Mission Impossible?
Community Integrated Care

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Michigan: Some Sobering Statistics

In 2012, out of 50 states with 1st place best, Michigan

• Ranks 37th in percent of obese adults
• Ranks 40th in percent of adults who smoke
• Ranks 30th in adults who report having diabetes
• Ranks 28th in stroke-related deaths
• Ranks 42nd in heart disease deaths

America’s Health Rankings 2012
http://www.americashealthrankings.org/MI/2012
Michigan Diabetes Statistics

• Over 10% of MI adults are diagnosed with diabetes (758,300 people); an additional 250,200 are undiagnosed.
• Tied for 13th in the nation for diabetes prevalence
• In 2011, $8 Billion was spent to treat diagnosed and undiagnosed diabetes in MI.

MDCH Diabetes in Michigan Update - 2013
## Paradigm Shift in Healthcare Delivery

<table>
<thead>
<tr>
<th>Trends and Directions in Healthcare Delivery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Illness</td>
</tr>
<tr>
<td>Acute Care</td>
</tr>
<tr>
<td>Inpatient</td>
</tr>
<tr>
<td>Individual Health</td>
</tr>
<tr>
<td>Fragmented Care</td>
</tr>
<tr>
<td>Independent Institutions</td>
</tr>
<tr>
<td>Service Duplication</td>
</tr>
<tr>
<td>Fee for service (payment for volume)</td>
</tr>
</tbody>
</table>
Innovation-Driven U.S. Health Care System Evolution (CMMI)

*Health System Transformation and Evolution Critical Path*

- **Uncoordinated Health Care System 1.0**
- **Coordinated Seamless Health Care System 2.0**
- **Community Integrated Health Care System 3.0**

- Episodic Non-Integrated Care
- Efficient, Accountable Care
- Community Integrated Healthcare
Health Determinants

Health Outcomes
- Mortality (length of life) 50%
- Morbidity (quality of life) 50%

Health Factors
- Health behaviors (30%)
- Clinical care (20%)
- Social and economic factors (40%)
- Physical environment (10%)

Policies and Programs
- Tobacco use
- Diet & exercise
- Alcohol use
- Sexual activity
- Access to care
- Quality of care
- Education
- Employment
- Income
- Family & social support
- Community safety
- Environmental quality
- Built environment
Innovation Driven US Health Care System Evolution

Health Care System AND Community Care System: PARALLEL Evolutions & Critical Path

Uncoordinated HEALTH CARE System 1.0
- Episodic Care
- Lack of Integration
- Poor Care Mgmt.

Coordinated Seamless HEALTH CARE System 2.0
- Efficient
- Accountable
- Person-centered

Community Integrated Health Care System 3.0
- Population-based
- Integrated Payment
- Healthy Living Focus

Uncoordinated COMMUNITY CARE System 1.0
- Confusing
- Inefficient
- Volume-based

Coordinated Seamless COMMUNITY CARE System 2.0
- Efficient
- Accountable
- Person-centered
Your mission, should you choose to accept it, is to imagine the possibilities of a fully integrated system of care for Joe Smith, and commit to doing one small thing to move that mission forward.
Imagine...

HEALTH CARE SYSTEM 1.0
Meet Joe Smith

• 58 years old

• Divorced - Daughter and grandson live in town

• Laid off from job for 6 months

• Has Medicaid

• Diabetes (8 years)

• High Blood Pressure (15 years)

• On Medications

• Smokes 1.5 packs per day (30 years)

• No regular exercise

• A “little” overweight
Pledged

Choose to lose 10%, Michigan.
Michigan.gov/mihealthiertomorrow
Get Started Kit

- Supermarket Survival Guide and Food Journal
- Refrigerator Magnets
- Folder
- Free coupons
- Poster
- Know Your Numbers
- Twice monthly messages
# Pledge Site Resource

## KNOW YOUR NUMBERS

As part of the Michigan 4 x 4, take this card to your doctor so you can measure your success together.

