Mission Impossible?
Community Integrated Care

Dana Watt RN, MSN – MiPCT and MPBH Project Consultant
Tom Curtis, MPA – Community Linkages Project Coordinator
Dawn Rodman, MS, CWHC – Michigan Health and Wellness 4 x 4 Plan Coordinator

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

Trends and Directions in Healthcare Delivery	
Illness	Wellness
Acute Care →	Primary Care
Inpatient →	Outpatient
Individual Health →	Community Well-Being
Fragmented Care →	Managed Care
Independent Institutions →	Integrated Settings
Service Duplication →	Continuum of Services
Fee for service (payment for volume) →	Global payments (payment for value/outcomes)

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

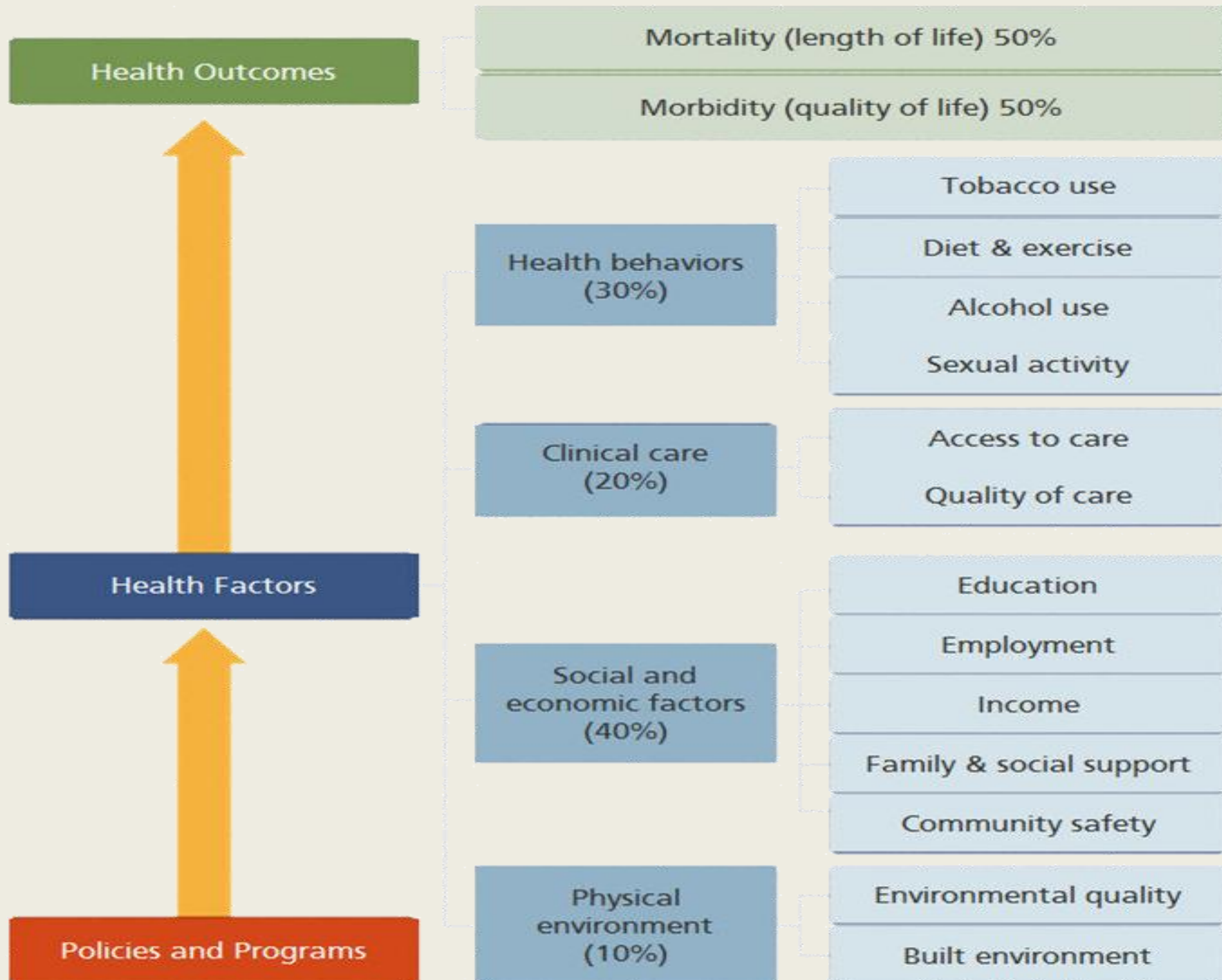
Community Integrated Health Care System 3.0

Episodic Non-Integrated Care

Efficient, Accountable Care

Community Integrated Healthcare

Health Determinants



University of Wisconsin *Population Health Institute* http://whatworksforhealth.wisc.edu/

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 Mgmnt.

Coordinated Seamless HEALTH CARE System 2.0

- Efficient
- Accountable
- Person-centered

Uncoordinated COMMUNITY CARE System 1.0

- Confusing
- Inefficient
- Volume-based

Coordinated Seamless COMMUNITY CARE System 2.0

- Efficient
- Accountable
- Person-centered

Community Integrated Health Care System 3.0

- Population-based
- Integrated Payment
- Healthy Living Focus

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

Michigan Department of Community Health

MDCH

Rick Snyder, Governor
James K. Haveman, Director

Pledged

Choose to lose 10%,
Michigan.
Michigan.gov/mihealthiertomorrow

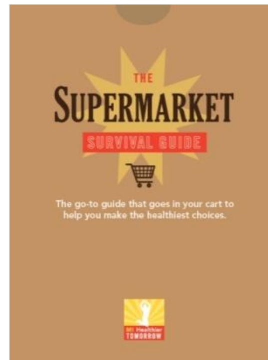
MI Healthier
TOMORROW

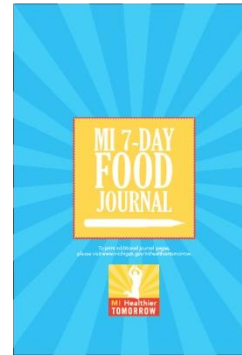
Michigan Department of Community Health
MDCH
Rick Snyder, Governor
James K. Haveman, Director

