The Michigan Primary Care Transformation Project

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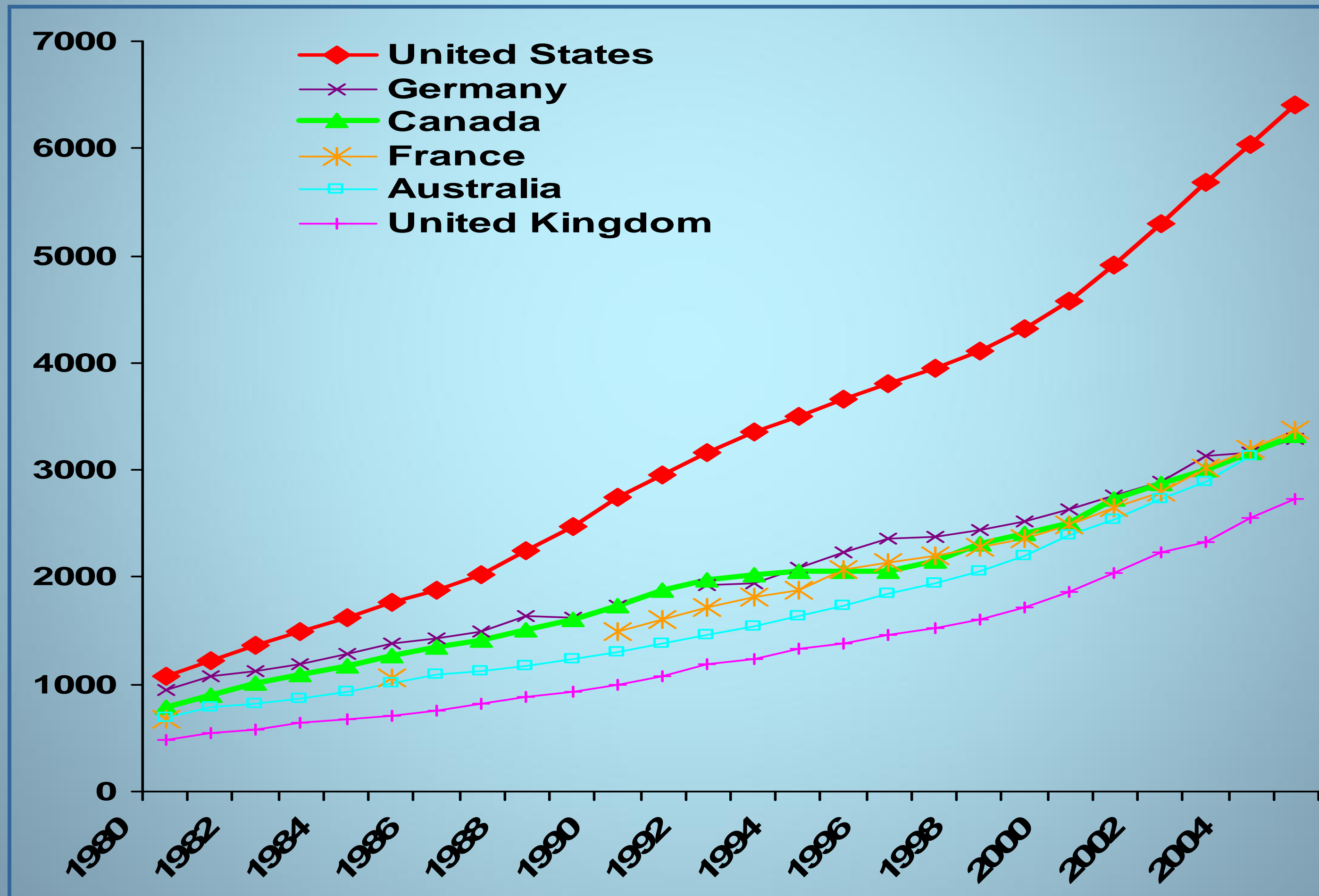
DPAC Meeting

October 20, 2011

Agenda

- Background for the CMS Demonstration
  - Purpose
  - Participants
- Michigan's Primary Care Transformation Project
  - Stakeholders
  - PCMH Characteristics
  - Clinical Focus Areas
  - Implications for Diabetes Care

