 Year Pilot and Care Manager Training and Practice Integration

Presenters

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Learning Objectives

1. Disseminate evaluation results from an innovative two-year pilot testing a PDCM model in a clinical setting
2. Outline the process of expanding this pilot to a statewide program
3. Utilize the lessons learned to provide practical tips and instruction on implementing similar PDCM programs in provider practices

Agenda

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
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<tbody>
<tr>
<td>12:00</td>
<td>I. The Beginning - Provider-Delivered Care Management Pilot</td>
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<tr>
<td>1:45</td>
<td>Break</td>
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<tr>
<td>2:00</td>
<td>2. The Spread - Building a Statewide Multi-Payer Provider-Delivered Care Management Program</td>
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<td>4:00</td>
<td>Break</td>
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<td>4:15</td>
<td>3. Lessons Learned</td>
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What is Care Management?

“Programs [that] apply systems, science, incentives, and information to improve medical practice and assist consumers and their support system to become engaged in a collaborative process designed to manage medical/social/mental health conditions more effectively.

The goal of care management is to achieve an optimal level of wellness and improve coordination of care while providing cost effective, non-duplicative services.”

— The Center for Health Care Strategies

The Story We’re Going to Tell

<table>
<thead>
<tr>
<th>Care Management 2010-2011</th>
<th>Care Management 2012-Present</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 POs</td>
<td>35 POs</td>
</tr>
<tr>
<td>49 Practices</td>
<td>380 Practices</td>
</tr>
<tr>
<td>258 PCPs</td>
<td>1500 PCPs</td>
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</tbody>
</table>

5 states with identical zip codes appear as one star
I. THE BEGINNING

PROVIDER-DELIVERED CARE MANAGEMENT PILOT

Blue Cross Blue Shield of Michigan

- Non-profit
- 4.7M Michigan members plus national members
- 45% Market share
- Strong Social Mission
- Wide range of products, including evolving in-house care management program
BCBSM In-House Care Management

<table>
<thead>
<tr>
<th>Year</th>
<th>Case Mgmt Program</th>
<th>Disease Mgmt Program</th>
<th>Targeted Outreach &amp; Shared Decision Making</th>
<th>“BlueHealth Connection” – Integrated Wellness &amp; Care Mgmt w/Nurse Call Line</th>
<th>Care Transitions Facility Precert Oncology Management Gaps in Care Mailings</th>
<th>Advanced Illness Pilot</th>
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<tbody>
<tr>
<td>1985</td>
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<td>2010-12</td>
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<td>2013</td>
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Physician Group Incentive Program

Catalyzing Statewide Health System Transformation in Partnership with Providers

<table>
<thead>
<tr>
<th>Year</th>
<th>Chronic Care Model</th>
<th>Patient-Centered Medical Home</th>
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<tbody>
<tr>
<td>2004</td>
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<td>2008</td>
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<td>2009</td>
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</table>

- Launch PGIP in partnership with Physician Organizations, leveraging economies of scale and clinical and technical expertise to create highly functioning systems of care
- Design and execute programs in a customized and collaborative manner
- Measure performance at the population level and reward improvement as well as absolute performance: initial focus on GDR and building patient registries

- Implement PCMH and quality/use Initiatives
  - Support building of PCMH infrastructure
  - In addition to GDR, measure preventive and evidence-based care, preventable ED use, high and low-tech imaging, IP use
- Expand PGIP to include specialists involved in chronic care

Provider Delivered Care Management

- Patients have trusted relationship with PCP
- Literature suggests higher engagement and favorable outcomes with in-person care management
- Primary care providers want to retain responsibility for managing their patients

Poof! You’re a PCMH-PDCM practice! [not]
**Physician Group Incentive Program**

**Catalyzing Statewide Health System Transformation in Partnership with Providers**

<table>
<thead>
<tr>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
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</table>

### Provider-Delivered Care Management

- Launch PDCM pilot with 5 Physician Organizations, based on 3 of the 12 PCMH domains
  - Individual Care Management
  - Care Coordination
  - Self-Management Support
- Michigan State University obtains AHRQ grant to compare provider-delivered with health-plan delivered care management

### PCMH-Neighborhood and Organized Systems of Care

- Launch expanded PDCM program as part of Michigan Primary Care Transformation Project (MiPCT)
- Build PCMH-Neighborhood: expand PGIP to include specialists
- Catalyze building of Organized Systems of Care that assume responsibility and accountability for managing the PCP-attributed population of patients across all locations of care

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**PDCM: Innovative, Low Risk, Adds Value**

- PDCM providers: highly engaged, active partners in practice transformation
  - Focused on improving outcomes of care and lowering costs in near-term
- Program is low-cost and low-risk
- Provides potential basis for future tiered network
Scope

PDCM Pilot

- Southern part of state
- 5 Physician Organizations, 52 practices
- 258 PCPs
- 2 years: April 1, 2010-March 31, 2012

Target Population & Services

PDCM Pilot

- Five major chronic conditions
- Moderate Care Management, Care Transitions
Staffing Requirements

- PDCM Pilot
  - No standardized care manager training required
  - No staffing ratios

Financing

- PDCM Pilot
  - Single payer
  - $100,000 per PO per year flat payment
  - All BCBSM members eligible
PDCM Lessons Learned
Information Needs vs. Admin Burden