Get Started Kit

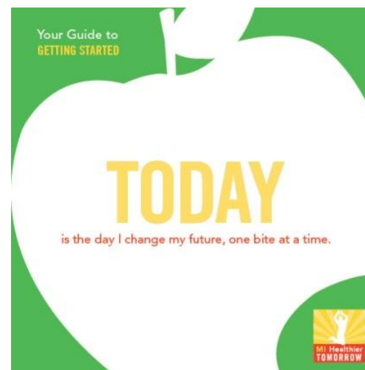
Folder

Free coupons

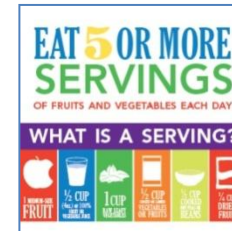




Supermarket Survival Guide and Food Journal



Poster



Refrigerator Magnets

KNOW YOUR NUMBERS

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

	STARTING	GOAL	CHECKUP PROGRESS
NAME:	DATE:	DATE:	DATE:
AGE:	WEIGHT: BMI:	WEIGHT: BMI:	WEIGHT: BMI:
HEIGHT:	BLOOD PRESSURE:	BLOOD PRESSURE:	BLOOD PRESSURE:
NOTES:	CHOLESTEROL LEVEL:	CHOLESTEROL LEVEL:	CHOLESTEROL LEVEL:
	BLOOD SUGAR LEVEL:	BLOOD SUGAR LEVEL:	BLOOD SUGAR LEVEL:

Know Your Numbers

Michigan Department of Community Health
MDCH
Rick Snyder, Governor
James K. Haveman, Director

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.

	STARTING		GOAL		CHECKUP PROGRESS	
NAME:	DATE:		DATE:		DATE:	
AGE:	WEIGHT:	BMI:	WEIGHT:	BMI:	WEIGHT:	BMI:
HEIGHT:	BLOOD PRESSURE:		BLOOD PRESSURE:		BLOOD PRESSURE:	
NOTES:	CHOLESTEROL LEVEL:		CHOLESTEROL LEVEL:		CHOLESTEROL LEVEL:	
	BLOOD SUGAR LEVEL:		BLOOD SUGAR LEVEL:		BLOOD SUGAR LEVEL:	

Michigan Department of Community Health
MDCH
Rick Snyder, Governor
James K. Haveman, Director

MDCH is an Equal Opportunity Employer, Services and Programs Provider.
20,000 printed @ .0816 cents with a total cost of $1,632.40

Knowing His Numbers

Uncontrolled diabetes and Cardiovascular disease

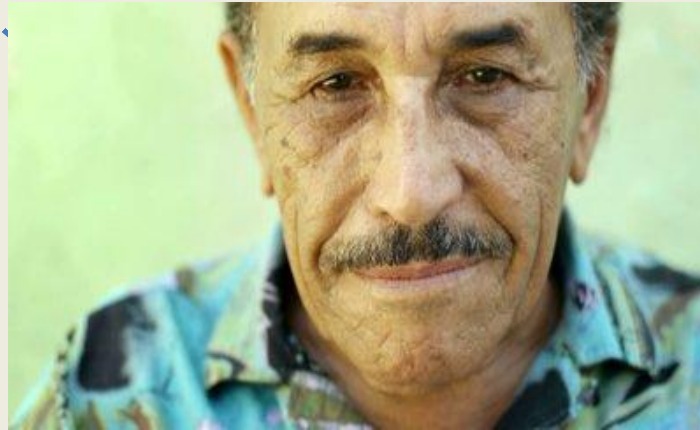
Joe’s Numbers	Normal /Desired Numbers For Type 2 Diabetes
Fasting Blood Sugar 160mg/dl	FBS = 70 to 130 mg/dl
BP = 176/108	BP < 140/60
LDL = 135	LDL < 100
BMI = 29.5 (overweight) 5’9” and 200 lbs.	BMI = 20 through 26

