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Michigan Summary of Care Report™ | 2019

Transforming Care and Quality Through Innovative Data Sharing

7th Edition

Contents

Introduction

The *Michigan Summary of Care Report™*, now in its seventh edition, highlights the care management strategies implemented by leading physician organizations (POs) across the state of Michigan. This year's report focuses on Provider-Delivered Care Management (PDCM), part of Blue Cross Blue Shield of Michigan's Patient-Centered Medical Home (PCMH) program. PDCM is a core element of Value Partnerships' Physician Group Incentive Program, and has been instrumental in providing complex care management to patients at participating POs. The report provides an overview of the PDCM program, including its impact on chronic disease patients, with looks at the tools, goals, obstacles, and future plans of the program. Through this overview, the report is intended to generate discussion among providers, payers, and other interested health care organizations seeking to refine their approach to chronic disease management and to achieve higher quality of care.

PCMH vs. PDCM

PDCM is used within a PCMH model of care. In PDCM, primary care physicians (PCPs) lead multidisciplinary care teams to improve the quality of care for chronic disease patients. There are no diagnostic restrictions, and the program includes both pediatric and adult patients. PDCM care focuses on:

- Regular communication between the patient and care team through in-person individual and group visits and telephone calls
- Attention to transitions of care (TOC), including coordination between specialists and PCPs
- Medication management and reconciliation
- Addressing social determinants of health (SDOH) by effectively using community resources

PDCM Connects Patients to Their Health Care Team

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PDCM Overview

Impact of PDCM on Chronic Disease Patients

Managing chronic disease is one of the most complex challenges confronting health care providers. According to the Centers for Disease Control and Prevention (CDC), 90% of total annual health care expenditures in the U.S. go toward treating patients with chronic and mental health conditions.[1]

Care management focuses on engaging patients in their health and health care through ongoing, frequent touchpoints with patients. The PDCM program facilitates patient engagement by ensuring that patients pay no out-of-pocket costs for care coordination services. In addition, one aspect of PDCM is a monthly member list created for POs that helps identify high-risk patients. Although providers often have the best and most timely information about their patients, this list augments that information by highlighting patients with:

- Six or more emergency department (ED) visits over 12 months
- Six or more inpatient visits over 12 months
- A high-risk score and high cost over 12 months
- 10 or more prescription medications over six months

With such a list, the provider-led care team can proactively reach out to candidates for care management services and begin to engage patients to improve their health.

History of the PDCM Program

The PDCM program at BCBSM was originally a two-year pilot project and then became part of a five-year demonstration from the Centers for Medicare & Medicaid Services (CMS), called MiPCT. The demonstration ran from January 1, 2012, to December 31, 2016, and was limited to a core group of established PCMH practices. In 2015, BCBSM expanded PDCM to include all PCMH practices. In 2019, all designated PCMHs are eligible to bill distinct care management codes for delivering in-office care management services. In addition, practices that deliver care management services and meet other criteria as specified by BCBSM may be eligible to receive value-based reimbursement for this enhanced care delivery model.

Three Phases of BCBSM PDCM		
Preliminary PDCM Pilot, 2010–2012	MiPCT Project, 2012–2016	Expanding PDCM Program, 2015–Present
• Five regions in MI • Five POs participating • 50+ practices • 258 PCPs	• Over 1,500 physicians • 350 practices • 300 nurse practitioners/ physician assistants • More than 30 POs statewide	All PCMH physicians and Comprehensive Primary Care Plus (CPC+) non-designated practices are eligible to deliver care management and bill PDCM codes
Tested data exchange, reimbursement, interventions	Ended December 31, 2016, and practices were "absorbed" into PDCM	Practices may qualify through an annual process for value-based reimbursement for PDCM

[1] CDC. (2018). Health and Economic Costs of Chronic Diseases. Retrieved from https://www.cdc.gov/chronicdisease/about/costs/index.htm#ref1. Accessed April 2019.

Key PDCM Results[1]

PDCM Demonstration Cost Savings, Medicare Population, 2012–2016

Savings in Medicare Expenditures

PCMH practices saved
$2.16
For every $1 in Medicare expenditures

PDCM practices saved a FURTHER
$4.54
over their PCMH-only counterparts

Michigan recorded an estimated net cost savings of **$230 million** for Medicare patients over the five years of the program.