Pilot
- Customers expect detailed care management process measures
- Administrative reporting outside claims system extremely burdensome

PDCM Expansion
- Filing PDCM claims for each encounter challenging for care managers
- Separate codes for assessments, in-person & phone encounters allow tracking of services

Standardized Staffing Requirements vs. Provider Autonomy

Pilot
- POs employ care managers for economies of scale
- Care managers have visible, active presence in practice

PCM Expansion
- Not all practices have volume or resources to employ RNs, PAs, or MSWs
- Need RN, PA or MSW to conduct annual comprehensive care management assessment
PDCM Pilot Challenges

- No standardized education for Care Managers
- Variation in availability of standardized patient education materials
- RN Staffing – taking on new CM role
  - “Did I sign up for this?” vs. “When can I do this full time?”
- Variation in ability to back fill and create time for new CM responsibilities
- Change management
  - communication leadership, practice staff, CM
- Sharing Lessons Learned – creating peer to peer CM support
  - needed to create new ways to share

PDCM Pilot - What We Learned

- Data – be selective about data
  - Do not create data requirements that are administratively over ambitious
- Communication and leadership is key
  - Engaged Leadership
    - Practice leadership is informed of progress, challenges
    - Formal and informal leaders – leverage!
  - Communication on all levels
    - Have consistent and frequent “all staff” communication
    - Requires frequent touch base meetings with those involved in the change
- Process change
  - Don’t assume practice staff involved in the change have knowledge of PDSAs
  - Teach model for improvement in small steps, real time
PDCM Pilot - UMHS Experience Challenges & Opportunities

- Physician Communication
  - Physician buy-in is challenging
- RN Workload
  - RN Time spent on non-clinical tasks
  - CM unable to run a registry report
  - Registry report not available
- Team Factors
  - Lack of defined workflows
- Data/Reporting
- Change Management
- Resources

Challenge:
- Implementation of PDCM Pilot - RN
- Moderate Care Management

PDCM Evaluation Results

CRISIS
Placeholder for Evaluation Results

[To be added after final internal approval]

Michigan Primary Care Transformation Project (MiPCT)

CRISIS
Meanwhile...

- In 2010, the Centers for Medicare and Medicaid Services issued an RFP for a three year state-based PCMH demonstration project
- At the time, Michigan had 477 practices designated as Patient Centered Medical homes though BCBSM, and less than 25 designated through NCQA
- Question - Could we turn a single-payer PCMH model into a multi-payer one???

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, Michigan is largest with approximately 50% of MAPCP practices
  - Michigan Primary Care Transformation (MiPCT)
  - Michigan start date: January 1, 2012
The Vision for a Multi-Payer Model

- Use the CMS Multi-Payer Advanced Primary Care Practice demo as a catalyst to redesign MI primary care
  - Multiple payers will fund a common clinical model, allowing global primary care transformation efforts
  - Support development of evidence-based care models
- Create a model that can be broadly disseminated
  - Facilitate measurable, significant improvements in population health for our Michigan residents
  - Contribute to national models for primary care redesign
- Form a strong foundation for successful ACO models

MiPCT Funding Model

- $0.26 pmpm Administrative Expenses
- $3.00 pmpm*, ** Care Management Support
- $1.50 pmpm*, ** Practice Transformation Reward
- $3.00 pmpm*, ** Performance Improvement
- $7.76 pmpm Total Payment by non-Medicare Payers***

* 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
Managing Populations: Tiered approach to care management

IV. Most complex
(e.g., Homeless, Schizophrenia)

III. Complex
Complex illness
Multiple Chronic Disease
Other issues (cognitive, frail elderly, social, financial)

II. Mild-moderate illness
Well-compensated multiple diseases
Single disease

I. Healthy Population

Michigan Primary Care Transformation Project
Advancing Population Management

PCMH Services

Complex Care Management
Functional Tier 4
All Tier 1-2-3 services plus:
- Home care team
- Comprehensive care plan
- Palliative and end-of-life care

Functional Tier 3
All Tier 1-2 services plus:
- Planned visits to optimize chronic conditions
- Self-management support
- Patient education
- Advance directives

Transition Care
Functional Tier 2
All Tier 1 services plus:
- Notification of admit/discharge
- PCP and/or specialist follow-up
- Medical reconciliation

Navigating the Medical Neighborhood
Functional Tier 1
Optimize relationships with specialists and hospitals
Coordinate referrals and tests
Link to community resources

Prepared Proactive Healthcare Team
Engaging, Informing and Activating Patients

PCMH Infrastructure

Health IT
- Registry / EHR registry functionality
- Care management documentation
- E-prescribing (optional)
- Patient portal (advanced/optional)
- Community portal (advanced/optional)
- Home monitoring (advanced/optional)

Patient Access
- 24/7 access to decision-maker
- 30% open access slots
- Extended hours
- Group visits (advanced/optional)
- Electronic visits (advanced/optional)

Infrastructure Support
- POI/HO and practice determine optimal balance of shared support
- Patient risk assessment
- Population stratification
- Clinical metrics reporting

*denotes requirement by end of year 1
Michigan Primary Care Transformation Project (MiPCT) in Comparison to PDCM Pilot

Same: PCMH Participating Providers

- PDCM Pilot
- MiPCT~ PDCM Expansion
- PGIP PCMH-Designated Practices
- PO Infrastructure