Uncoordinated Care

Recently Hospitalized for Pneumonia

Hospital

Family Doctor



Healthy Food

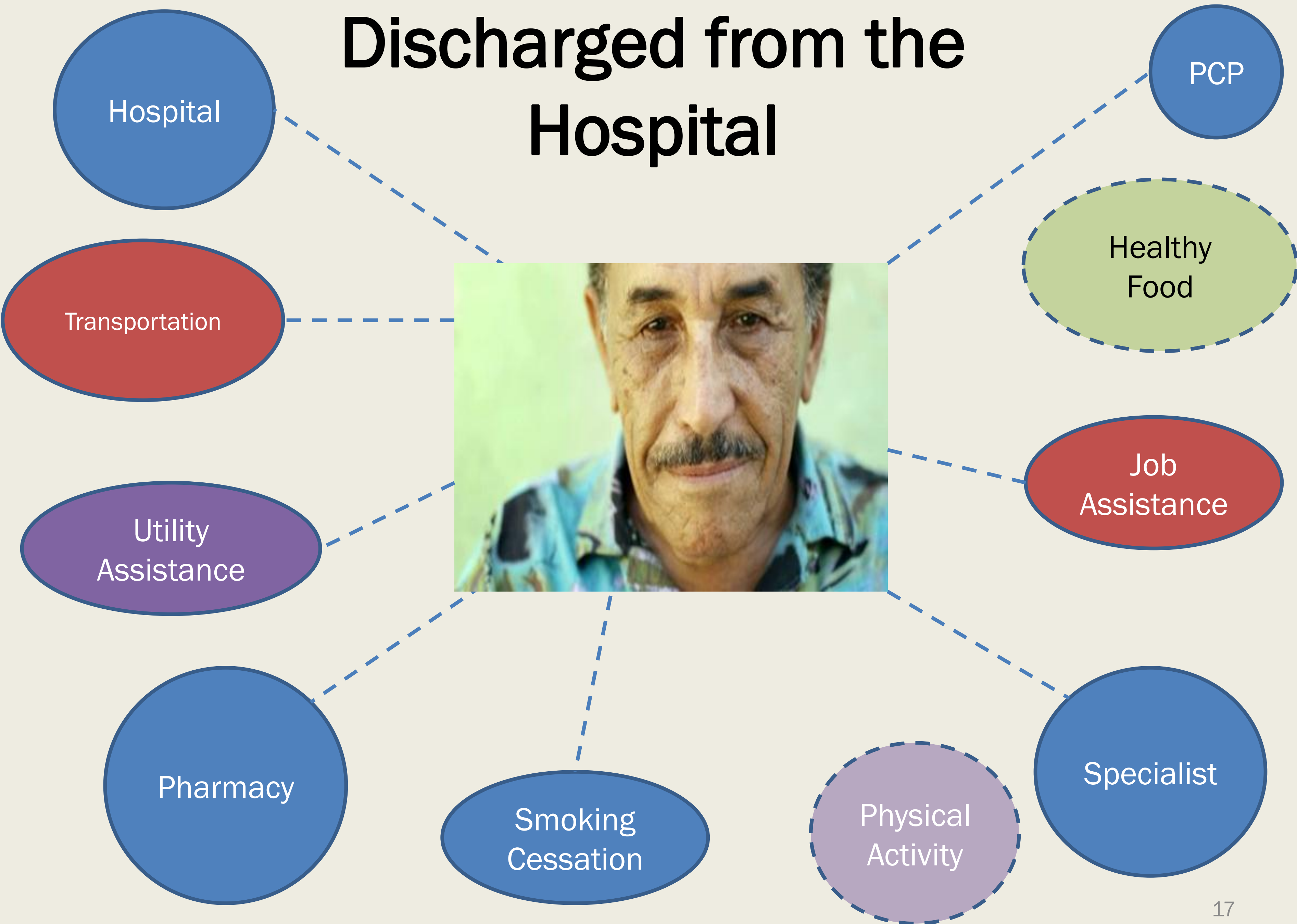
Pharmacy

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

Specialists
- Pulmonologist
- Endocrinologist
- Cardiologist

Physical Activity

Discharged from the Hospital



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

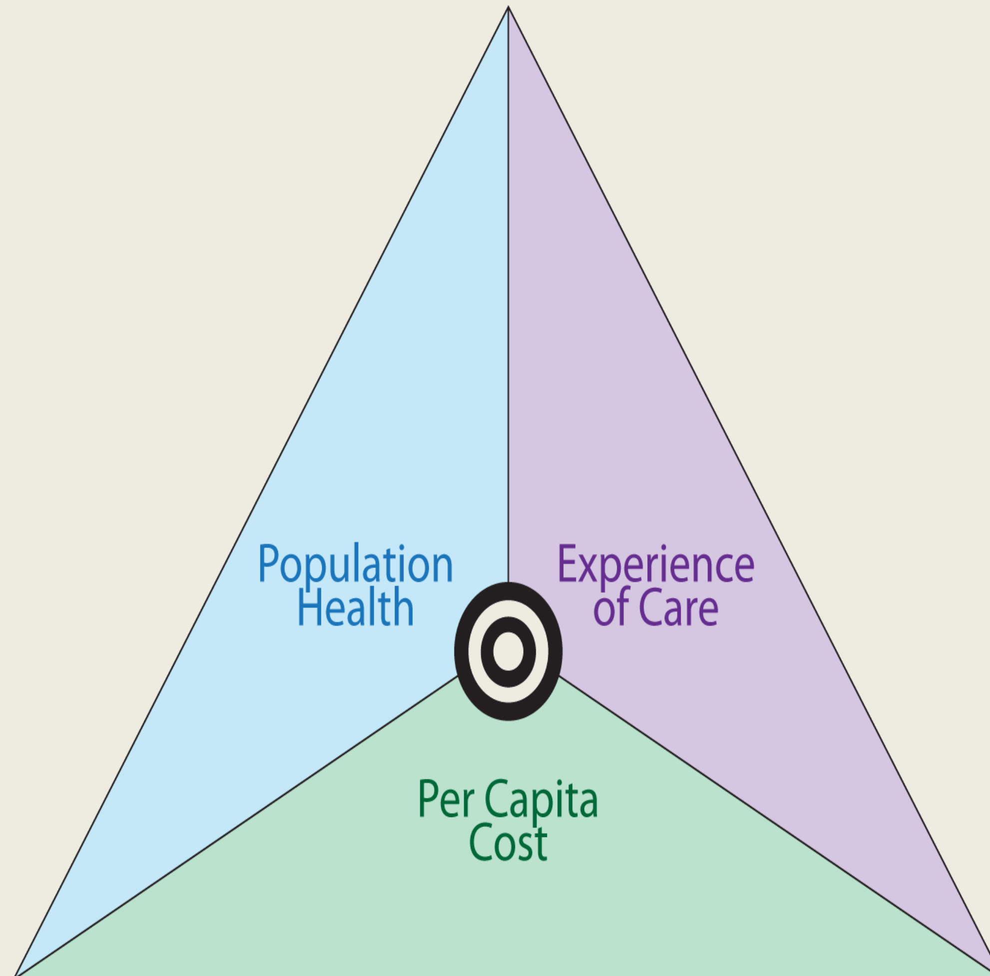
Patient-Centered Medical Home (PCMH)