Average Health Spending Per Capita ($ US): The ubiquitous and unsustainable Cost Curve



K. Davis et al. Slowing the Growth of U.S. Health Care Expenditures: What Are the Options?, The Commonwealth Fund, January 2007, updated with 2007 OECD data

Cost of Chronic Disease Care

- Total US healthcare expenditures were $ 2.2 **TRILLION** in 2007
- 60-70% of ALL healthcare costs arise from treating chronic diseases including hypertension, diabetes, kidney disease, obesity…)
- 10% of patients (those with multiple, complex chronic illness) account for 70% of Medicare expenditures

Quality of Chronic Illness Care

In 2006, Americans with chronic diseases received only about 56% of recommended care

- The range was between 11 and 79% for various chronic diseases (those with diabetes received only 45% of recommended care)

Source: Rand Health: First National Report Card on Quality of Healthcare in America, 2006

- Commonwealth Fund Report released today: "The U.S. made gains between 2007 and 2009, but we still failed to improve when compared to best performers among other nations"

Purpose of the CMS Advanced Primary Care Practice Demo

To allow Medicare to join Medicaid and commercial insurers in State-sponsored health reform initiatives aimed at evaluating whether the PCMH model improves health, improves satisfaction with care, and reduces health care costs

New Systems are Needed

"Americans can have a health care system of the quality they need, want, and deserve…"

BUT

"Higher quality cannot be achieved by further stressing current systems of care. The current systems cannot do the job. Trying harder will not work. Changing systems of care will."

