Michigan Primary Care Transformation Project (MiPCT)
Objectives

• Identify the national drivers in U.S. health care which are the impetus for health care reform

• Describe the components of the MiPCT demonstration

• Explain the role of the MiPCT care manager in the primary care setting

• Describe MiPCT evaluation metrics and progress to date

• Identify care management strategies used in MiPCT that may be implemented in your own practice
Health Care Rankings – Comparison of Countries
U.S. Spends Greater Percentage of GDP on Health Care Than Other Nations

Percent of gross domestic product (GDP) spent on health care, 2002

<table>
<thead>
<tr>
<th>Country</th>
<th>Percentage of GDP Spent on Health Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>United States</td>
<td>14.6</td>
</tr>
<tr>
<td>Germany</td>
<td>10.9</td>
</tr>
<tr>
<td>France</td>
<td>9.7</td>
</tr>
<tr>
<td>Canada</td>
<td>9.6</td>
</tr>
<tr>
<td>Australia (2001)</td>
<td>9.1</td>
</tr>
<tr>
<td>OECD Median</td>
<td>8.5</td>
</tr>
<tr>
<td>New Zealand</td>
<td>8.5</td>
</tr>
<tr>
<td>Japan (2001)</td>
<td>7.8</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>7.7</td>
</tr>
</tbody>
</table>

U.S. Adults Receive Half of Recommended Care, and Quality Varies Significantly by Medical Condition

United States Aging Population

Population age 65 and over and age 85 and over, selected years 1900–2008 and projected 2010–2050

NOTE: Data for 2010–2050 are projections of the population. Reference population: These data refer to the resident population. SOURCE: U.S. Census Bureau, Decennial Census, Population Estimates and Projections.
Chronic Care Model

The Chronic Care Model

Community
Resources and Policies

Health Systems
Organization of Health Care

Self-Management Support

Delivery System Design

Decision Support

Clinical Information Systems

Informed, Activated Patient

Productive Interactions

Prepared, Proactive Practice Team

Improved Outcomes

Developed by The MacColl Institute
© ACP-ASIM Journals and Books
Patient Centered Medical Home (PCMH)

• The medical home is not simply a place but a model of the organization of primary care that delivers the core functions of primary health care.

• The medical home encompasses five functions of and attributes:
  ▫ Comprehensive Care
  ▫ Patient centered
  ▫ Coordinated Care
  ▫ Quality and safety
  ▫ Accessible services

http://pcmh.ahrq.gov/page/defining-pcmh
PCMH as the Foundation for ACO
Population Management

The goal of Accountable Care Organizations should be to reduce, or at least control the growth of, healthcare costs while maintaining or improving the quality of care patients receive (in terms of both clinical quality, patient experience and satisfaction).

- Harold Miller

Source: Premier Healthcare Alliance
CMS Multi-Payer
Advanced Primary Care Practice (MAPCP)
Demonstration Project
CMS Multi-Payer Advanced Primary Care Practice (MAPCP) Demonstration 2012-2014

- **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
## MAPCP Demo: Participating States 2012-2014

<table>
<thead>
<tr>
<th>State</th>
<th>Practices</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maine</td>
<td>22 practices</td>
</tr>
<tr>
<td>Michigan</td>
<td>377 practices</td>
</tr>
<tr>
<td>Minnesota</td>
<td>159 practices</td>
</tr>
<tr>
<td>New York</td>
<td>35 practices</td>
</tr>
<tr>
<td>North Carolina</td>
<td>54 practices</td>
</tr>
<tr>
<td>Pennsylvania</td>
<td>78 practices</td>
</tr>
<tr>
<td>Rhode Island</td>
<td>13 practices</td>
</tr>
<tr>
<td>Vermont</td>
<td>110 practices</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>848 practices</strong></td>
</tr>
</tbody>
</table>
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
  - Allows 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
  - Bend the current (non-sustainable) cost curve
  - Contribute to national models for primary care redesign
- Form a strong foundation for successful ACO models
MiPCT Demonstration Timeline