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

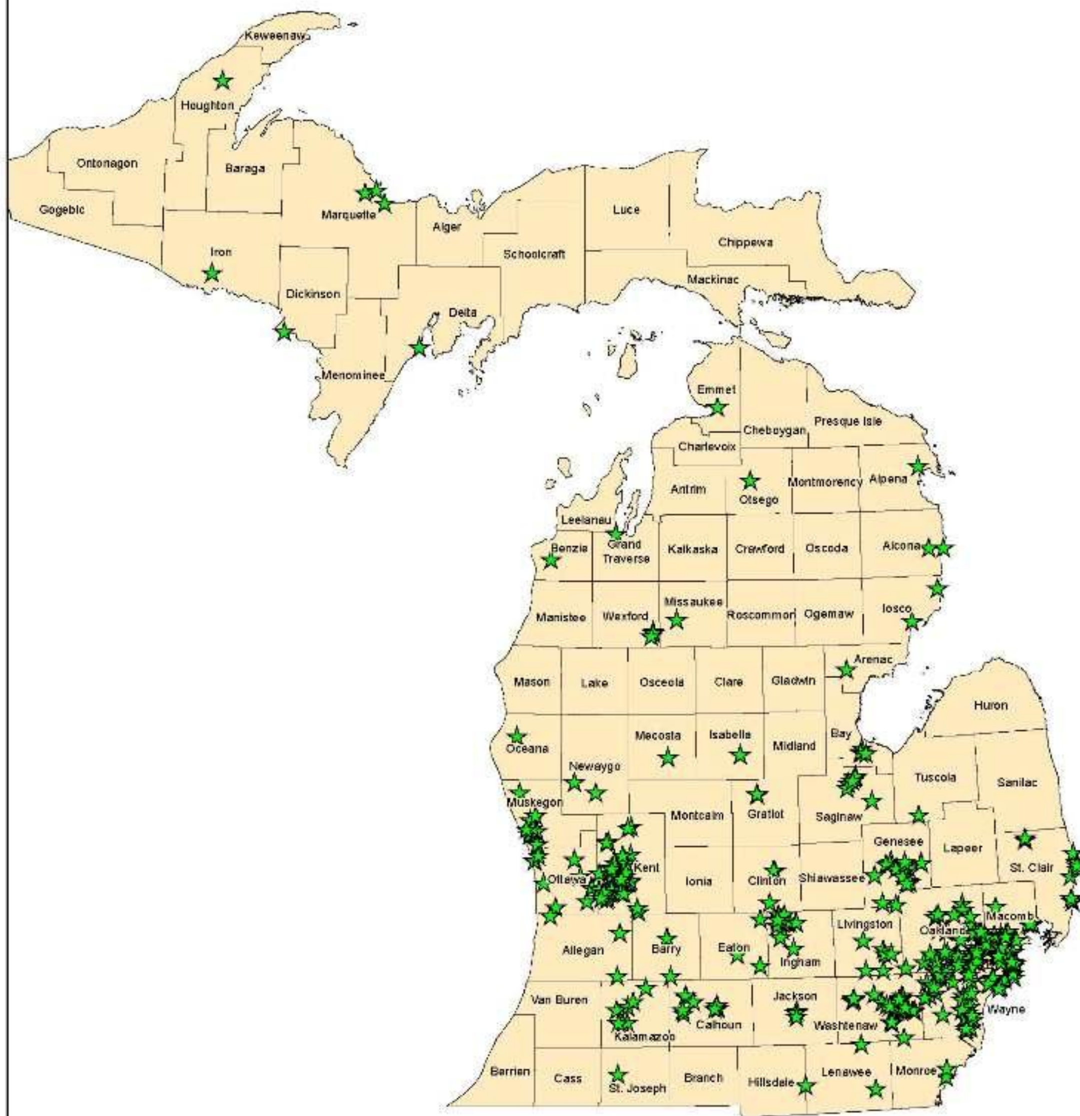
Success = Improved Population Health, Improved Patient & Provider Experience of Care, and Reduced Cost



Participating Provider and Payer Partners as of September 30, 2013

Practices	PO/PHO	Physicians	Payers
375	35	1663 + 181 NPs and PAs	5 Medicaid Managed Care, Medicare FFS, BCBSM, BCN, and Priority Health

Serving over a million children and adults!


Michigan Primary Care Transformation Project
Participating Primary Care Practices
Keweenaw
Houghton
Ontonagon
Baraga
Gogebic
Marquette
Alger
Luce
Chippewa
Iron
Schoolcraft
Mackinac
Dickinson
Delta
Menominee
Emmet
Cheboygan
Presque Isle
Charlevoix
Antrim
Otsego
Montmorency
Alpena
Leelanau
Benzie
Grand Traverse
Kalkaska
Crawford
Oscoda
Alcona
Manistee
Wexford
Missaukee
Roscommon
Ogemaw
Iosco
Arenac
Mason
Lake
Osceola
Clare
Gladwin
Huron
Oceana
Mecosta
Isabella
Midland
Bay
Newaygo
Tuscola
Sanilac
Muskegon
Montcalm
Gratiot
Saginaw
Genesee
Lapeer
St. Clair
Kent
Ottawa
Ionia
Clinton
Shiawassee
Macomb
Livingston
Oakland
Allegan
Barry
Eaton
Ingham
Van Buren
Jackson
Wayne
Kalamazoo
Calhoun
Washtenaw
Berrien
Cass
St. Joseph
Branch
Hillsdale
Lenawee
Monroe
updated March 2012