Care Management Focus
Different: Scope

**PDCM Pilot**
- Southern part of state
- 5 POs & 52 practices
- 258 PCPs
- 2 years: April 1, 2010-March 31, 2012

**MiPCT**
- Statewide
- 35 POs & 380 practices
- 1,500 PCPs
- 3 years: Jan 1, 2012 – Dec 31, 2014

Different: Target Population & Services

**PDCM Pilot**
- Five major chronic conditions
- Moderate Care Management, Care Transitions

**MiPCT**
- No diagnostic criteria—team selects patients from risk-stratified population
- Complex Care Management, Care Coordination, Care Transitions, Moderate Care Management
Different: Staffing Requirements

PDCM Pilot
- No standardized care manager training required
- No staffing ratios

MiPCT
- Separate care manager training required for moderate and complex care managers
- Minimum staffing ratios

Different: Financing

PDCM Pilot
- Single payer
- $100,000 per PO per year flat payment
- All BCBSM members eligible

MiPCT
- Multi-payer
  - Medicare
  - Medicaid managed care
  - BCBSM
  - BCN
  - Priority Health (7/13)
- Multiple payment methodologies
- About 50% BCBSM members eligible due to self-funded customers not participating
MiPCT Payment Methodologies

- Two different payment methodologies
  - BCBSM/BCN – Fee for service with multiple codes
  - Medicare/Medicaid – Per Member Per Month payment

- Added significant complexity to implementation

- Not all BCBSM/BCN members covered under demo
  - Some self-funded customers did not opt in to process
MiPCT Caseload Allocations

- Complex care managers (Tier 4)
  - 1 per 5,000 MiPCT patients (active cases ~ 150)
  - Target: patients with multiple co-morbidities and/or high utilization
  - Goal: coordinate care, maximize function
- Care managers (Tier 3)
  - 1 per 5,000 MiPCT patients (work with ~ 10%)
  - Target: patients with moderate complexity illness
  - Goal: mitigate risk factors, optimize chronic conditions, provide self-management support

MiPCT Care Manager Staffing Model

<table>
<thead>
<tr>
<th><strong>Our Plan</strong></th>
<th><strong>Reality</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Moderate CMs and Complex CMs</td>
<td>• Resource allocation to fund salary of CMs + staffing decision = Hybrid Care Manager</td>
</tr>
<tr>
<td>• MiCMRC provides Complex Care Management training for 160 - 200 CMs</td>
<td>• Hybrid Care Managers emerged, Large numbers!</td>
</tr>
<tr>
<td>• Curriculum designed for each CM role</td>
<td>• Rethink training for Care Manager roles</td>
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MiPCT – 2 years

- 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
- IT tools
  - documentation tools have improved
  - leveraging IT enables improved team communication & better patient tracking/reporting
- Patient attribution and eligibility challenges workflow, resources to identify eligible patients

MiPCT Team and PO Leaders Work together to Define Care Management Best Practice & Benchmark

- Define CM standard work
  - Gather and share examples of standard work developed by CMs, POs, and practices
- Conduct “go sees” – ongoing by Master Trainers, Clinical Leads
  - Gather and share best practice processes, resources, tools, staff job descriptions
  - Continue to identify gaps – assist with developing solutions

No Care Management Daily Activity Benchmark available – must find a way to develop and test benchmarks
Care Manager Patient Activity Benchmark
Where is the Evidence?

MiPCT Benchmark* for Care Manager Activity
Care manager’s patient caseload – 3rd Quarter PO Data

<table>
<thead>
<tr>
<th>Care Manager Role</th>
<th>90th Percentile Qtr 3 face to face/FTE</th>
<th>Encounters per day = Benchmark*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complex</td>
<td>92</td>
<td>7 encounters per day</td>
</tr>
<tr>
<td>Hybrid</td>
<td>255</td>
<td>8 encounters per day</td>
</tr>
<tr>
<td>Moderate</td>
<td>163</td>
<td>6 encounters per day</td>
</tr>
</tbody>
</table>

Care Manager Volume
Quarters 1-3, 2013

Total (raw) Number of Encounters and Patients

Number of Encounters and Patients Per Care Manager FTE
MiPCT – Building Care Manager (CM) Patient Caseload

- Building the CM caseload - Phased in approach recognizing variables
  - Patient population
  - Care manager hire /training completion dates
  - Care manager experience prior to MiPCT
  - Physician referrals
  - Physician buy in
  - Infrastructure to support care management delivery

MiPCT Benchmark for Care Manager Caseload

- Increasing Care Manager’s patient caseload
  - Enroll minimum:
    - 3-4 new patients per week -full time Complex CM
    - 4-6 full time HCM
    - 6 or more full time MCM
  - For Hybrid care managers
    - Caseload = 40% moderate, 60% complex patients
    - Adjust number of moderate and complex patients in caseload based on the practice’s MiPCT patient population acuity
Building a Caseload - How Do The Best Performing Practices Do It?

Front office staff screen member lists, confirm current eligibility, identify gaps in care, etc.