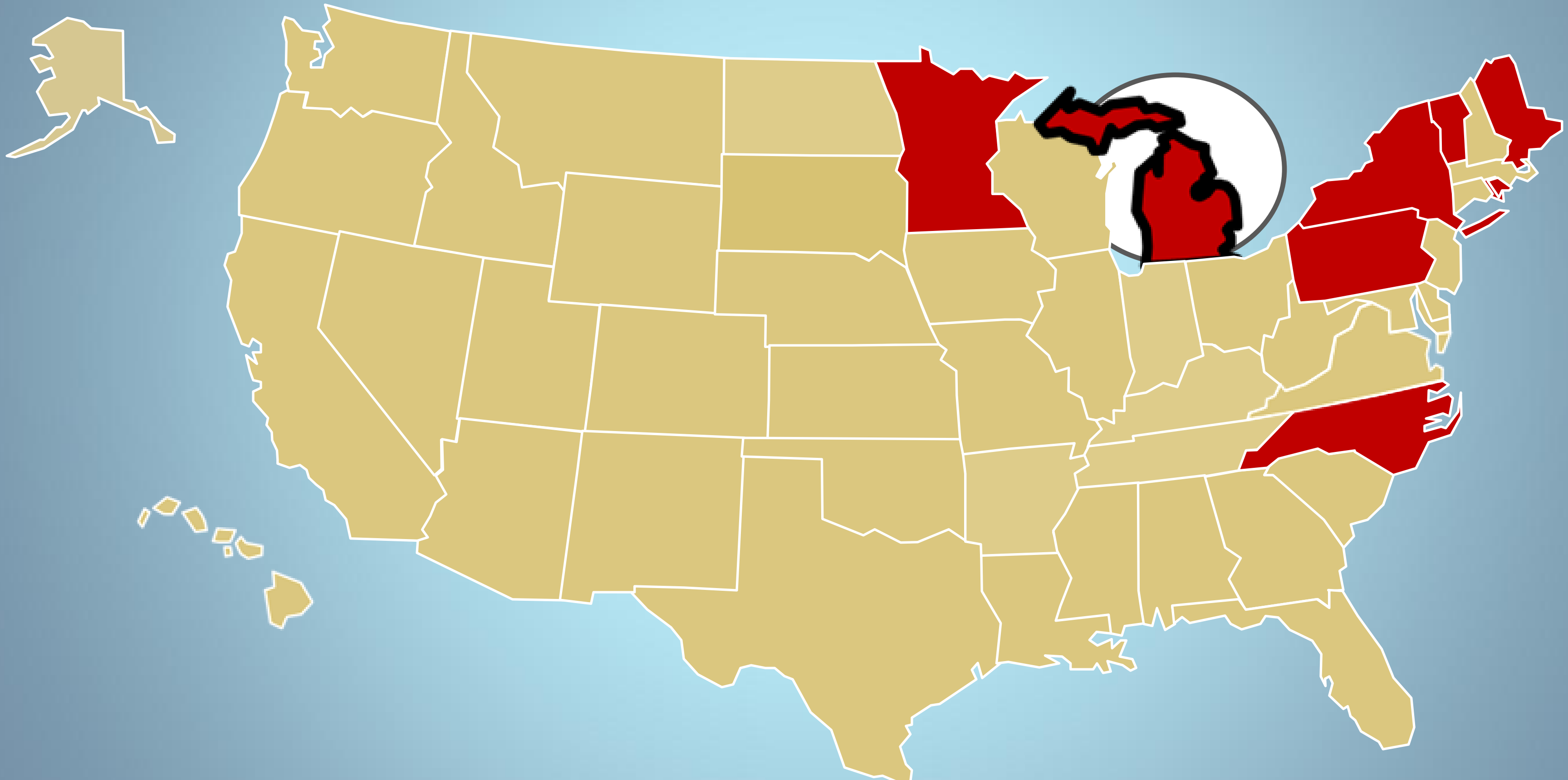
IOM 2001 – *Crossing the Quality Chasm*

7

CMS Multi-Payer Advanced Primary Care Practice (or PCMH) Demonstration

- MDCH award notification: November 16, 2010
- 8 other states also were selected for participation
- Demonstration runs from **January 1, 2012** through **December 31, 2014** (3 years)

Michigan Wins Multi-Payer PCMH Demonstration Award



= States winning Medicare Multi-Payer Advanced Primary Care Initiative grants to realign payment incentives and build patient-centered medical homes

Source: CMS, March 2011 (http://www.cms.gov/demoprojectsevalrpts/md/itemdetail.asp?itemid=cms1230016)

MAPCP Demo: Participating States

State	Practices		Year 3
• Maine	22 practices	→	42 (year 3)
• **Michigan**	**477 practices**		
• Minnesota	159 practices	→	340 (year 3)
• New York	35 practices		
• North Carolina	54 practices		
• Pennsylvania	78 practices		
• Rhode Island	13 practices		
• Vermont	110 practices	→	220 (year 3)
• TOTAL	948 practices	→	1,259 (year 3)

Michigan's Demo: Providers and Beneficiaries

- PO/PHO/IPAs: 34
- PCMH Designated Practices: 477

- Beneficiaries:
  - Medicare 358,000
  - Medicaid managed care 248,000
  - Privately insured <u>1,153,000</u>