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

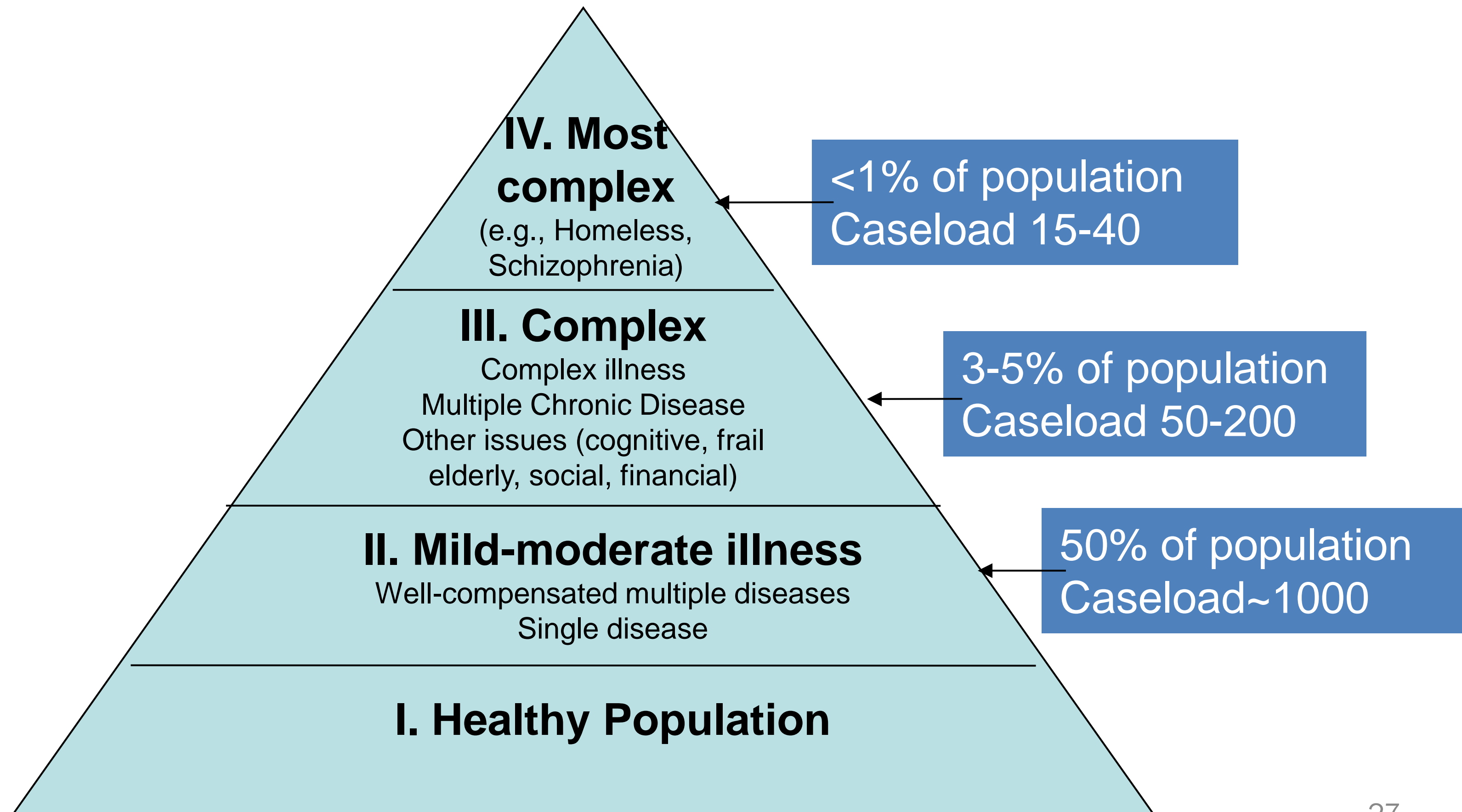
Regular payment for healthcare services

+

Additional per member per month (pmpm) dollars

Practice Transformation	$1.50 pmpm
Care Management	$3.00 pmpm
Performance Incentives	$3.00 pmpm
	$7.50 pmpm

Managing Populations: Stratified approach to patient care and care management



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!

PATH Program

Nutritionist

Hospital

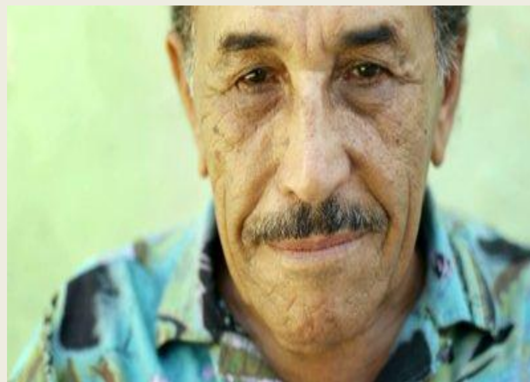
Specialist

Pharmacy

Family doctor / Care Manager

Diabetes Educator

- Returned to previous level of functioning
- Working on diet and exercise goals to improve health
- Blood pressures and blood sugars usually normal
- Stopped smoking