Office, PO and Nursing management support team-based care

Physicians partner with the Care Manager and refer patients

Team meets regularly as a team to discuss successes and opportunities for improvement

VIDEO: The Happy Secret to Better Work

http://new.ted.com/talks/shawn_achor_the_happy_secret_to_better_work
BREAK – 1:45 to 2:00 PM

INTERACTIVE ACTIVITY
2 to 2:20 PM
Spread and Sustainability: Building the Team
II. THE SPREAD

Building a
Statewide
Program

MiPCT Care Manager Role
MiPCT Care Management Priorities

- Care managers work in close proximity to PCP team
  - In PCP office as much as possible
  - Work with PCP team to meet their needs
  - Evidence supports this model as superior to vendor-based
- Ensure Complex Care Management coverage
  - Manage high-complexity, high-cost patients
  - Patients selected based on risk score plus PCP input
- Focus on evidence-based interventions
  - Medication reconciliation
  - Care transitions
  - In-person contact with patients whenever possible
  - Comprehensive care plan for complex patients

MiPCT Care Management: Basic Principles

- Care manager is a member of the PCMH team
- Close partnership with patient’s physician
  - Help patients achieve health goals
  - Coordinate care, provide follow up between visits
- Who can be an MiPCT care manager?
  - Complex care manager: Registered Nurse, Licensed Social Worker (MSW), Nurse Practitioner, Physician Assistant
  - Other team members can also provide care management services: Pharmacist, Registered Dietician, Certified Diabetes Educator, etc.
Care Management Continuum:

Primary Care Population Health Strategies

- 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)

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

Functions of a Care Manager

- Partners with practice leadership team to integrate care management
- Assesses healthcare, educational, and psychosocial needs of patient/family
- Provides self management support
  - focus is typically on lifestyle and behavior change
- Provides patient/family education
  - with teach back
- Implements evidence-based care
  - chronic disease protocols and guidelines
- Assists with transitions between settings
  - includes medication reconciliation
- Assists with advance directives
Hiring Care Managers

Hiring Existing RNs for Care Manager Position

<table>
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<tr>
<th>Pros</th>
<th>Cons</th>
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<tbody>
<tr>
<td>• Recognition of existing RN’s professional growth and development/interest</td>
<td>• Practice leadership, PCP and/or staff set in “ways” – not fully aware of new CM role</td>
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<tr>
<td>• Trust relationships with staff and PCP, practice leaders in place</td>
<td>• RN is expected to take on new CM role and keep some/all of triage responsibilities</td>
</tr>
<tr>
<td>• Knowledge of IT, processes, practice culture, patient population</td>
<td>• If practice leaders do not fully support and implement care management at the practice level; Perception of staff – “no longer on our team”</td>
</tr>
<tr>
<td>• Organizational knowledge – tools, resources</td>
<td>• Does the RN have a choice to become CM? RN may be dissatisfied with new role (i.e. not what I was hired to do)</td>
</tr>
<tr>
<td>• Medical neighborhood knowledge – specialists, agencies, patient education and support</td>
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Hiring an External Candidate for Care Manager Position

<table>
<thead>
<tr>
<th>PROs</th>
<th>Cons</th>
</tr>
</thead>
<tbody>
<tr>
<td>• New role – partners with leadership to define expectations</td>
<td>• CM has steep learning curve</td>
</tr>
<tr>
<td>• Opportunity to hire “best fit” candidate</td>
<td>• New Role, practice, organization, medical neighborhood</td>
</tr>
<tr>
<td>• Match population needs to candidate’s strengths - licensure/experience,</td>
<td>• PO and practice – those hiring and interviewing may have little experience with care management:</td>
</tr>
<tr>
<td>• Enthusiasm of CM hired</td>
<td>• knowledge of CM role?</td>
</tr>
<tr>
<td>• CM must build trust/relationships</td>
<td>• aware of the characteristics of candidate who will be a “good fit”</td>
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Role Comparison: Moderate Risk Care Manager (MiPCT Tier 3), Complex Care Manager (MiPCT Tier 4)

<table>
<thead>
<tr>
<th></th>
<th>Moderate Risk Care Manager (MCM)</th>
<th>Complex Care Manager (CCM)</th>
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<tbody>
<tr>
<td>Patient Population</td>
<td>Moderate risk patients identified by registry, PCP referral for proactive and population management.</td>
<td>High risk patients identified by PCP referral and input, risk stratification, patient MiPCT list.</td>
</tr>
<tr>
<td>Patient Caseload</td>
<td>Caseload 500 (approx. 90 - 100 active patients); one MCM per 5,000 patients.</td>
<td>Caseload 150 (approx. 30 - 50 active patients); one CCM per 5,000 patients.</td>
</tr>
<tr>
<td>Focus of Care Management</td>
<td>Proactive, population management. Work with patients to optimize control of chronic conditions and prevent/minimize long term complications.</td>
<td>Targeted interventions to avoid hospitalization, ER visits. Ensure standard of care, coordinate care across settings, help patients understand options.</td>
</tr>
<tr>
<td>Duration of Care Management</td>
<td>Typically a series of 1 to 6 visits</td>
<td>Frequency of visits high at times, duration of months</td>
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MiPCT Care Manager Models

- **Moderate** Care Managers - Chronic disease management and self-management support.