GOAL: To sustain our gains (effective, efficient team-based care with embedded Care Managers) post-demonstration period
MiPCT Clinical Model: Optimizing Patient Engagement, Improving Population Health
Managing Populations: Stratified approach to patient care and care management

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

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

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

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

Managing populations involves a stratified approach to patient care and care management, focusing on different levels of health and disease complexity.
### Michigan Primary Care Transformation Project
#### Advancing Population Management

## PCMH Services

<table>
<thead>
<tr>
<th>Complex Care Management</th>
<th>All Tier 1-2-3 services plus:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Functional Tier 4</td>
<td>▪ Home care team</td>
</tr>
<tr>
<td></td>
<td>▪ Comprehensive care plan</td>
</tr>
<tr>
<td></td>
<td>▪ Palliative and end-of life care</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Care Management</th>
<th>All Tier 1-2 services plus:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Functional Tier 3</td>
<td>▪ Planned visits to optimize chronic conditions</td>
</tr>
<tr>
<td></td>
<td>▪ Self-management support</td>
</tr>
<tr>
<td></td>
<td>▪ Patient education</td>
</tr>
<tr>
<td></td>
<td>▪ Advance directives</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Transition Care</th>
<th>All Tier 1 services plus:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Functional Tier 2</td>
<td>▪ Notification of admit/discharge</td>
</tr>
<tr>
<td></td>
<td>▪ PCP and/or specialist follow-up</td>
</tr>
<tr>
<td></td>
<td>▪ Medication reconciliation</td>
</tr>
</tbody>
</table>

| Navigating the Medical Neighborhood | ▪ 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/HIE (adv/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
- PO/PHO and practice determine optimal balance of shared support
- Patient risk assessment
- Population stratification
- Clinical metrics reporting

*denotes requirement by end of year 1
MiPCT PO/Practice Expectations

• Care management
  ▫ Performed for appropriate high and moderate risk individuals

• Population management
  ▫ Proactive patient outreach
  ▫ Point of care alerts for services due
  ▫ Patient registry functionality by end of year one

• Access improvement
  ▫ 24/7 access to clinician
  ▫ 30% same-day access
  ▫ Extended hours
How Will We Define Success?
Quality and Experience of Care Metrics:
MI and National Evaluations are Different, with common elements

**National**

Diabetes care:
- LDL-C screening
- HbA1c testing
- Retinal eye examination
- Medical attention for nephropathy
- All 4 diabetes tests
- None of the 4 diabetes tests

Ischemic Vascular Disease:
- Total lipid panel test

Patient experience (CAHPS)

**Michigan**

- Diabetes
- Asthma
- Hypertension
- Cardiovascular
- Obesity
- Adult preventive care
- Child preventive care
- Childhood lead screening (Medicaid)

- Patient experience (CAHPS)
- Provider/staff experience
Budget Neutrality and ROI

• Budget Neutrality
  ▫ The minimum required
  ▫ Amount expended in additional payments to providers (practices and POs) plus administrative costs must be equal to or less than the amount saved by avoiding unnecessary services (e.g., ambulatory care-sensitive ED visits and inpatient stays, redundant testing, etc.)
  ▫ Must trend toward budget neutrality at the end of Year Two (2013)

• ROI
  ▫ The GOAL
  ▫ “Return on Investment”
  ▫ Saving more in avoidable costs than is spent on additional payments to providers and administrative costs
How will CMS define success?

The tie to budget neutrality and ROI
Evaluation Details

• Statistical analysis of the effect of care management, care transitions, community linkages, IT, patient access on quantifiable outcomes, using:
  ▫ Claims data
  ▫ Clinical quality indicators
  ▫ Patient survey on experience of care
  ▫ Provider/clinic staff survey on work life satisfaction

• Key interviews and feedback gathering from practice and PO representatives
Strategies for achieving...