PDCM Utilization Improvements, Commercial Population, 2018

PDCM Primary Care Sensitive ED Visits

Compared with their PCMH-only counterparts for ED visits that could have been treated in a primary care setting, PDCM practices had:

7.2%
lower rate for adult population

5.8%
lower rate for pediatric population

PDCM Ambulatory Care Sensitive Inpatient Visits

Compared with their PCMH-only counterparts for inpatient visits that could have been treated in an ambulatory care setting, PDCM practices had:

11.5%
lower rate for adult population

PDCM Radiology Services

Compared with their PCMH-only counterparts, PDCM practices had:

Adult Population

2.1%
lower rate of high tech radiology services

2.5%
lower rate of low tech radiology services

Pediatric Population

1.9%
lower rate of low tech radiology services

Estimated PDCM Cost Savings, Commercial Population, 2018

Cost Savings in Commercial Population

An internal analysis showed savings estimates of:

4% or **$17–23**
per member per month for PDCM-engaged members

PDCM Program Growth

PDCM became payable for most members throughout 2017. Growth was rapid from 2017 to 2018 as a result, with a 46% increase in the number of practices fully delivering PDCM, and a 79% increase in the number of members receiving PDCM services.

[1] Data Source: BCBSM Value Partnerships Self-Reported, 2019

Physician Organization Profiles

Answer Health is a clinically integrated organization based in Grand Rapids that was formed in 2017 by the merging of Physicians' Organization of Western Michigan (POWM) and West Michigan Physicians Network (WMPN). Answer Health supports more than 700 independent physicians and the patients they serve by improving the quality and outcomes of patient care, controlling costs, ensuring efficiency in health care services, strengthening the position of private practice physicians, and monitoring and reducing overuse, underuse, and misuse of clinical resources. For more information, visit http://answerhealth.com/.

Great Lakes Physicians Organization (GLPO) is a 300+ member physician group delivering health care services within a 10-county region of central Michigan. Great Lakes Organized Systems of Care (GLOSC), a division of GLPO, comprises independent primary care and specialty physicians who participate in risk- and value-based payer arrangements. GLOSC primary care physicians also participate in the Great Lakes Accountable Care Organization. Together, these entities support population health management through partnerships with local health systems and other agencies. Utilization of a patient longitudinal record and registry gives providers insight into their patient's needs, including data analytics and reporting. Together, the infrastructure built for GLOSC physicians allows for the delivery of efficient and effective care to the patient, employer, and the community. For more information, visit https://glosc.org/.

Integrated Health Partners (IHP) is a PO wholly owned by the Calhoun County Physician Organization, Inc. It comprises approximately 130 physicians, about 50 of whom are primary care, plus advanced practice professionals. IHP is accredited by the National Committee for Quality Assurance (NCQA) in credentialing/recredentialing and utilization management. The PO provides a number of services to its member practices, including practice coaching (Lean, process improvement, PCMH assistance, data review); credentialing and recredentialing; educational services; learning collaboratives; contracting with health plans; registry; admit, discharge, transfer (ADT) connectivity; data aggregation and analysis; and care management. In addition, IHP holds CPC+ cohort sessions to assist in meeting CPC+ requirements such as integrated behavioral health care, use of data for process improvement, and template development. To further address the impact of chronic disease in its community, IHP participates in the National Diabetes Prevention Program from the CDC. For more information, visit http://www.integratedhealthpartners.net/.

MedNetOne Health Solutions (MedNetOne) is a health care management/patient care organization offering infrastructure, clinical, and technology services to more than 900 private practice physicians and other independent care providers, including behavioral health specialists. MedNetOne is a leader in advancing the development and implementation of the PCMH, the PCMH neighborhood, and advanced primary care initiatives. Its physician/provider members are focused on fully integrated, population-based, patient-centric practices that enhance patient outcomes and meet government health care reform mandates. For more information, visit http://www3.mednetone.net/.

Oakland Southfield Physicians (OSP) is a physician-led Independent Practice Association (IPA), with sizes from sole practitioners to large groups with a dozen or more physicians. OSP represents more than 430 physicians, mostly in primary care, across seven counties in southeastern Michigan. Created in 1986 with a focus on supporting primary care in Michigan, OSP seeks to free physicians from the administrative burdens of health care, thereby allowing physicians to spend more time caring for patients. OSP provides care for more than 185,000 patients. For more information, visit https://www.ospdocs.com/.

PDCM Key Learnings

Care Team Member Overview, Background, Education

Most of the care team members at participating PDCM POs are registered nurses (RNs); select practices have care team members who are nurse practitioners, physician assistants, licensed social workers, behavioral health specialists, or pharmacists.