  TOTAL Beneficiaries 1,759,000

Criteria for Practice Participation

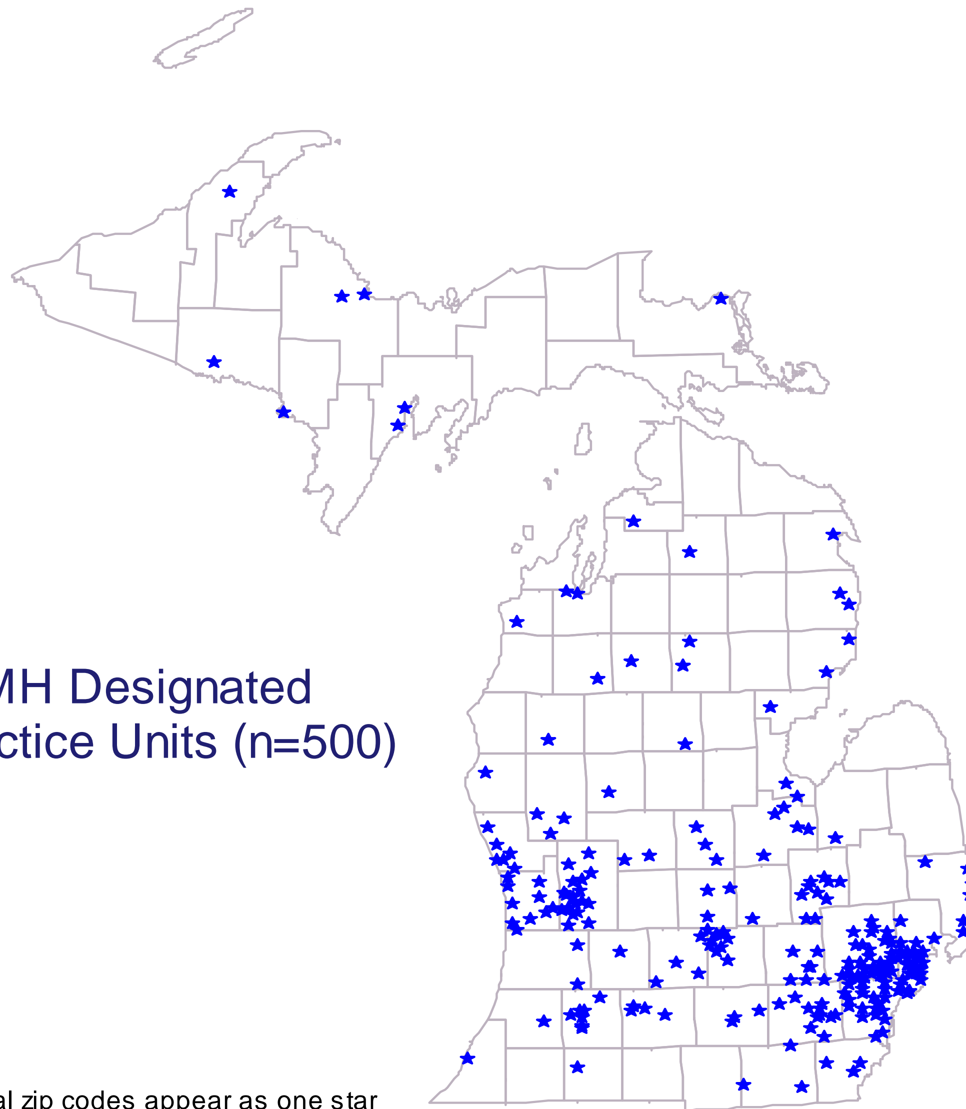
Current PCMH designation

Maintain PCMH designation over the 3-year demo

Member of a participating PO/PHO/IPA

Agreement to work on four focused Initiatives:

1. **Care Management**
2. **Self-Management Support**
3. **Care Coordination**
4. **Linkage to Community Services**



2010 PCMH Designated PGIP Practice Units (n=500)

* Sites with identical zip codes appear as one star

Payer Participation

Commercial	**Government**
• Blue Cross Blue Shield of MI • Blue Care Network	• Medicare • Medicaid Managed Care

Payers provide:

- Financial support for practice transformation and PCMH services

Payers expect:

- Improvements in cost, quality of care, and patient experience
- Budget neutrality (or better!) by end of year 3

Patient-Centered Medical Home

A patient-centered medical home (PCMH) is a medical practice – usually primary care – that has been TRANSFORMED* and is providing services to every individual served by the practice that address acute, chronic and preventive needs

*** TRANSFORMATION includes: team-based care with the patient at the center, use of health information technology, coordination of care, and shared decision-making, providing services that are accessible, evidence-based, comprehensive, cost-effective and satisfying to patients, physicians and staff**

Michigan Primary Care Transformation (MiPCT) Funding Model

$0.26 PMPM Demo Administrative Expenses
$3.00 PMPM* Care Management Support
$1.50 PMPM* Practice Transformation Infrastructure
$3.00 PMPM Performance Incentive
$7.76 PMPM **Total Payment by Payers ****