<table>
<thead>
<tr>
<th>STARTING</th>
<th>GOAL</th>
<th>CHECKUP PROGRESS</th>
</tr>
</thead>
<tbody>
<tr>
<td>NAME:</td>
<td>DATE:</td>
<td>DATE:</td>
</tr>
<tr>
<td>AGE:</td>
<td>WEIGHT:</td>
<td>BMI:</td>
</tr>
<tr>
<td>HEIGHT:</td>
<td>BLOOD PRESSURE:</td>
<td>BLOOD PRESSURE:</td>
</tr>
<tr>
<td>NOTES:</td>
<td>CHOLESTEROL LEVEL:</td>
<td>CHOLESTEROL LEVEL:</td>
</tr>
<tr>
<td></td>
<td>BLOOD SUGAR LEVEL:</td>
<td>BLOOD SUGAR LEVEL:</td>
</tr>
</tbody>
</table>

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MI Healthier TOMORROW

Michigan Department of Community Health

MDCH is an Equal Opportunity Employer, Services and Programs Provider. 20000 printed 08/07/16 costs with a total cost of $1,612.40.
Knowing His Numbers

Uncontrolled diabetes and Cardiovascular disease

<table>
<thead>
<tr>
<th>Joe’s Numbers</th>
<th>Normal /Desired Numbers For Type 2 Diabetes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fasting Blood Sugar 160mg/dl</td>
<td>FBS = 70 to 130 mg/dl</td>
</tr>
<tr>
<td>BP = 176/108</td>
<td>BP &lt; 140/60</td>
</tr>
<tr>
<td>LDL = 135</td>
<td>LDL &lt; 100</td>
</tr>
<tr>
<td>BMI = 29.5 (overweight) 5’9” and 200 lbs.</td>
<td>BMI = 20 through 26</td>
</tr>
</tbody>
</table>
Uncoordinated Care
Recently Hospitalized for Pneumonia

- No shared, electronic record;
- No one tracking outcomes of care;
- Don’t call? Don’t get care!

- Hospital
- Family Doctor
- Pharmacy
- Specialists • Pulmonologist • Endocrinologist • Cardiologist
- Physical Activity

Healthy Food
Discharged from the Hospital

- Hospital
- PCP
- Specialist
- Pharmacy
- Transportation
- Healthy Food
- Job Assistance
- Utility Assistance
- Smoking Cessation
- Physical Activity

17
Imagine...

HEALTH CARE SYSTEM 2.0
The Michigan Primary Care Transformation (MiPCT) Project
Center for Medicare & Medicaid Services (CMS) Multi-Payer Advanced Primary Care Practice Demonstration Project

Michigan: 1 of 8 states participating in the CMS Demo

Duration: 3 years - 2012 through 2014

Impetus: Escalating, unsustainable health care costs and mediocre performance on indicators of health

Objective: Demonstrate whether the PCMH model of care improves health outcomes and contains costs
Patient-Centered Medical Home (PCMH)

A team-based health care delivery model led by a physician, P.A., or N.P. that provides comprehensive and continuous medical care to children, youth and adults with the goal of obtaining maximized health outcomes.

Care coordination requires additional resources

- **health information technology**
- **appropriately trained staff** to provide coordinated care through team-based models.
- **payment models** that compensate for care coordination and care management services that fall outside the face-face patient encounter
Success = Improved Population Health, Improved Patient & Provider Experience of Care, and Reduced Cost
## Participating Provider and Payer Partners as of September 30, 2013

<table>
<thead>
<tr>
<th>Practices</th>
<th>PO/PHO</th>
<th>Physicians</th>
<th>Payers</th>
</tr>
</thead>
<tbody>
<tr>
<td>375</td>
<td>35</td>
<td>1663</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td></td>
<td>+ 181 NPs</td>
<td>Medicaid Managed Care, Medicare FFS, BCBSM, BCN, and Priority Health</td>
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<tr>
<td></td>
<td></td>
<td>and PAs</td>
<td></td>
</tr>
</tbody>
</table>

Serving over a million children and adults!
Expectations of MiPCT PO’s/Practices

• **Population management**
  – Electronic registry functionality by end of year 1
  – Proactive patient outreach
  – Point-of-care alerts for services due

• **Improve Access to Care**
  – 24/7 access to clinician
  – 30% same-day access
  – Extended hours

• **Coordination of Care**
  – Embed care managers within practices to provide case management and self management support
## Payment Reform

Regular payment for healthcare services

+ Additional per member per month (pmpm) dollars

<table>
<thead>
<tr>
<th>Service</th>
<th>Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practice Transformation</td>
<td>$1.50 pmpm</td>
</tr>
<tr>
<td>Care Management</td>
<td>$3.00 pmpm</td>
</tr>
<tr>
<td>Performance Incentives</td>
<td>$3.00 pmpm</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$7.50 pmpm</strong></td>
</tr>
</tbody>
</table>
Managing Populations: Stratified approach to patient care and care management

I. Healthy Population
   - <1% of population
   - Caseload 15-40

II. Mild-moderate illness
   - 3-5% of population
   - Caseload 50-200
   - Well-compensated multiple diseases
   - Single disease