SHORT TERM SAVINGS
• High-risk patient intensive care management
• 24/7 clinical decision maker access to prevent unnecessary ED utilization and inpatient admissions
• Baseline data analysis for utilization outliers and focused root cause analysis
• Educate on evidence-based approaches to care (e.g., low back pain management)

LONG TERM SAVINGS
• Focus on all “tiers” of patient population
• Recognize and reward performance on intermediate markers of chronic conditions to prevent long-term complications (BP in diabetes, etc.)
• Focus on primary prevention/screening
• Work to build self-sustaining healthy communities
MiPCT Participants 2012 - 2014
Practice Participation Criteria

• PCMH-designated in 2010, and maintain PGIP or NCQA designation over the 3-year demonstration
• Part of a participating PO/PHO/IPA
• Agree to work on the four selected focus initiatives:
  o Care Management
  o Self-Management Support
  o Care Coordination
  o Linkage to Community Services
Participants

- 377 practices
- 35 POs
- 1,700 physicians
- 5 Payers
  - Medicare
  - Medicaid managed care plans
  - BCBSM
  - BCN
  - Priority Health
MiPCT Participating Health Plans - Payment Methodologies

- Two different payment methodologies
  - BCBSM/BCN – Bill for the Care management visit (Fee for service with multiple codes)
  - Medicare/Medicaid – Per Member Per Month payment

- Adds significant complexity to implementation

- Not all BCBSM/BCN members covered under demo
  - Some self-funded customers did not opt in to process
MiPCT Care Manager Role
What is Care Management?

“What 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
Care Management Continuum:

Primary Care Population Health Strategies

1. Panel Management
   - Registries
   - Gaps in Care Outreach
   - Planned Visits

2. Care Management for Chronic Dz
   - Self Management Support
   - Medication Management
   - Care Coordination
   - Patient Education
   - Patient Activation

3. Complex Case Management for high risk/cost patients
   - 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

http://qhmedicalhome.org/safety-
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
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
Role Comparison: Moderate Risk Care Manager (MiPCT Tier 3), Complex Care Manager (MiPCT Tier 4)

<table>
<thead>
<tr>
<th>Patient Population</th>
<th>Moderate Risk Care Manager (MCM)</th>
<th>Complex Care Manager (CCM)</th>
</tr>
</thead>
<tbody>
<tr>
<td></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>
</tr>
</tbody>
</table>
MiPCT Care Management: Communication & Training
I. 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 15-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 payer all patient registries to track and follow up with patients, especially those with multiple chronic diseases. In addition, MiPCT pays 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 1,600 providers in almost 500 practices. All of the insurance companies and physician organizations in Michigan have been invited to participate.

Care Management:

- What is it?
- Who does it?
- How does it fit in a Primary Care Practice?
- Staffing Models – which one works for MY practice?
- Care Manager Job Descriptions
MiPCT Complex Care Manager
Train the Trainer Program

MiPCT Leadership Team

Master Trainer
- Clinical Leads

Master Trainer
- Clinical Leads

Master Trainer
- Clinical Leads

Master Trainer
- Clinical Leads
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 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
MiPCT Transition of Care Intervention

- Care Manager conducts Transition of Care follow up phone call within 24-48 hours post hospital discharge
- Then weekly x 4 – phone visit
- Address:
  - Medication reconciliation
  - Follow up - PCP appt., specialist appt., tests
  - Social support
  - Assessment – barriers
  - Red flags
  - Care coordination
  - Inform patient/caregiver
    - Access to PCP office – “how to”
MiPCT TOC Lessons Learned - Primary Care Practice (PCP)

Notification to PCP of patient admit/hospital
- In 2011, discharge varied widely, inconsistent
- Progress to date: patient admit/hospital discharge notification to PCP practice reported by POs is significantly more prevalent
- Examples of notifications:
  - Fax discharge summary
  - Electronic notification
  - MiPCT Care Manager has access to hospital EMR

Leveraging IT resources:
- Some MiPCT POs/practices provide electronic notification directly to the MiPCT Care Manager/PCP practice
  - MiPCT patient list with alert of patient admit/ER visit for the subset of hospitals within their own health system
  - Add ADT info here

In progress...
MiPCT Care Manager Curriculum

Ongoing

- **Webinars – statewide**
  - Best Practice, chronic conditions, process, project updates
  - Two per month first 2 years, now 1 to 2 per month