- **Complex** Care Managers - Complex care coordination

- **Hybrid** Care Managers – patient population includes both Moderate and complex patients
MiPCT Care Management: Communication & Training

MiPCT Resources & Communication

Physician Organization (PO) Leaders
- PO Leadership and MiPCT Leadership
  - Webinars
  - Phone and in-person meetings

- PO Leader Engagement
  - Members MiPCT Committees
  - Members of MiPCT Work Groups

- Share Best Practice, MiPCT Updates
  - PGIP BCBSM Quarterly meeting
  - MiPCT Summit Regional Conference

- MiPCT Website www.mipctdemo.org
MiPCT Training, Resources & Communication

MiPCT Care Managers
- MiPCT Complex Care Management Course
  - In person, standardized curriculum, monthly

- Webinars
  - Two per month first 2 years, now monthly

- Conference Calls - regional/specialty
  - New, offer every other month

- MiPCT Newsletter – Practice FLASH

- Michigan Care Management Resource Center website
  - www.micmrc.org

Getting Started – MiPCT Implementation Guide

Michigan Primary Care Transformation (MiPCT) Implementation Guide
1. Background
   a. MiPCT Orientation

The Michigan Primary Care Transformation Project (MiPCT) is a demonstration project testing the value of the patient-centered medical home (PCMH) model. This model expands access to primary care while improving care coordination. This model has been increasingly important given the rise in multiple chronic diseases and the dramatic increase in health care costs. The traditional model of health care delivery, with 10-minute in-person appointments and disconnected primary care physicians and specialists, is not working for patients or their doctors.

MiPCT addresses the shortcomings in the current system by providing funding to primary care physicians to hire care managers and implement all physician patient registries to track and follow-up with patients, especially those with multiple chronic diseases. In addition, MiPCT physicians to expand office hours and offer same day appointments. Finally, MiPCT rewards physicians for improving their patients' health and avoiding unnecessary emergency department visits and hospitalizations.

MiPCT was developed in November 2010 after Michigan was selected by the Center for Medicare and Medicaid Services (CMS) as one of eight states to participate in the CMS Multi-Payer Advanced Primary Care Practice Demonstration. Michigan has the largest demonstration project in the country, reaching approximately 1.2 million patients served by 3,600 providers in almost 900 practices. All of the insurance companies and physician organizations in Michigan have been invited to participate.
Managing Populations: Tiered approach to care management

IV. Most complex
  (e.g., Homeless, Schizophrenia)
  <1% of population
  Caseload 15-40

III. Complex
  Complex illness
  Multiple Chronic Disease
  Other issues (cognitive, frail elderly, social, financial)
  3-5% of population
  Caseload 50-200

II. Mild-moderate illness
  Well-compensated multiple diseases
  Single disease
  50% of population
  Caseload ~1000

I. Healthy Population

MiPCT Care Manager Required Training

- MiPCT Complex and Hybrid Care Manager training
  - Complex Care Management Course:
    - One week “in person” didactic training in MI
    - MiPCT approved Self Management program

- Moderate Care Manager training
  - Chronic care model, self-management support
  - MiPCT-approved programs identified throughout state
MiPCT Complex Care Manager
Train the Trainer Program

Responsibilities | Master Trainer | Clinical Lead
---|---|---
FTE allocation for train the trainer model | 0.5 FTE | 0.2 FTE
Complex patient caseload | No patient caseload | Slightly reduced patient caseload
Areas of responsibility | MiPCT Care Manager Training – ex. Complex Care Management Course | Facilitates small group discussions, networking and sharing best practices
 | Facilitates, presents and leads CCM courses on going: webinars, interactive group activities, in person presentations | Oversight responsibility of CCM Clinical Leads in region
 | Oversight responsibility of CCM Clinical Leads in region | Coaching, mentoring CCMs, HCMs in region
 | Collaborates with Clinical Leads to identify best practices, opportunities, address barriers, and to develop tools | Collaborates with Master Trainer to identify topics for development of care manager curriculum, tools, resources
 | Meetings with Master Trainers, Clinical Leads, MiPCT leadership | Participates in meetings with Master Trainers and 1:1 and group meetings with CCMs, HCMs
MiPCT Care Manager Training Details

- Complex Care Manager training
  - Partnership with Geisinger Health System
    - Master Trainers and Clinical leads: three weeks in Pennsylvania
      - One week didactic training
      - Two week preceptorship
    - Partnership to build the curriculum for MiPCT Complex Care Management in MI
  - Licensed Complex Care Manager Documentation Tools
    - Standardized, evidence based
  - Support to develop the train the trainer model

MiPCT Complex Care Management Course Curriculum

- MiPCT 101
- Fundamentals of Complex Care Management
- Community resources
- Care transitions
- Care coordination
- Medication reconciliation
- Identification of High Risk Patients
- Care Management – 5 Step Process
  - Screen, enroll, assess, management, case closure
- Specific Assessment Tools
- Health Plan Payment Policy
- Evidence based care
- Care Manager visit documentation tools
CCM Course Curriculum (cont.)