III. Complex
   - 50% of population
   - Caseload~1000
   - Complex illness
   - Multiple Chronic Disease
   - Other issues (cognitive, frail elderly, social, financial)

IV. Most complex
   - (e.g., Homeless, Schizophrenia)
   - <1% of population
   - Caseload 15-40
MiPCT Embeds Care Managers within Practices

Complex Care Manager – 1:5000 covered lives
(Nurse, physician assistant, nurse practitioner or social worker)
  – Provides case management after hospitalizations
  – Assists with the management of complex patients

Moderate Care Managers - 1:5000 covered lives
(Nurse, social worker, dietitian, pharmacist, etc.)
  – Provides self-management support to optimize chronic illness control and prevent complications
Care Management Resource Center
UMHS/BCBSM Sponsored

• Goal: Identify and disseminate effective, evidence-based care management models throughout Michigan

• Initial focus is MiPCT practices – will be available to all Michigan PO/PHOs/practices
  ▫ Established curriculum for training complex care managers
  ▫ Webinars, workshops and mentoring
  ▫ Web-based resources
Outcomes

• Michigan Data Collaborative (multi-payer database) is ready to produce regular reports on the cost and quality of care in MiPCT practices.

• Planning for sustainability is underway and will be a big focus of the final year.
  – Aim is to continue and expand the model once the demonstration concludes.
Joe
Hospitalized for Pneumonia

- 58 years old
- Divorced
- Laid off for 6 months

Diagnoses
- Diabetes
- High Blood Pressure
- Smokes
- Overweight
Care Manager Phone Encounter
(1 day after discharge)

• Overall
  - Weak but doing ok
  - Daughter checking on him every day

• Medication review
  – Jose had not filled 2 new prescriptions
    • Called pharmacy to arrange for home delivery

• Treatment follow-up
  – Blood sugar levels are not well controlled
    • Conferred with doctor and gave instructions
    • Scheduled an appointment with the family doctor and care manager that week
4 Days Post Discharge

Physician
• Reviewed the hospital discharge plan and needed appointments
• Adjusted medications and diet to stabilize blood sugar
• Started smoking cessation medication

Care Manager
• Reviewed information on diet and medications to stabilize blood sugar, blood pressure
• Assisted with scheduling specialist appointments
• Assisted in getting new prescriptions changed to medications covered by Jose’s insurance
• Set up appointments with dietician and diabetes educator
• Helped Jose identify health goals and a self-management plan
• MDCH Quitline
• Called weekly for 1 month
6 Weeks Post Discharge

• Had appointments with
  – Dietician
  – Diabetes educator
  – Cardiologist
  – Pulmonologist
  – Endocrinologist
• Met with care manager to set healthy goals and a plan for achieving them
• Enrolled in a MI PATH program
Outcomes

2 Months after Hospitalized Joe has ...

Returned to his previous level of functioning

• Working on diet and exercise goals to improve health
  • Blood pressures and blood sugars are usually in normal range
  • Stopped smoking!
• Returned to previous level of functioning
• Working on diet and exercise goals to improve health
• Blood pressures and blood sugars usually normal
• Stopped smoking
• Joe’s healthcare needs were addressed, however...
• Length and quality of life depends on one’s community and it’s environment, places where people live, work, learn and play.
Michigan Health and Wellness
4 x 4 Plan

First Year Implementation

• Multimedia public awareness campaign – adults - pledge to lose 10%.
  www.michigan.gov/mihealthiertomorrow or www.facebook.com/mihealthiertomorrow

• Community coalitions – cross-section of local partners working together to create policies and environments to enable healthy eating and physical activity.

• Partners throughout Michigan to help implement the 4 x 4 Plan.
  1. Employers
  2. Trade and other professional organizations
  3. Education System
  4. Departments of state government

• Within the Michigan Department of Community Health, maintain infrastructure to support the 4 x 4 Plan implementation energizing the local coalitions, and partners.
Local Coalitions Work Together to Create a Healthy Community

- Faith-Based
- Education/Academics
- Mental Health
- Healthcare
- Business
- Parks & Rec
- Planning & Economic Development
- Non-Profit
- Community-Based
THE HEALTHY COMMUNITY
Where you live, work, learn, and play have a big effect on how healthy you are.

A HEALTHY ENVIRONMENT enhances an individual's ability to make healthier choices.

Make Healthy Choices!

Every dollar spent on community-based programs that stress being physically active, eating well, and not using tobacco can save $5.60 in medical costs.

A HEALTHY COMMUNITY ensures equal access to health resources for all residents.