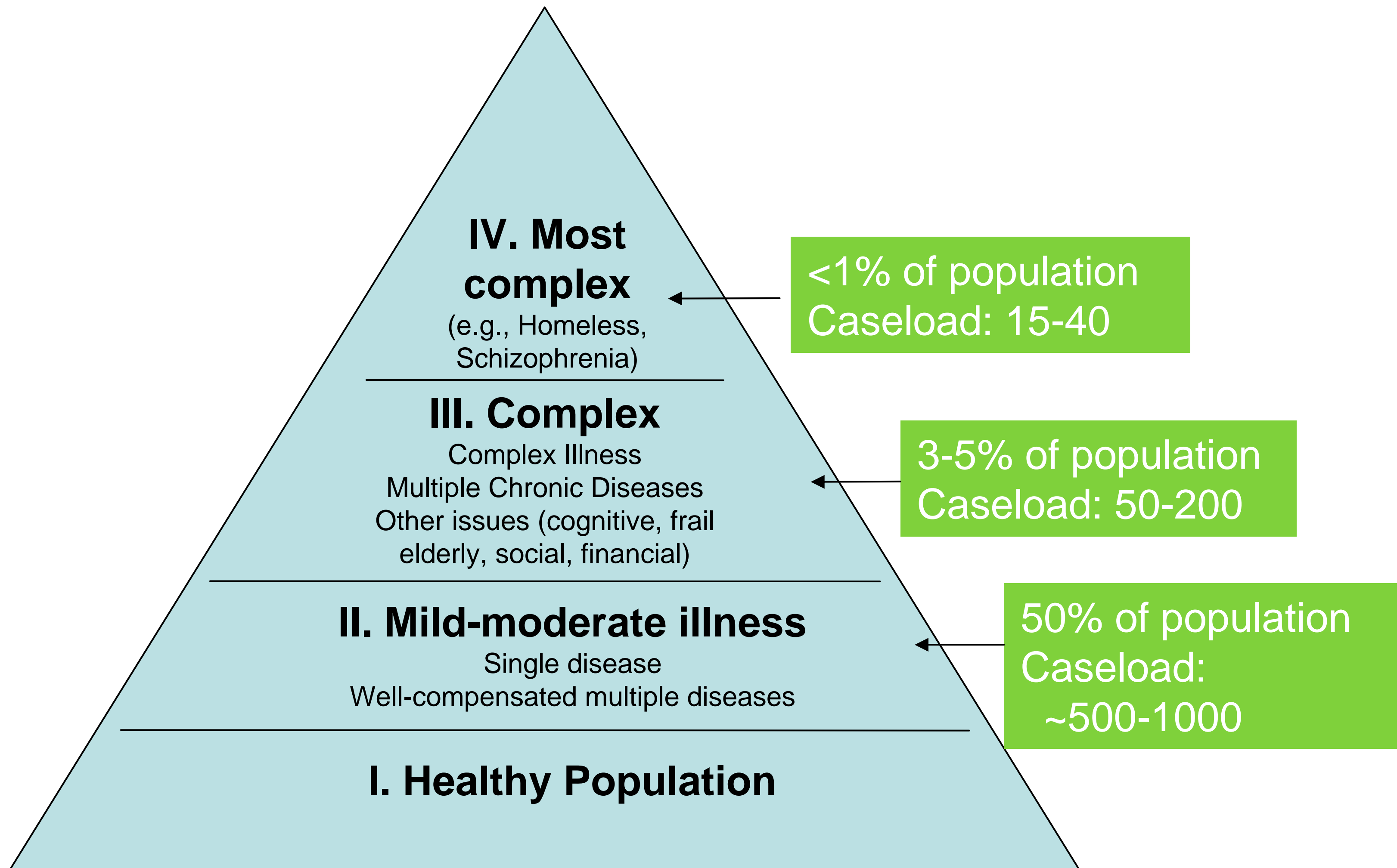
*** Or equivalent**
**** Medicare will pay additional $2.00 PMPM to cover additional services for the aging population (total of $9.76)**

NOTE: Plans with existing payments toward MiPCT components may apply for and receive credits through a review process

Transformation to PCMH

Traditional Practice		**PCMH**
Acute Care, Sporadic Chronic Care and Preventive Care		Patient-Centered Care and Population Management
Doctor Does it All		Health Care Team Partners with Patient
Paper Charts and Records		Multiple Electronic Tools
Fragmented Care		Care is Coordinated and Integrated

Managing Populations:
Tiered approach to care management



PCMH Practices…

- Create prepared, proactive healthcare teams
- Provide enhanced and convenient access to care
- Use secure health information technology to promote quality and safety
- Use evidence-based medicine and clinical decision support tools
- Coordinate care in partnership with patients and families
- Identify and measure key quality indicators
- Seek feedback on performance and accept accountability for process improvement and health outcomes