- **Find what works for the PO**—The practices in the PDCM program vary significantly in size (from solo practices to offices with dozens of providers), so they have had to tailor the care manager role to their individual practice volume. Some have found that they need multiple full-time care managers to meet the needs of their patient populations, and others have found that they can share a care manager part time with another practice.
- **Collaborate and share best practices**—Care team members find value in conducting case reviews and presentations, meeting and consulting with other care team members within and outside their POs, and sharing best practices. Some POs provide an established forum for this type of knowledge sharing, with regularly scheduled meetings for their care teams. Further, best practices are often disseminated to POs around the state, payers, educational entities such as Michigan Center for Clinical Systems Improvement (MiCCSI), and community agencies as well.
- **Training and continuous learning**—To receive reimbursement for PDCM services, all care managers are required to have complex care management training such as through the Michigan Care Management Resource Center (MiCMRC) Complex Care Management Course, and also participate in continuous education courses annually. In particular, care team members across the POs have found that education and trainings related to motivational interviewing techniques and self-management support have been crucial to success in their roles.

Goals & Milestones

POs involved in PDCM have created individualized goals—often by office and by care team member—in addition to meeting established BCBSM incentives for the growth of care management and achievement of key population health outcomes among their patients.

- **Expand PDCM engagement across practices**—Most POs interviewed had a goal of expanding care management to more of their eligible practices (many working toward 80–100%) to ensure that all patients in need have access to their services.
- **Expand PDCM engagement within practices**—Care team members play a critical role in helping physicians meet the needs of patients; therefore, solidifying care team members as a standard part of the workflow is critical. Many POs have a goal of expanding the role of care team member to address advance care planning, monitor for SDOH, provide education on and connection to community resources, communicate across care settings, and manage transitions of care.
- **Quality measures**—Central to the PDCM program is achieving improvement in quality measures such as decreasing inappropriate ED use, decreasing readmission rates, and increasing self-management and health literacy of all patients.

PDCM Key Learnings

Tools for Success

From technology and workflows to collaboration and education, the PDCM POs employ a range of tools to ensure the success of their care team members.

- **Deploy technology**—PDCM care team members access electronic health records (EHRs) and patient registries to monitor existing patients and proactively identify patients who would benefit from care management services. Care team members are able to monitor ADT feeds to know when their patients are being treated in a hospital, skilled nursing facility, post-acute-care facility, or ED so that they can follow up with patients and facilitate transitions of care as necessary. POs, particularly those with significant populations of Medicaid patients, employ an SDOH screening instrument to find patients who could have underlying socioeconomic factors that affect their health.
- **Educate and train**—Ongoing education has been key to the success of the PDCM program. POs provide regular continuing education trainings for their affiliated care team members. In addition, the MiCMRC maintains an extensive library of educational programs for care team members, and it hosts monthly webinars in which care team members dive deeper into the pathophysiology of diseases, including diabetes, asthma, and congestive heart failure.
- **Provide forums for collaboration**—Networking among care team members has been an important tool for all of the POs. Some have bimonthly care team member meetings to review cases, share best practices, learn about appropriate medical coding, and keep everyone up to date on issues, rules, and expectations.

Top Tips

From the POs

- Care managers play a pivotal role with physicians in helping patients reach their health goals. When reaching out to PDCM patients by phone, care managers address gaps in care, develop a rapport with the patient, and determine how to help them achieve their goals. They also provide resources and, if necessary, encourage them to see their PCP. The main goal is to achieve a healthier patient population, by having satisfied patients and providers, reduced hospital admissions, reduced ED visits, lower costs, and adherence to the principles of population health.

  —MedNetOne

- We are working on a number of quality measures related to process. We started with a focus on diabetes, hypertension, and opioids, and are now moving into behavioral health. We are working to get behavioral health on the radar of the practices and connect patients with appropriate resources—care team members are trained to help reduce the barriers to care that are created by issues such as anxiety and depression.

  —GLOSC

- To facilitate improvement in our areas of focus, we hold a Care Management Collaborative. The collaborative meets quarterly for a full day and, in the months between, for two-hour lunch sessions. At these meetings, speakers on the various areas of focus provide information to assist practices in coordinating care across the health care continuum. In addition, we review data and work with practices on process improvement activities.

  —IHP

PDCM Key Learnings

Addressing Obstacles

Changing workflows, processes, and personnel in an office inherently comes with challenges. POs in the PDCM program have all encountered obstacles to success, and they work earnestly to overcome them.

- **Defining the role**—PDCM is a new model of care for many practices, so clearly outlining the care team member's role and responsibilities is crucial for success. They are not simply another set of hands to help shoulder the workload of a practice—their work is specialized, billable, and important to the care of patients. Leadership from the POs provides direction for and boundaries around the role of a care team member.
- **Gaining physician buy-in**—Physician leadership at the practice level has proven critical to ensuring that care team members have a consistent and defined role in patient care. Some providers feel that they already provide follow-up and education to patients. However, once the care team member is established in a practice, many physicians say that they cannot imagine running their practice without the support of a care team member.
- **Logistical considerations**—Embedding a care team member in a practice comes with a set of practical challenges to address. From the physical (is there an extra exam room where the care team member can meet with patients?) and technological (setting up care team members with appropriate access to EHRs, patient portals, secure messaging) to the operational (what is the hiring pool like in our area?), these "on the ground" realities must be overcome.