- Parks & recreational facilities
- Schools
- Community centers
- Healthy homes
- Public transit
- Clinic/health services
- Bike paths
- Sidewalks
- Farmers markets
- Healthy workplaces
4 X 4 Plan Coalitions
Local Coalitions

6 Funded Coalitions – Unique Communities, Each with their Own Plan

- Berrien County Health Department – Be Healthy Berrien, Benton Harbor
- Capital Area Health Alliance – Choosing Health, Okemos
- District Health Department #10 – Northwest Michigan Cancer Prevention and Awareness Coalition, Ludington
- Greater Flint Health Coalition – Commit to Fit!, Flint
- Inter-Tribal Council of Michigan (12 Federally Recognized Tribes and the American Indian Health & Family Agency – Detroit Area), Sault Ste. Marie
- Oakland County Health Division/Healthy Pontiac, We Can! – Pontiac
Six strengthened coalitions made healthy eating and physical activity easier for 1,670,649 residents

Achieved policy and environmental change using technical support, assessments and toolkits

- Assessed worksites, engaged employees, created spaces to enable healthy eating and physical activity
- Enhanced free, safe places and methods for physical activity in parks, playgrounds and walking trails
- More healthy vending, nutrition education classes, and patient education by doctors
- Reduced consumption of fast food and increased consumption of fruits/vegetables
- New farmer’s markets, produce stands, individual and community gardens
- Promotion of the 4 x 4 messages across all sectors and within the media
- Policies eliminated the sale of sugar-sweetened beverages and smoking
- More physical activity for students
Within their unique communities, all the coalitions will target:

- Increase **healthy dining** options across sectors
- Substantially increase **access to places** where people can be physically active in safe and enjoyable ways, with an emphasis on **walking**
- Increase access to community programs designed to increase physical activity that fit into people’s **daily routine**
- Implement strategies that build, strengthen and maintain **social networks** to provide supportive relationships with respect to **physical activity**.
- Promote **worksite wellness strategies** by implementing policies and practices that improve food and beverage offerings, reduce barriers to be physically active in the work place (use [www.mihealthtools.org/work](http://www.mihealthtools.org/work))
- Use 4 x 4 campaign messages and integrate in intervention strategies.
- Healthcare Coordinated through PCMH
- Connected with local Farmer’s Market
- Participating with mall walking program; qualifies for free park pass
Imagine...

COMMUNITY CARE SYSTEM 2.0
Michigan Pathways to Better Health (MPBH) Demonstration Project

Piloting the Pathways Community HUB Model
CMS Health Care Innovation Award (HCIA)

Michigan Pathways to Better Health (MPBH) Demonstration Project

Award: MPHI, 3-year cooperative agreement

Duration: July 2012—June 2015

Impetus: If left unaddressed, social determinants of health will prevent people from getting and staying healthy

Objective: Demonstrate whether the Pathways Community HUB model improves outcomes and reduces costs

Target: Adults with Medicaid and/or Medicare insurance, and 2+ Chronic Conditions.

Locations: Ingham, Muskegon, and Saginaw Counties
Michigan Pathways to Better Health

Pathways Community HUB Model Components

• Community Health Workers
• Care Coordination Agencies
• RN or SW Clinical Supervisors
• Pathways
• Community HUB
• Neutral Convener
Pathways Model
A Tool to Measure Outcomes

1 - Find

Target Population - Find those at greatest risk

2 - Treat

Confirm connection to evidence-based care

3 - Measure

Measure the results

OUTCOMES
Regional organization and tracking of care coordination
- Focus on at-risk
- Eliminate duplication
- Benchmarks – confirmed connection to care

Community HUB Network
Imagine…

COMMUNITY-INTEGRATED HEALTHCARE SYSTEM 3.0

MI Pathways to Better Health

- Food Assistance
- Utility Assistance
- Transportation
- Smoking Cessation
- Job Assistance

HUB / CHW

MI Primary Care Transformation

- PATH Program
- Nutritionist
- Hospital
- Specialist
- Pharmacy
- Diabetes Educator

Family doctor / Care Manager

Physical Activity

Healthy Food

MI Health & Wellness 4 X 4 Plan
State Innovation Model (SIM) Planning Project

Award from CMS to develop a plan through consensus-building to transform the Michigan health system and reform the payment system to reward performance and value, not volume.

• Intensive process to produce the State Plan, with an opportunity to apply for implementation funding

• MANY Michigan leaders are participating

• Further organize the community to address high-impact health determinants
Your mission, should you choose to accept it, is to share one small thing you could do to help move us closer to the possibility of a fully integrated system of care for Joe Smith.
Thank You!

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