Healthcare and the Community Environment

- 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

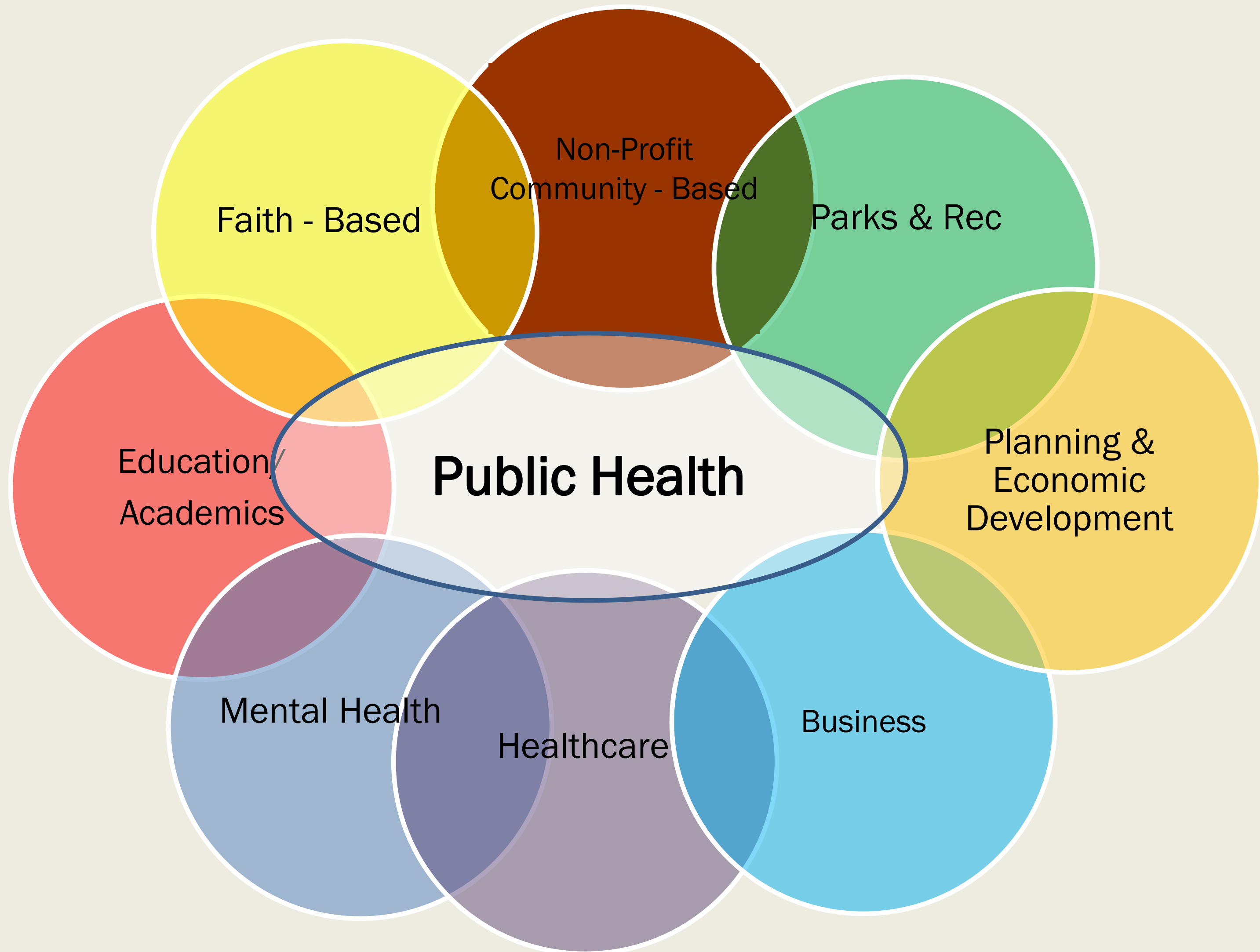
First Year Implementation

- 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



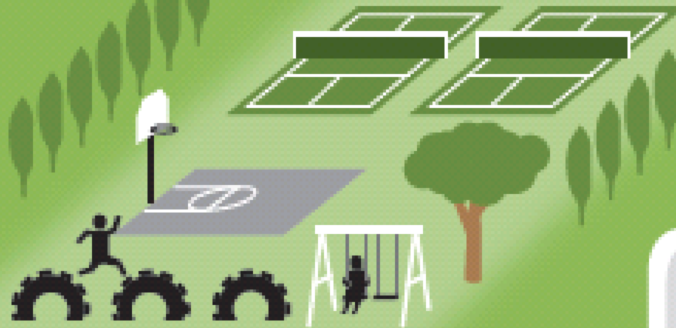
THE HEALTHY COMMUNITY

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.

Farmers markets

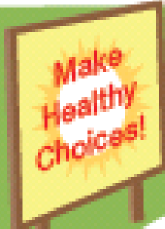


Parks & recreational facilities

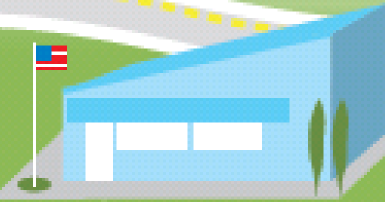
Schools

Community centers

Bike paths



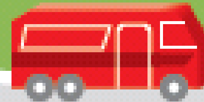
Sidewalks



Clinic/health services

A HEALTHY COMMUNITY

ensures equal access to health resources for all residents.

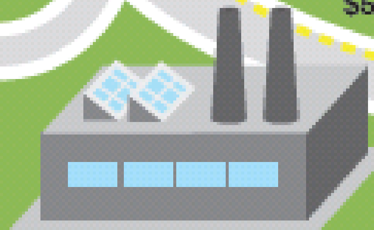


Public transit

Healthy homes

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.