- **Conference Calls – regional/specialty**
  - Facilitated by Master Trainer
  - Care Manager sharing peer to peer, interactive

- **MiPCT Practice Flash Newsletter** - monthly

- **CCM Blended Activity Course offered monthly**
  - > 350 Care Managers trained

- **Work Groups - Care Manager, PO**

- **Michigan Care Management Resource Center website** [www.micmrc.org](http://www.micmrc.org)
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
Team Based Care
Management Delivery
The PATH to Commitment: Engaging Stakeholders

PATH to Commitment

1. Awareness/Understanding
2. Belief
3. Commitment
4. Compliance

*Capturing the Heads, Hearts and Hands of People to Effect Change: The Road to Commitment,* Roland Loup and Ron Kolier, DD Journal, Fall 2005.
Town Hall Meetings

Goal: To provide a forum in the local communities for providers/care managers to:

- Share stories of their transformation journey including;
- what they are most proud of
- what has been most challenging in developing a successful team based care management program in their practice.
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”
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
MiPCT Resources & Communication for PO Leaders

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

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

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

- MiPCT Newsletter - PO FLASH bimonthly

- MiPCT Website www.mipctdemo.org
Care Management Delivery by the Practice TEAM

- Planned patient care i.e. huddles, processes, work flow, policies
- Care Manager and PCP partnership
- Office staff – defined roles and responsibilities
- PCMH meetings monthly, action plan, follow up
- PO and Practice Leadership
- Information technology, support
MiPCT Care Management - Case Presentations
Case 1: Care Manager (CM) Post Hospital Follow-up

- 59 year old male s/p digit amputation, discharged from hospital
  - Other Diagnoses: Diabetes, HTN, Hyperlipidemia, Neuropathy

- Pre-assessment
  - Right foot dressing, not weight bearing
  - I/D consult in the hospital
  - Appears that no changes in medications were made in the hospital
  - MRSA on inpatient culture (pending results at DC)
  - A1C 6.2; LDL 98 BP: 132/78

- Care giver support
  - At time of discharge lives with wife, who has macular degeneration and DM
  - Unemployed, not working due to foot ulcer
Care Manager - First Office Visit with Patient

CM completes office visit with patient and wife

Medication reconciliation:
-- Patient brought in all pills to visit. He reports taking Bactrim for wound infection.
-- Medication reconciliation identified patient on Bactrim without known reason—not clear on discharge plan

Care Coordination:
– I/D specialty appointment in mid April
– Questions on his follow-up visits

Self Management Support:
– Patient questions on control ranges
– Patient self-regulating Lantus doses based on his HS blood sugars

Risk Assessment

▫ Patient and wife report inability to “see” the wound and are uncomfortable with wound changes.
▫ Fear of wound not healing and their skill in managing the wound care

Depression Assessment

▫ PHQ2 negative
Day 1: Care Coordination - Closing the Gap

Complex Care Manager (CCM) reviews inpatient hospital stay information and discharge plan directly in record

Determines that Bactrim doses will be out on Saturday, and pt. lab report show MRSA—unknown to Infectious Disease (I/D), Hospitalist and PCP as culture report was not available at time of discharge

Contacts I/D specialist to obtain an earlier appointment—patient not set to go until 3 weeks later

CM speaks with I/D directly and receives refill on Bactrim and appointment for upcoming Monday

Sets up homecare to monitor wound at home (not in place at DC). Wife not able to do dressing changes due to macular degeneration

CM speaks directly with Home Health Agency RN, reviewed history, meds and treatment plan
Week 1-Care Manager follow up

Phone visit-Self Management Support
- Addressed patient and spouse concern regarding wound care
- Education and teach back of ranges of blood sugar
- Educated on contacting office for medication adjustment for blood sugar out of range
- Follow-up phone scheduled for the following week
- Assessment completed, self management goal agreed upon
  - Check Blood sugar daily, record results