Case studies & Interactive Group Work
- SWOT
- Exercises – ex Transition of Care, Medical Neighborhood

Building peer to peer support
- Strengths document – share contact/strengths

Care Management - Building a Patient Caseload
- Care manager and PCP review MiPCT list sorted by risk and payer
  - Target moderate and complex patients that are in need of care
  - Recent hospital/ED discharges
  - Just-in-time office visits
Care Management Patient Screening - MiPCT Patient List

- PO distributes MiPCT patient list to Care Managers
- Review patients scheduled the next day for PCP visit
- Admit/discharge notifications for transition of care calls
- PCP, team referral
- Compare to MiPCT member list; assess appropriateness
- Discuss with PCP: Is patient recommended for care management?
- Yes = identify patient is eligible for G9001
- Outreach with patient (visit, phone)
- Compare to MiPCT care management?
- Yes = identify patient is eligible for G9001

ENROLLMENT/ENGAGEMENT

- Assess, develop care plan, implement interventions, monitor and update care plan
- Submit G/CPT code billing if appropriate

MANAGEMENT/INTERVENTION

CLOSURE (as appropriate)

MiPCT Care Manager Curriculum

Ongoing

- Webinars – statewide
  - Best Practice, chronic conditions, process, project updates
- Conference Calls – regional/specialty
  - Facilitated by Master Trainer
  - Care Manager sharing peer to peer, interactive
- Practice Flash Newsletter
- CCM Course offered monthly
  - > 350 Care Managers trained
- Care Manager, PO workgroups
Michigan Care Management Resource Center – micmrc.org

- BCBSM/UMHS collaboration
- Initial focus is MiPCT practices, but available to all PGIP POs/PHOs/practices
- Web-based resource for templates, tools, evidence-based information, care manager job descriptions, etc.
- Webinars, workshops and mentoring in care management
- Personalized care management consultation service

Goal is to help disseminate effective, evidence-based care management models throughout Michigan

www.micmrc.org
“It is not the strongest of the species that survives, nor the most intelligent that survives. It is the one that is the most adaptable to change.”

- Charles Darwin

MiPCT Today

CRISIS
MiPCT Year Three:
Statewide Progress to Date

- Statewide infrastructure including Steering Committee, subcommittees, administrative/clinical leadership
- Over 350 Care Managers hired and trained
  - Building caseloads of targeted high-risk patients
- Building infrastructure in partnership with participating Physician Organizations
  - Ongoing Care Manager training, coaching, mentoring
  - Team-based learning collaboratives
- Multi-payer database
  - Risk-stratified member lists
  - Performance dashboards

Care Management – It takes a team!
Care Management Delivery by the Practice

- PCMH meetings monthly, action plan, follow up
- Patient
- PO and Practice Leadership
- Information technology, support
- Care Manager and PCP partnership
- Office staff – defined roles and responsibilities

Planned patient care i.e. huddles, processes, work flow, policies

http://www.youtube.com/watch?v=Pk7yqlTMvp8
Change Management

TransformED Recommendations

- Medical home requires more than just the four pillars and technological support
  - (four pillars: access, comprehensive care, coordination of care, relationships over time)
- In addition, it requires a strong organizational core (material and human resources, organizational structure, clinical process) and adaptive reserve (healthy relationship infrastructure, an aligned management model, facilitative leadership).

Crabtree et al, Summary of the National Demonstration Project and Recommendations for Patient-Centered Medical Home.Ann Fam Med 2010: 8 (Suppl 1) S80 – S90
What have we learned?

- Practices that never get started have leadership that is either ineffective or opposed to change.
- Practices that transformed have Adaptive Reserve – the ability to learn and change.
- Key feature of adaptive reserve is unified leadership that can:
  - envision a future,
  - have a strategy for getting there,
  - facilitate staff involvement, and
  - devote time to make and evaluate changes

Adaptive Changes Challenges

- "Changes which can be addressed only through changes in people's priorities, beliefs, habits and loyalties."
- Changes which have no known answer—learning the way to solutions is required

Therefore, people need to be engaged (through intrinsic motivation) to collaborate on learning the way.

Heifetz et al. The Practice of Adaptive Leadership 2009
Adaptive Leadership

- Facilitates learning the way to new solutions
- Use authority as a resource to
  - Direct attention to the adaptive challenge
  - Both challenge and support people to learn the way to change
  - Foster engagement (intrinsic motivation and commitment)

Heifetz et al. The Practice of Adaptive Leadership 2009

The PATH to Commitment: Engaging Stakeholders

**PATH to Commitment**

- Commitment
- Resilience
- Belief
- Engagement
- Understanding
- Compliance

*"Engaging the Wealth and Power of People to Effect Change The Path to Commitment:" Robert Greenleaf (1977) Journal, Fall 2009.*
Reactivity and Resistance

“I cannot overstate how frightening it is to lose a sense of influence or control”

Daryl R. Connor, Managing at the Speed of Change. 1999

“What people resist is not change per se, but loss…”

(e.g. competence, comfort, security, reputation, time, money)

Heifetz et al. The Practice of Adaptive Leadership 2009

Additional thoughts about resistance

- Resistance is a part of every change
- Resistance shows that people are thinking critically and care
- What looks like resistance may be someone working their way to belief and commitment
- There is ENERGY for change in resistance!!
Responding to Reactivity and Resistance

- First use active listening to get into their shoes
  - Use open ended questions to explore understanding, purpose, choice, complements and commitment.
- Work toward mutual goals
  - Reframe concerns into possible barriers
- Problem solve barriers
- Move toward PDSA cycles
- Provide support coaching, training, support as needed
- Follow-up

References

- O’Neill, Mary Beth *Executive coaching with backbone and heart.*
- Neil J. Baker, M.D. Adaptive change challenges and the hemodynamics of change. IHI workshop April 2013
Learning Collaborative