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

4 X 4 Plan Coalitions - 2013 Results

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

4 x 4 Plan Community Coalitions

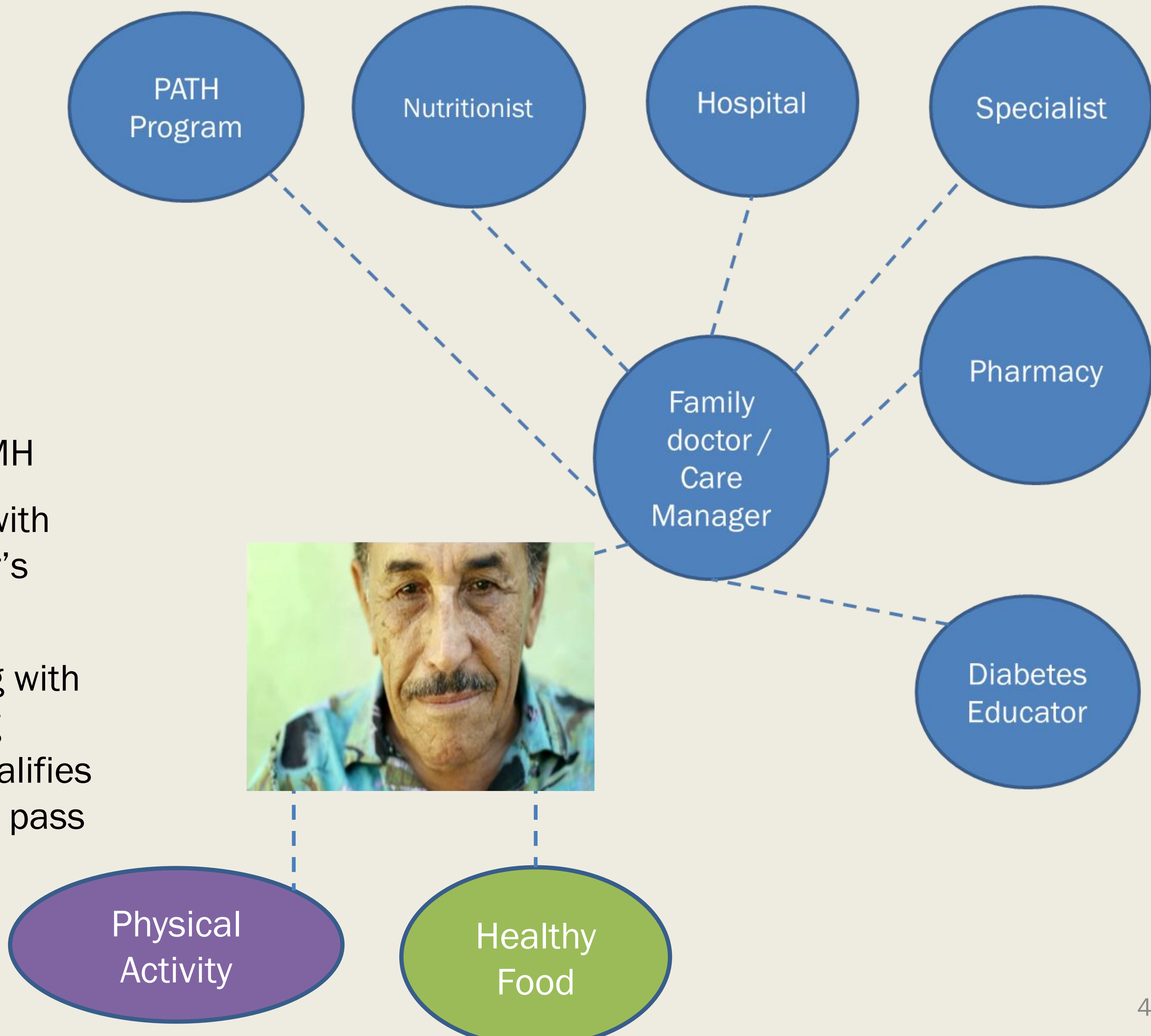
2013 - 2014 Strategies

- 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)
- Use 4 x 4 campaign messages and integrate in intervention strategies.

Title Slide

- 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: Population	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