Follow up CM Call later in the week
- Patient states he is doing better, still not ambulating.
- Worried about getting his medications as he is not able to drive and he is due for refills.
- Homecare nurse has been out and visits are every 2 days—wound healing nicely.
- Contacted I/D specialist to review treatment plan, ongoing ABX. Reinforced this plan with the patient.
- Still has questions about his meal planning and the best foods for he and his wife.
- Mentions he has some swelling in his legs.
Week 2: Care Manager Phone Visit, Care Coordination

**Ongoing Care Coordination**

- More in-depth history on swelling.
- Contacted homecare to coordinate plan of care
  - arrange for collaborative call at the time of the home visit to review findings and discuss necessary treatment changes.
- Contacted pharmacy
  - Arranged for home delivery of refills.
- Contacted dietician
  - Arranged for phone education to support patient food choices in controlling blood sugar.
- medication reconciliation; reviewed with patient current diuretic meds and dosing.
- assess swelling
- assess wound healing
- progress of self management goal
Case 2: Transition of Care - Post Hospital Discharge

- 65 year old woman history of breast cancer 25 years ago
- Admitted to hospital after a syncopal episode at church
- Suffered skull and finger fracture
- During hospital course patient was found to have severe Mitral Regurgitation and underwent heart catheterization
Transition of Care - 24 hr. Post Hospital Care Manager Phone visit

Care manager reviews hospital discharge summary

- Post discharge phone call made within 24 hours post discharge
  - Patient’s concern identified
    - pressure dressing in place with no patient instructions
    - patient is confused about how to take her medications
  - Assessment
  - Provide education
    - after hours access to PCP practice
    - wound care – HHA Care Manager will assist
    - Red flags – shortness of breath, weight gain, dizziness, fever, redness/swelling around wound
- Completed medication reconciliation
  - Patient has a new prescription for Toprol but did not start to take this medication
    - Contact daughter who is able to pick up from pharmacy and bring to patient
- Verified that patient received oxygen and understood use and care of oxygen
Transitions of Care

- **Care Manager actions 24hrs post hospital visit:**
  - Coordination of care
    - Referral for home care visit that day
    - Spoke directly with Home Health Agency Care Manager
      - shared phone visit assessment findings, patient’s concern
  - Follow up call with HHA RN
    - Discussed HHA RN visit plan (i.e. wound, med rec, patient education, and patient to take daily weights)
    - HHA RN visit is scheduled weekly
  - Verified that patient had follow up appointments with PCP, cardiothoracic surgeon
Transition of Care: Day 2 Follow up Phone visit

- **Care Manager actions:**
  - Follow up phone visit two days post discharge
  - Medication reconciliation
  - Assess weight, HF symptoms, wound healing
    - Patient’s weight is stable, no swelling, no shortness of breath
  - Then weekly times 4 phone visits
  - Verified PCP appointment day 3 post hospitalization, will see Care Manager face to face same day
What’s Next
MiPCT Care Manager Case review and Practice Assessment

Care Manager Case reviews

- completed by Clinical Leads using a standard MiPCT evaluation tool.
- Findings provide data regarding progress and areas requiring improvement for both the PO/practice and MiPCT.
- PO’s, practices and Care managers identified for Best Practice Work group.

MiPCT Practice Assessment

- Practice assessment is in conjunction with the Care Manager Case Review.
- Practice assessment identifies infrastructure associated with MiPCT Care Manager Best Practice.
- Practice assessment data used by both the PO/practice and MiPCT to identify progress made and existing barriers.
MiPCT Care Management Best Practice Work Group - Background

- Care management activity across the state is varied.

- Care management best practices do exist and it will be beneficial to gather and analyze these best practice activities via a MiPCT work group to identify models and improvement processes.

- Work Group Participants
  - Invitation based on performance criteria of CM encounter data, MiPCT quality and utilization metrics for Adult population
    - PO Leaders
  - Care Managers
  - Clinical Leads
  - Physician(s)
**MiPCT Care Management Delivery in the Practice:**

Individual Care Manager (CM): How does the care manager complete daily work?

