Population Health and Management of Complex Patients

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BCBSM Value Partnerships Programs
Moving from *Fee for Service* to Fee For Value

**Physicians**

**Physician Group Incentive Program**

PGIP includes nearly 20 initiatives aimed at improving quality, utilization and costs

**Patient Centered Medical Home**

12 PCMH Initiatives with over 145+ capabilities for PCPs and specialists to implement

**Provider Delivered Care Mgt.**

Care management delivered in the PCMH-PCPs office by qualified care managers with clinical team

**Professional, Process & Hybrid Collaborative Quality Initiatives**

Michigan Urological Surgery Improvement Collaborative
Michigan Oncology Quality Consortium
Integrated Michigan Patient-Centered Alliance on Care Transitions

**Hospitals**

**Hospital Incentive Program**

Hospital Pay-for-Performance program

Rewards up to 5% based on efficiency, population performance, readmissions, daily census reporting and participation in selected CQIs

**Value-based Contracting (VBK)**

Provides funding for population management infrastructure development

**Blue Distinction Centers**

National designation for high quality & cost-efficient hospitals for bariatric surgery, cardiac care, cancer care, knee/hip surgery, maternity, spine surgery, and transplants

**Hospital Collaborative Quality Initiatives (CQIs)**

- Anesthesiology Performance Improvement and Reporting Exchange
- BCBSM Cardiovascular Consortium
- Hospital Medicine Safety Collaborative
- Michigan Anticoagulation Quality Improvement Initiative
- Michigan Arthroplasty Registry Collaborative for Quality Improvement
- Michigan Bariatric Surgery Collaborative
- Michigan Emergency Department Improvement Collaborative
- Michigan Radiation Oncology Quality Collaborative
- Michigan Society of Thoracic & Cardiovascular Surgeons Quality Collaborative
- Michigan Spine Surgery Improvement Collaborative
- Michigan Surgical Quality Collaborative
- Michigan Trauma Quality Improvement Program
- Michigan Value Collaborative

**Organized Systems of Care**

A community of caregivers organize to meet the needs of a population defined by patient attribution to PCPs integration across provider groups (PCP, specialist, facility) in a collaborative manner
2015 Performance comparisons, for PCMH-designated practices compared to non-PCMH designated PGIP practices

- **8.7%** Lower rate of high-tech radiology usage
- **10.9%** Lower rate of low-tech radiology usage
- **10.9%** Lower rate of emergency department visits
- **26.0%** Lower rate of ambulatory care-sensitive inpatient discharges
- **12.6%** Lower rate of primary care-sensitive emergency department visits

Patient Centered Medical Home

Adults (18-64)
Provider Delivered Care Management

Part of our Value Partnerships Programs
What is Provider Delivered Care Management?

Primary care physicians lead multi-disciplinary care teams in the patient-centered medical home.

Care managers and qualified health professionals deliver services to patients with chronic conditions.

Expands traditional health-plan delivered care management; convenient for patient, maximizes existing relationships.

No diagnostic restrictions; available to adults and pediatrics; intervention includes groups, face-to-face, and phone visits.

PDCM expanding to selected specialists in July 2017, provided they meet program criteria.
### Provider Delivered Care Management: History

<table>
<thead>
<tr>
<th>2010-2012</th>
<th>2012-2016</th>
<th>2015-Present</th>
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</table>
| • PDCM Pilot  
• 5 regions across Michigan; 5 physician organizations; 50+ practices with 258 PCPs  
• Tested reimbursement, intervention, data exchange, effective models | • Michigan Primary Care Transformation Project (MiPCT); Michigan one of eight states in the Multipayer Advanced Primary Care Practice (MAPCP) demonstration Project  
• Over 1,900 physicians in 350 practices across MI, plus over 300 nurse practitioners and PAs  
• Ended on 12/31/16; practices then were “absorbed” into PDCM | • All PCMH designated physicians eligible to deliver care management and bill PDCM codes, effective 7/1/15 (ongoing process).  
• Practices meeting additional criteria may qualify for value-based reimbursement for PDCM (annual process)  
• Expanding to key specialists on 7/1/17 |
BCBSM’s Participation in Multi-Payer Initiatives

- Michigan Primary Care Transformation Project (2012-2016)
- State Innovation Model PCMH Pillar (2017-2019)
- Comprehensive Primary Care Plus (2017-2021)
MiPCT Participants