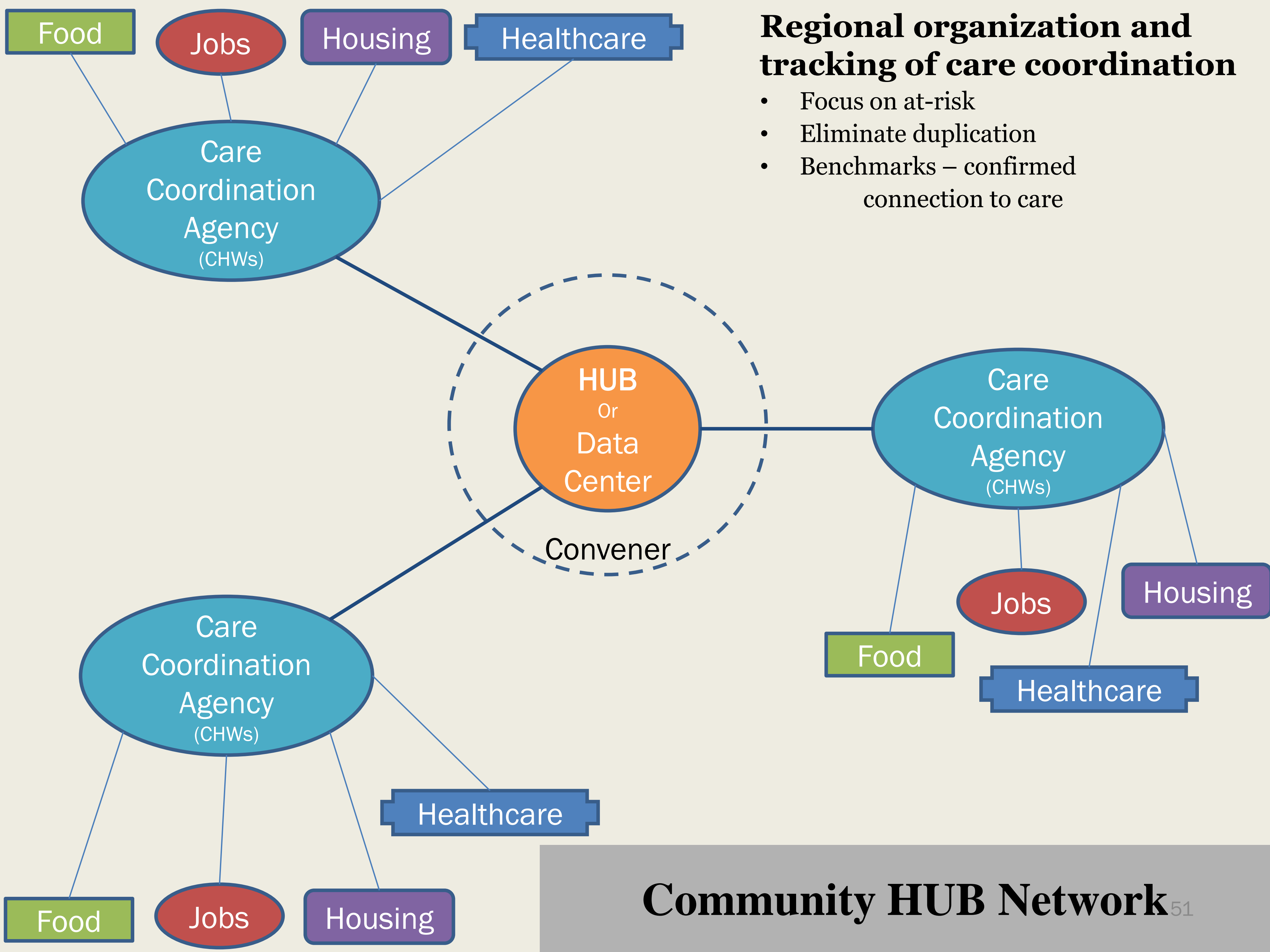
2 - Treat

Confirm connection to evidence-based care

3 - Measure

Measure the results

OUTCOMES

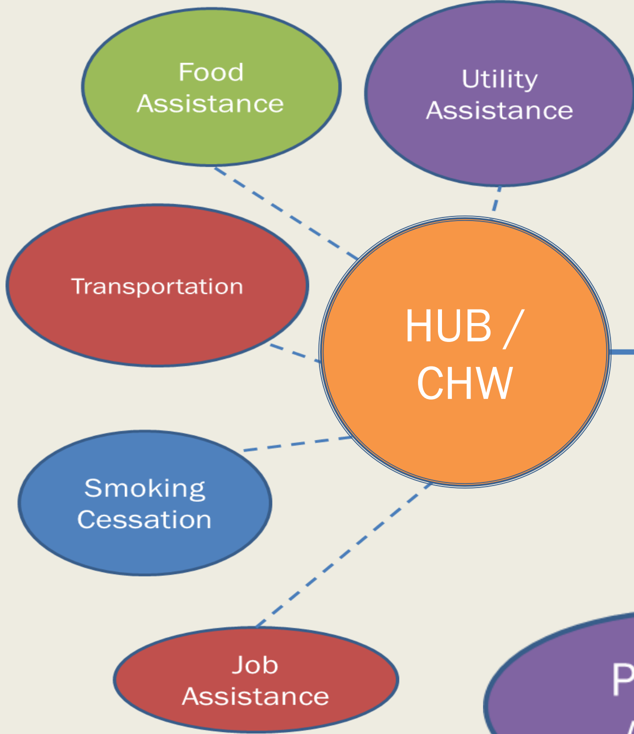

Regional organization and tracking of care coordination
Focus on at-risk
Eliminate duplication
Benchmarks – confirmed connection to care
Food
Jobs
Housing
Healthcare
Care Coordination Agency (CHWs)
HUB Or Data Center
Convener
Care Coordination Agency (CHWs)
Jobs
Housing
Food
Healthcare
Care Coordination Agency (CHWs)
Healthcare
Food
Jobs
Housing
Community HUB Network

Serving
Latino
Communities

Imagine…

COMMUNITY-INTEGRATED HEALTHCARE SYSTEM 3.0

MI Pathways to Better Health



MI Primary Care Transformation

PATH Program

Nutritionist

Hospital

Specialist

Family doctor / Care Manager

Pharmacy

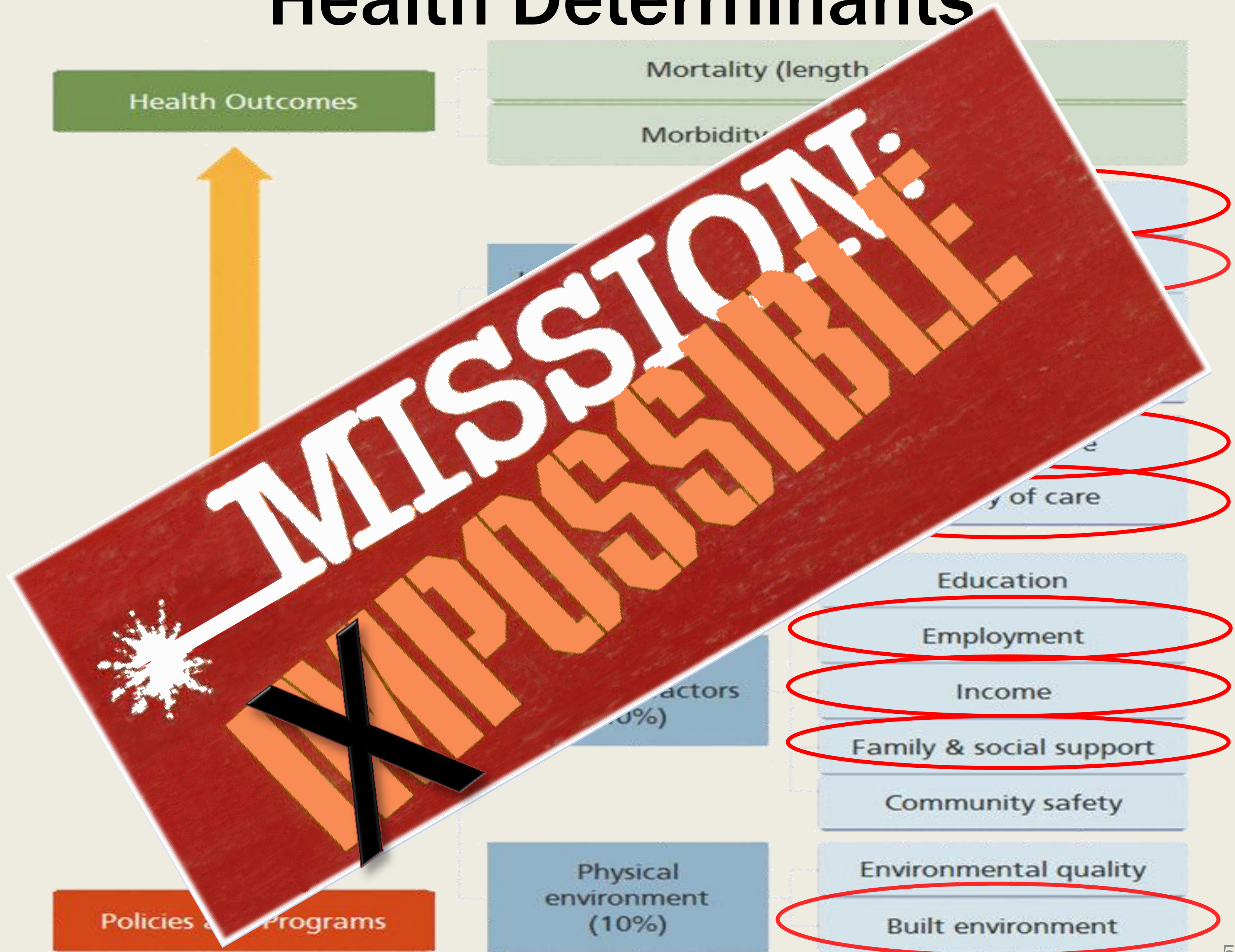
Diabetes Educator

Physical Activity

Healthy Food

MI Health & Wellness 4 X 4 Plan

Health Determinants



University of Wisconsin *Population Health Institute* http://whatworksforhealth.wisc.edu/

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!

Tom Curtis, MPA
curtist2@michigan.gov
(517) 241-1287

Dawn Rodman, MS, CWHC
rodmand@michigan.gov
(517)373-7958

Dana Watt, MSN
wattd@michigan.gov
(517) 373-4246