System Factors: Leadership, Infrastructure & Practice embedment

**Individual Care Manager:** CM Role, CM Skill, Patient Acuity

**System Factors:** Practice Embedment
Four Focus Areas

- Care Management Fundamentals
  ▫ 5 Step CM process for moderate and complex patients

- Sharing Innovative Best Practices
  ▫ Identify what is working

- “New work” development
  ▫ Focus on topics with high level of impact to contribute to efficient and effective care management delivery
  ▫ CM best practice participants form a sub group – develop guidelines

- CM activity – what does effective and efficient care management look like?
  ▫ Non direct patient care such as care coordination
Potential Outcomes of this Work Group

• **Shared learning of CM Best practice innovative work**
  ▫ Document “what works” to achieve increased Care Management encounters / benchmark goals and quality outcomes
  ▫ Integrating Care Management Best Practice strategies into practice more broadly.

• **Document “what has been tried and does not work”**
• **Evidence based best practice model utilizing patient acuity as the driver for care interventions.**
  ▫ Address Complex and moderate risk patients and improved patient outcomes

• **Toolkit**
  ▫ Resources, tools, workflows developed by MiPCT participants posted on MiPCT website.

• **Reference list**
  ▫ Evidence based resources, articles and websites
Share Care Management Best Practice

- MiPCT Summit Conferences-October 2014
- Shared Care Management Best Practice learning on Michigan Care Management Resource Center website
- MiPCT Care Management educational webinars and conferences
1. How are We Doing? 
Recap and MiPCT Results to Date
State Evaluation

Conducted by: Michigan Public Health Association (MPHI)
## Care Manager Activity Benchmark Performance

### Quarter 4

<table>
<thead>
<tr>
<th>Care Manager Role</th>
<th>90&lt;sup&gt;th&lt;/sup&gt; Percentile Quarterly Encounters/FTE</th>
<th>Translates to: Encounters per day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complex</td>
<td>439</td>
<td>7 encounters per day</td>
</tr>
<tr>
<td>Hybrid</td>
<td>362</td>
<td>6 encounters per day</td>
</tr>
<tr>
<td>Moderate</td>
<td>352</td>
<td>6 encounters per day</td>
</tr>
</tbody>
</table>
3rd Care Manager Survey

• Data were collected via Survey Monkey® June 9 - June 26, 2014

• 421 Care Managers were emailed invitations to participate

• 50% completed the survey (N=209)

• Data cleaning and analysis was performed using SPSS v19.0
Care Manager Survey Results

Average Self-reported Patient Caseload at Time of Survey

- Hybrid Care Manager
- Moderate Care Manager

May: 39, 60, 67
December: 63, 74, 95
June: 66, 84, 92
Physicians Support MiPCT

Physicians that Care Managers work with support the concepts of the MiPCT care management team-based care

- May 2013:
  - Strongly agree: 48
  - Agree: 107
  - Neither agree nor disagree: 39
  - Disagree: 9
  - Strongly disagree: 12

- December 2013:
  - Strongly agree: 69
  - Agree: 79
  - Neither agree nor disagree: 32
  - Disagree: 53

- June 2014:
  - Strongly agree: 72
  - Agree: 83
  - Neither agree nor disagree: 20
  - Disagree: 11
  - Strongly disagree: 1

Legend:
- Strongly agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly disagree
Practice staff, other than physicians that Care Managers work with support the concepts of the MiPCT care management team-based care.
Key Quality Data Recap
MiPCT 2015 and Beyond
To be considered a success:
Outcomes of MiPCT beneficiaries must improve at a greater rate than the comparison beneficiaries.
Lessons Learned

1. Don’t impose burdensome provider reporting requirements.

2. Don’t underestimate importance of Convener (Physician Organization) engagement, resources, and leadership.

3. Don’t underestimate difficulties of care management integration into practices.

4. Don’t continue engaging patients who no longer need care management.

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.

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.

7. Do rely on PCP and team input as well as claims data and risk scores to select patients for care management.

8. Don’t underestimate importance of engaging and motivating physicians.
Let’s Talk!

Questions, Ideas and Opportunities