Future Plans

Individual POs and their practices are taking PDCM in new directions. Many seek expansion and scalability, both in terms of the number of patients served as well as the patient conditions and needs that they target.

- **"Move upstream"**—One PO is focused on intervening with patients at earlier stages to avoid development or progression of chronic conditions. This focus goes beyond care management to health coaching, and will require different types of staff, different thought processes, and improved use of data to find these individuals earlier in the disease progression process. Indeed, many POs have established early-intervention programs in place to manage rising risk patients and those with complex care management needs.
- **Addressing SDOH**—Practices plan to actively work with care team members to screen for SDOH and other compliance barriers and then connect patients with community resources to solve the SDOH identified. Similarly, practices are expanding their focus on behavioral health to ensure that patients receive needed mental health care and appropriate follow-up.
- **Expanding to specialty**—To meet patients where they are, POs are beginning to add care team members to specialty practices, including cardiology, cancer/hematology, and nephrology. Care team members of specialty practices can then bill for the same types of education, coordination, and patient monitoring services.

The Future of PDCM

BCBSM is striving toward even higher volumes of care management delivery in the future. Actions taken to facilitate this growth in 2019 include simplifying billing guidelines to ease complexity and administrative burden for practices; expanding the care team to include medical assistants and community health workers; developing a mechanism to divert patients from the ED in instances when transport would result in unnecessary utilization; partnering more actively with in-house care management to create a streamlined co-management process for members and practices; creating an external partnership to increase the dissemination of best practices and create an environment in which desired outcomes can flourish; and modifying the reimbursement approach to focus on improvements in diabetes management, blood pressure control, and inpatient and ED utilization. These efforts demonstrate BCBSM's commitment to making PDCM even more responsive to physician, customer, and patient needs.

Case Studies

Care Team Member Helps Type 2 Diabetes Patient Lower A1c by Addressing Barriers to Medication Adherence

A patient with Type 2 diabetes was connected with the PDCM program at IHP. Her initial A1c level was uncontrolled, at 12.3%. Working with IHP care team members over the course of 10 months in 2018, she was able to lower her A1c to 8.6%. At the beginning of 2019, however, the patient told her care team member that she was no longer able to afford the medication that she was prescribed. The care team identified an appropriate alternative therapy with a copay assistance program. After one month on the new medication, the patient's A1c level was 8.5%—maintaining her previously achieved level. Had the care team not learned about the patient's financial difficulties and the patient stopped taking her medication, this progress could have been in jeopardy.

PDCM Provides Community Connections to Help Patient and Aging Parent

Sometimes, a patients' lack of attention to their own health is a direct result of caring for another's illness. During a primary care appointment at IHP, a man with multiple chronic conditions described his aging, declining parent, who required 24-hour care at home. The son was the primary provider of this in-home care—and he was meeting the needs of his mother with dementia before he met his own. The physician referred the patient to the on-site care team member, who conducted a deeper discussion about the patient's personal barriers to health. The care team member had a network of community resources at the ready, so she was able to provide a referral to the local Agency on Aging as well as information on respite care. Both services have provided help for the mother, so the patient had the time and resources to focus on his own health concerns.

Top Tips

From the POs

- One key learning we have experienced is that not every nurse makes a good care manager. It takes a specific type of background—care managers have to be encouragers and motivators. Tasks are not specifically assigned, so they have to be autonomous and seek out work and, sometimes, patients. And they have to be comfortable talking with physicians. We have refined our hiring process as a result of these learnings and have prospective care team members shadow and work in the practice before getting hired. We have found some great fits for the role.

  —Answer Health

- One of the biggest barriers we have had to overcome is practices not understanding what a care manager's role is. To tackle that issue, we created a one-page summary explaining what the role of a care manager is—and is not! We represent hundreds of physician practices, so we also have to manage more than 20 different EHR systems, which creates a training, logistical, and consistency hurdle.

  —OSP

"Just this week, I spoke with a patient who was able to work with care management to help optimize his diet for diabetes. Although we had been able to control his diabetes reasonably well with medication and advice about diet, the extra care management visits prompted him to make changes to his habits that allowed us to decrease his medication. Another benefit is extending our reach outside the office—to the patient's home—through the care management team. This has given me insights into patient care and barriers that would otherwise be unseen, because the patient may not think to tell us. I have also seen an improvement in compliance in treatment plans.

I look forward to continued care management coordination that helps patients achieve excellent health outcomes."

—Michael Maddens, MD, United Physicians

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