- IHI framework for learning collaborative
  - Multi day sessions (1 day each)
  - Every other month, 6 month total timeline
  - Team based sessions – including physicians and care managers
  - “Standard curriculum”
    - Care management model
    - Roles/responsibility
    - QI knowledge base – PDSA, measurement of improvement
    - Team collaboration and shared learnings
    - Risk stratification, patient identification
    - Special topics- palliative care, community partnerships, teach back, medication reconciliation, sustaining/spread
Teams

- 29 teams in 4 waves
- Represented all delivery models
  - Employed /independent
  - Residency
  - More larger systems represented
- Minimal attrition in attendance
- Highly valued for the team planning time
- Need for collaborative leadership to be highly adaptable to team “pain points”

Metrics

<table>
<thead>
<tr>
<th>Percent of Patients with a Post Hospital/ED Discharge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Telephone Follow-up:</td>
</tr>
<tr>
<td>Note: Pediatric practices may want to track patients</td>
</tr>
<tr>
<td>using urgent care facilities</td>
</tr>
<tr>
<td>Percent of Patients with a Complete Discharge</td>
</tr>
<tr>
<td>Summary in the Medical Record</td>
</tr>
<tr>
<td>Percent of Patients with a Post Hospital/ED Discharge</td>
</tr>
<tr>
<td>Clinic Visit Follow-up</td>
</tr>
<tr>
<td>Percent of Patients with a Medication Reconciliation</td>
</tr>
<tr>
<td>after a hospital or ED discharge</td>
</tr>
<tr>
<td>Percent of Patients with a Documented Self-</td>
</tr>
<tr>
<td>management Goal</td>
</tr>
<tr>
<td>Percent of Patients with Advance Directives Flagged</td>
</tr>
<tr>
<td>in the Medical Record</td>
</tr>
</tbody>
</table>

Percent: 100
Data Outcomes  “Experts possess more data than judgment”  Colin Powell

- Improvements
  - 48 hour follow up after discharge (25% improvement)
  - Discharge summary available at visit (13% improvement to 95%)
  - Quality improvement meetings occurring consistently (monthly)
  - Case review between care manager and providers stabilized at 10-12 times / month (2-3 times / week)
  - Huddles occurring 75% of the scheduled clinic days
- Improving numbers but not consistent trend
  - Setting of self-management goals
  - Obtaining advanced directives in the medical record
- No change
  - Medication reconciliation

Challenges - “That which doesn’t kill me makes me stronger”  Friedrich Nietzsche

- Variable needs of the teams – various starting points and skill sets
- Data collection
  - Need for it to be a team sport
  - Sustaining data collection
  - Technology to support data collection
- Rapid implementation timeline – 4 waves in 6 months
  - Insufficient time to study wave learnings prior to next wave
  - Limited action period time for the teams between sessions
Learnings “If we knew what it was we were doing it would not be called research would it?” Albert Einstein

- Time for team planning is critical and highly valuable
- Data is a “team sport”
  - Reporting needs to be cross team activity
  - Sustaining reporting is crucial
- Keep the care manager from “getting dumped on”
- Importance of “list” but can be distracting
- Embedment takes more time than anticipated
- Created sustainability worksheet/template but didn’t have enough time to utilize effectively

INTERACTIVE ACTIVITY - 3 to 3:30

Speed Dating:
1 - Care Management Role
2 - Health Plan Engagement and Evaluation
3 - Clinical Team Integration
MiPCT Data and Evaluation

MiPCT Multi-Payer Data Repository

Collect data
- Claims and eligibility
- Patient Lists (from Payers)
- Registry & Immunization
- EMR data from participating POs

Build a multi-payer claims and clinical database

Calculate quality and utilization measures

Create reports and dashboards

Provide reports, dashboards, and listings to participating POs
MDC: MiPCT Dashboards

Population Membership
- Attributed members by Payer

Risk Information
- # of members by Risk Level

Population Information
- # patients by Chronic Condition (Asthma, CKD, CHF, etc)

Quality Measures
Screening and Test Rates
- Diabetes tests, Cancer Screens, etc

Prevention
- Immunization Rates, Wellness Visits, etc.

Comparison to Benchmarks

Utilization Measures
Rates
- ED Use, Admissions, Re-admissions, etc

Comparison to Benchmarks

Measures & Reports

MiPCT Quality Measures by Payer

<table>
<thead>
<tr>
<th>QUALITY FOR PAYER</th>
<th>QUALITY INDICATORS</th>
<th>EXPRESS QUALITY</th>
<th>HEDERA QUALITY</th>
<th>MERICAN QUALITY</th>
<th>PREMEDICAL QUALITY</th>
<th>MEDICAL QUALITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td># of members</td>
<td>32.5%</td>
<td>33.7%</td>
<td>32.5%</td>
<td>33.7%</td>
<td>33.7%</td>
</tr>
<tr>
<td>Diabetes Hemoglobin</td>
<td># of members</td>
<td>42.4%</td>
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</tr>
<tr>
<td>Diabetes Nephropathy</td>
<td># of members</td>
<td>38.6%</td>
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</tr>
</tbody>
</table>

MiPCT ED Utilization by Payer

<table>
<thead>
<tr>
<th>QUALITY FOR PAYER</th>
<th>QUALITY INDICATORS</th>
<th>EXPRESS QUALITY</th>
<th>HEDERA QUALITY</th>
<th>MERICAN QUALITY</th>
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</tr>
</tbody>
</table>
### Measures & Reports