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Focus #1: Individual Care Management

- **Goal:**
  - Ensure patients with chronic conditions receive organized, planned care that empowers them to take greater responsibility for their health, thereby improving overall health status and decreasing preventable health care costs

- **Means:**
  - Establish multidisciplinary teams
  - Stratify patient population to identify those at increased risk
  - Use registries or EHRs to plan care and track status
  - Use decision support tools to assure care is evidence-based
  - Adjust payment to cover the costs of additional services

Care Management (continued)

- **Moderate Care Managers** (RN/other professional)
  - 1 per 5,000 MiPCT beneficiaries (active work with ~ 10% of panel)
  - Target: Patients with moderate complexity or illness
  - Goal: Mitigate risk factors, optimize chronic conditions, provide self-management support
- **Complex Care Managers** (generally RN)
  - 1 per 5,000 MiPCT beneficiaries (active cases ~ 150)
  - Target: Patients with multiple co-morbidities and/or high utilization
  - Goal: Coordinate care, maximize function

Focus #2: Self-Management Support

- Providers, patient, caregivers create a care plan
- Staff uses effective methods to engage patients in self-management
  - Assessing knowledge gaps and reinforcing education
  - Motivational interviewing
  - Setting a healthcare goal and follow up
- Refers or links patient/family to community services
  - Patient's health care team may include specialists, dietitian, social worker, mental health consultant, others
  - Refer to community resources and programs including self-management, support groups

23

Self-Management Resources in the Community

- Diabetes Education, e.g., DSME
- Support Groups, e.g., MI PATH
- Smoking Cessation Classes
- Stress Management Classes
- Physical Activity or Exercise Opportunities
- Nutrition Counseling

Focus #3: Care Coordination

- Coordination across specialists and settings

  Average Medicare patient sees 7 different physicians/year; complex patients may see up to 16

- Prompt feedback of specialist consultation reports to primary care physicians and patients

- Information about availability and quality of specialty services and community resources

- Tracking of tests, test results, procedures, and the filling of prescriptions to monitor patient adherence to mutually agreed-upon treatment plans

25

Care Coordination (continued)

- Post hospitalization follow-up and support (transitions of care)
- Communication among health care providers who care for a patient, but do so in different geographic locations or at different times
- Systems to prevent errors that occur when multiple physicians or sites are involved in care

Focus #4: Linkages to Community Services

Definition:

Vulnerable elders, socially-challenged patients, and complex patients with multiple co-morbidities may require ancillary clinical, mental health and personal care services. This is often best provided in the community setting.

Means:

Physician Organizations are assembling directories of local resources. Practices are developing processes for making referrals, receiving feedback and assessing whether needs of their patients have been met.

Practices Establish Relationships With Community Resources

Patients/Caregivers Need

- Disease-Specific
  - **Classes**
  - **Support groups**
- Home Health Care Services
- Respite Care
- Transportation
- Employment
- Housing
- Healthy Food and Exercise Options
- Assistance paying for meds
- Substance Abuse Programs
- Many other things!

Resources

- Local Health Departments
- 211 Call Center
- Local Agencies on Aging
- Housing Assistance Programs
- Faith-Based Organizations
- Home Health Care Organizations
- Disease-Specific Organizations

  e.g., Heart, Lung Societies, Kidney Foundation, Arthritis Foundation, etc.
- Exercise Facilities, e.g. YMCA
- Social Service Agencies
- Safety-Net Service Organization

Potential Opportunities to Improve Diabetes Care Within Demonstration Practices

- Embed evidence-based guidelines in patient registry or EMR
- Communicate DSME class schedules to PO’s and Care Managers to increase referrals
- Offer DSME at PO or within Practices
- Draw attention to excellent educational materials
- Encourage POs and practices to send staff for PATH Training and then conduct support groups

29

State/Local Community Linkages Committee

Members:

- Local Health Departments
- MDCH: Chronic Disease, MCH, CSHCS, Medicaid, Mental Health, Substance Abuse
- MDHS
- UM-SPH
- Cooperative Extension
- Kent County CHAP
- MiPCT Steering Committee Representatives
- Others

Questions?