- 350 practices
- 37 Physician Organizations (POs)
- 1,953 PCPs
  - 303 are NPs and PAs
- 1.2 million patients
  - Medicare (16%)
  - Medicaid managed care plans (19%)
  - BCBSM (35%)
  - BCN (20%)
  - Priority Health (11%)
# 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>
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<tbody>
<tr>
<td></td>
<td>▪ Home care team</td>
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<tr>
<td></td>
<td>▪ Comprehensive care plan</td>
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<td></td>
<td>▪ Palliative and end-of life care</td>
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<table>
<thead>
<tr>
<th>Care Management</th>
<th>All Tier 1-2 services plus:</th>
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<tbody>
<tr>
<td></td>
<td>▪ Planned visits to optimize chronical conditions</td>
</tr>
<tr>
<td></td>
<td>▪ Self-management support</td>
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<tr>
<td></td>
<td>▪ Patient education</td>
</tr>
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<td></td>
<td>▪ Advance directives</td>
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<thead>
<tr>
<th>Transition Care</th>
<th>All Tier 1 services plus:</th>
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<tbody>
<tr>
<td></td>
<td>▪ Notification of admit/discharge</td>
</tr>
<tr>
<td></td>
<td>▪ PCP and/or specialist follow-up</td>
</tr>
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<td></td>
<td>▪ Medication reconciliation</td>
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<table>
<thead>
<tr>
<th>Navigating the Medical Neighborhood</th>
<th>▪ Optimize relationships with specialists and hospitals</th>
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<tbody>
<tr>
<td></td>
<td>▪ Coordinate referrals and tests</td>
</tr>
<tr>
<td></td>
<td>▪ Link to community resources</td>
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### PCMH Infrastructure

<table>
<thead>
<tr>
<th>Health IT</th>
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<tbody>
<tr>
<td>- Registry / EHR registry functionality *</td>
</tr>
<tr>
<td>- Care management documentation *</td>
</tr>
<tr>
<td>- E-prescribing (optional)</td>
</tr>
<tr>
<td>- Patient portal (advanced/optional)</td>
</tr>
<tr>
<td>- Community portal/HIE (adv/optional)</td>
</tr>
<tr>
<td>- Home monitoring (advanced/optional)</td>
</tr>
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<table>
<thead>
<tr>
<th>Patient Access</th>
</tr>
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<tbody>
<tr>
<td>- 24/7 access to decision-maker *</td>
</tr>
<tr>
<td>- 30% open access slots *</td>
</tr>
<tr>
<td>- Extended hours *</td>
</tr>
<tr>
<td>- Group visits (advanced/optional)</td>
</tr>
<tr>
<td>- Electronic visits (advanced/optional)</td>
</tr>
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<tr>
<th>Infrastructure Support</th>
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<tr>
<td>- PO/PHO and practice determine optimal balance of shared support</td>
</tr>
<tr>
<td>- Patient risk assessment</td>
</tr>
<tr>
<td>- Population stratification</td>
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<tr>
<td>- Clinical metrics reporting</td>
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*denotes requirement by end of year 1
Emphasis on Care Management Features Associated With Positive Outcomes

• Care delivery by multidisciplinary teams
• Care delivery in collaboration with PCP
• Attention to care transitions
• Medication reconciliation
• Both in-person visits and telephonic encounters
• Patient selection important - Risk stratification plus PCP input
Provider Delivered Care Management: Patient Selection and Engagement

• **Patient selection:**
  - Participating practices are provided with a claims-based patient list which includes risk score and utilization (inpatient, ED, etc.) information
  - Patients with “very high” risk score are flagged
  - Patients are selected for care management based on a combination of claims and clinical data, with PCP and team input

• **Patient engagement:**
  - Most successful if PCP encourages patient to participate in the program
  - Care management can be tailored to the member’s specific needs:
    - Registered Nurse, Social Worker, or Nurse Practitioner/Physician Assistant acts as “lead” care manager
    - Other team members include PharmDs, behavioral health, registered dieticians
  - Emphasis on patient goal-setting and self management support
  - Frequent communication between care team members and PCP
Michigan Care Management Resource Center (MiCMRC)

- Collaboration between BCBSM and University of Michigan
  - Additional funding from other payers through multi-payer projects
- Foundational curriculum, ongoing webinars, in-person sessions
- Mentoring system for care managers
- “Care Management Connection” monthly newsletter
- Facilitate “best practice” presentations
- Additional curriculum and toolkits:
  - Integrating Behavioral Health
  - Palliative care
  - Addressing Social Determinants of Health
- Over 800 care managers trained to date
- www.micmrc.org
Complex Care Management Training Curriculum

- Fundamentals of Complex Care Management
- Care Management – 5 Step Process
  - Screen, enroll, assess, manage, case closure
- Community resources
- Care transitions
- Care coordination
- Medication reconciliation
- Identification of High Risk Patients
- Specific Assessment Tools
- Health Plan Payment Policy
- Evidence based care
- Care Manager visit documentation tools
Michigan Data Collaborative (MDC):
Multi-Payer Database

Collect data from multiple Payers and aggregate it in one database

• Creates a more complete picture of a patient’s information when they:
  • Receive benefits from multiple insurance carriers
  • Visit physicians from different Practices, Physician Organizations or Hospitals

• Phase 1 – claims data

• Phase 2 - claims and clinical data
MAPCP Program Results: BCBSM

• BCBSM conducted a recent study on the PDCM program (January 2017). Practices included those participating in MAPCP.