#### ED Summary Report

<table>
<thead>
<tr>
<th>Practice No.</th>
<th>Member ID</th>
<th>ID Number</th>
<th>Name</th>
<th>Date of Birth</th>
<th>Age</th>
<th>Gender</th>
<th>Plan Type</th>
<th>Provider Name</th>
<th>Provider Code</th>
<th>Practice Unit Name</th>
<th>Practice Unit Code</th>
<th>Total ED Visits</th>
<th>Most Recent ED Visit Date</th>
<th>Total PCS Rate</th>
</tr>
</thead>
</table>
| 123         | 456       | 789       | John Doe | 12/23/1984   | 38  | M      | Medicare | SMITH, John   | 123456           | Practice C 1     | 2013-01-01       | 2013-01-01       | 2.5%
| 789         | 012       | 345       | Jane Doe  | 01/12/1990   | 35  | F      | Medicare | SMITH, Jane    | 67890            | Practice B 1     | 2013-02-15       | 2013-02-15       | 3.0%

#### Patient listings

<table>
<thead>
<tr>
<th>Member ID</th>
<th>ID Number</th>
<th>Name</th>
<th>Date of Birth</th>
<th>Age</th>
<th>Gender</th>
<th>Plan Type</th>
<th>Provider Name</th>
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<th>Practice Unit Name</th>
<th>Practice Unit Code</th>
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<td>M</td>
<td>Medicare</td>
<td>SMITH, John</td>
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<td>SMITH, Jane</td>
<td>67890</td>
<td>Practice B 1</td>
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</tr>
</tbody>
</table>

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### How will CMS define success?

The tie to budget neutrality and ROI

- Population Health
- Experience of Care
- Per Capita Cost

Identify high utilizers and provide detail.
### 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

### Quality and Experience of Care Metrics:

**MI and National Evaluations are Different, with common elements**

<table>
<thead>
<tr>
<th>National</th>
<th>Michigan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes care:</td>
<td>Diabetes</td>
</tr>
<tr>
<td>- LDL-C screening</td>
<td>- Asthma</td>
</tr>
<tr>
<td>- HbA1c testing</td>
<td>- Hypertension</td>
</tr>
<tr>
<td>- Retinal eye examination</td>
<td>- Cardiovascular</td>
</tr>
<tr>
<td>- Medical attention for nephropathy</td>
<td>- Obesity</td>
</tr>
<tr>
<td>- All 4 diabetes tests</td>
<td>- Adult preventive care</td>
</tr>
<tr>
<td>- None of the 4 diabetes tests</td>
<td>- Child preventive care</td>
</tr>
<tr>
<td>Ischemic Vascular Disease:</td>
<td>- Childhood lead screening (Medicaid)</td>
</tr>
<tr>
<td>- Total lipid panel test</td>
<td></td>
</tr>
<tr>
<td>Patient experience (CAHPS)</td>
<td></td>
</tr>
</tbody>
</table>
MiPCT Care Manager Survey

- Two surveys: May 2013 & December 2013
- Survey completion
  - May: N=228
  - December: N=213

- 56% (128/228) of those that took the survey in May took it again in December

- 40% (85/213) of respondents in December were first-timers

December 2013 MiPCT Care Manager Survey

- Data were collected via Survey Monkey® Dec.16, 2013- Jan 5, 2014
- 424 Care Managers were emailed invitations to participate
- Data cleaning and analysis was performed using SPSS v19.0
Care Manager Survey Results

Self-Reported Care Manager Role (N=213)

- Hybrid: 61%
- Complex: 22%
- Moderate: 17%

How Care Managers Build Caseloads

- Physician referrals: 91%
- MiPCT list: 79%
- Electronic admit discharge notifications: 63%
- ED visit summaries: 57%
- Review in advance the practice visit schedule: 54%
- Registry: 40%
- Patient self-referrals: 30%
- Staff Meetings/Huddles: 28%
- Fax discharge summaries: 21%
- Other discharge list: 17%
- Other: 5%
Care Manager Survey Results

Another staff member is designated to assist with:

- Physician referrals
- MIPCT list
- Electronic admit discharge notifications
- ED visit summaries
- Review in advance the practice visit schedule
- Registry
- Patient self-referrals
- Staff Meetings/Huddles
- Fax discharge summaries
- Other discharge list
- Other

22% of all respondents specifically noted that no other staff member is designated to assist with any of the tasks.

Care Manager Survey Results (May 2013)

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 (May 2013)

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

BREAK – 4:00 to 4:15 pm

Please vote for the Lessons Learned you want to hear about
III. LESSONS LEARNED

Lessons Learned

1. Don’t impose burdensome provider reporting requirements. (Margaret & Lisa & Min)
2. Don’t underestimate importance of Convener (Physician Organization) engagement, resources, and leadership. (Jean)
3. Don’t underestimate difficulties of care management integration into practices. (Marie)
4. Don’t continue engaging patients who no longer need care management. (Mary Ellen)
5. Do recognize that technology can be both a barrier and a benefit: resolve IT issues such as how to manage monthly patient lists and document care plans early in process. (Mary Ellen)
6. Do conduct targeted training based on project goals, discussions with clinical leadership and care manager feedback, both initially and during ongoing follow-up training. (Marie)
7. Do rely on PCP and team input as well as claims data and risk scores to select patients for care management. (Jean)
8. Don’t underestimate importance of engaging and motivating physicians (Kevin)