• When examining a treatment group of 3,799 members versus a matched comparison group that also had 3,799 members, found the following results for 2014:
  – The treatment group had **$144.17 lower PMPM medical costs** than the comparison group
  – The treatment group had **37.9 fewer emergency department visits per 1,000 members** than the comparison group
  – The treatment group had **40 fewer inpatient admits per 1,000 members** than the comparison group
**MAPCP National Results: Medicare**

<table>
<thead>
<tr>
<th>State</th>
<th>MAPCP Demonstration states</th>
<th>Gross savings in Years One and Two</th>
<th>Total MAPCP Demonstration fees</th>
<th>Net savings in Years One and Two</th>
<th>Return on fee investment</th>
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<tbody>
<tr>
<td>New York</td>
<td>157,032</td>
<td>$12,637,119*</td>
<td>$3,258,078</td>
<td>$9,379,041</td>
<td>3.88</td>
</tr>
<tr>
<td>Rhode Island</td>
<td>60,214</td>
<td>$5,795,880</td>
<td>$1,093,374</td>
<td>$4,786,506</td>
<td>5.74</td>
</tr>
<tr>
<td>Maine</td>
<td>247,558</td>
<td>-$32,518,083</td>
<td>$7,238,571</td>
<td>-$39,756,696</td>
<td>-4.49</td>
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<tr>
<td>Minnesota</td>
<td>106,616</td>
<td>-$19,553,595</td>
<td>$1,258,309</td>
<td>-$20,811,903</td>
<td>-15.54</td>
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<tr>
<td>North Carolina</td>
<td>152,322</td>
<td>$9,955,916</td>
<td>$4,166,490</td>
<td>$5,789,426</td>
<td>2.39</td>
</tr>
<tr>
<td>Michigan</td>
<td>1,518,542</td>
<td><strong>$380,069,806</strong></td>
<td><strong>$43,964,835</strong></td>
<td><strong>$336,104,971</strong></td>
<td><strong>8.64</strong></td>
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<tr>
<td>Pennsylvania</td>
<td>217,997</td>
<td>$4,906,765</td>
<td>$3,916,170</td>
<td>$990,594</td>
<td>1.25</td>
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<tr>
<td>Vermont</td>
<td>381,814</td>
<td>$35,699,155</td>
<td>$8,603,828</td>
<td>$27,095,327</td>
<td>4.15</td>
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<tr>
<td>Total</td>
<td>2,842,095</td>
<td>$396,992,963</td>
<td>73,415,655</td>
<td>$323,577,266</td>
<td>5.41</td>
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Savings are for Medicare patients attributed to providers in the Michigan Primary Care Transformation Project (MiPCT) for 2012 and 2013. Study conducted as part of the national Multi-Payer Advanced Primary Care evaluation, of which Michigan was a participant from 2012-2016.

Source: Research Triangle Institute
New BCBSM Program - High Intensity Care Model

• BCBSM program designed to target high cost Medicare Advantage members
  – To date, implemented by 8 physician organizations (6 in SE MI, 2 in W MI)

• Builds on PCMH, PDCM and other population health strategies

• Clinical model based on Indiana University program: Geriatric Resources & Assessment for Care of Elders (GRACE)
  • Majority of services are home-based, delivered by dedicated teams composed of NP/RN & MSW
  • Additional team members include pharmacist, nutritionist, LPN, and medical director
  • Team has access to patient’s electronic health record and regularly confers with PCP
  • Comprehensive care plans include valuable information gathered from visits to the patient’s home, including family/caregiver input, that enhances PCP’s ability to manage patient

• Standardized Care Team training provided through MiCMRC
HICM Targeting Criteria

**Targeting method component 1:** chronic disease comorbidity
- Determine the number of chronic conditions each member has from a list of 35 chronic diseases.

**Targeting method component 2:** indicators of high utilization or poor care management:
- Number of acute inpatient hospital stays in 12 months
- Number of emergency department visits in 12 months, 0-30 days after which ≥1 of the following occurred:
  - Another emergency department visit OR an acute inpatient hospital stay
- Number of visits to a specialist in 12 months
- Number of distinct generic class numbers (GCNs) dispensed in 12 months
- Information from Medicare Advantage Health Assessment:
  - Member responded ‘fair’ or ‘poor’ to “In general, would you say your health is:’
  - Member reported needing help with activities of daily living
  - Member reported losing weight without trying over 6 months
- Facility + professional PMPM costs 24 months

**The two components are combined to develop a weighted risk score**
Early Evidence of Positive HICM Impact on Patients and Providers

- Participating Physician Organizations (POs) report HICM is having very positive impact:
  - Significantly improved medication adherence and management
  - Avoided repeat use of the ER
  - Avoided admissions and readmissions
    - One PO reported decrease in admissions among HICM engaged members from over 130/1000 to 20/1000, and decrease in ER admissions from 17/1000 to zero.
  - Strengthening patients’ relationship with PCP
  - Guiding patients into palliative care at an earlier point
- POs report high patient satisfaction and often dramatic impact on patients’ health and quality of life
- Care managers love HICM - very dedicated to patients
- Average program cost: $235 PEPM
- More data needed in order to perform robust evaluation