Agenda

• Overview of University of Michigan
• Population Management Evolution
• UM Approach & Strategy
• Future Direction
• Questions
University of Michigan Health System

- 1.9 million out-patient visits per year
- 45,000 hospital admissions per year
- 15 Primary Care Health Centers
- 4 Hospitals (990 licensed beds)
- 9,000 full-time-equivalent staff
- 1,700 faculty members
- 960 house officers / residents
- Home grown EMR / data warehouse converting to EPIC
UMHS Strategies to Address the Evolving Healthcare Landscape

• Manage payment reform demonstration projects (i.e. ACOs)
• Improve care coordination across UMHS
• Engage UMHS providers to transform care delivery
• Engage providers external to UMHS
• Collaborate with payers on payment reform efforts
Evolution of Population Management at UMHS

- **2012** Pioneer ACO: CMS
- **2012** Michigan Primary Care Transformation (MiPCT): Multiple
- **2011** PGP Transitions Demonstration Project: CMS
- **2009** Performance Recognition Program: BCN
- **2008** Speaking Together: RWJ
- **2006** GME Chronic Care & Quality: AAMC-AHRQ
- **2005** Physician Group Incentive Prg: BCBSM
- **2005** Chronic Care Collaborative: AAMC
- **2004** Physician Group Practice (PGP) Demonstration Project: CMS
- **2002** Prescribing Pilot: BSBSM

- **2012** Population Health
- **2008** Quality Management Program
- **2005** Faculty Group Practice assumes out-patient ownership
- **2003** 5 MMC Disease Management Programs receive approval by JCAHO
- **2002** iCARE† – pharmacy initiatives
- **1998** GUIDES – measurement/implementation
- **1998** Medical Management Center (MMC)
- **1996** GUIDES* – guidelines development

* GUIDES = Guidelines Utilization, Implementation, Development and Evaluation Studies
† iCARE = Improving Care with Appropriate, Responsible, cost-Effective prescribing
Physician Group Practice (PGP) Demonstration Project

- Geisinger Clinic
- Marshfield Clinic
- The Everett Clinic
- St John’s Health System
- Deaconess Billings Clinic
- The University of Michigan
- Dartmouth-Hitchcock Clinic
- Park Nicollet Health Services
- Forsyth / Novant Medical Group
- Integrated Resources (Middlesex)


- Designed to encourage increased care coordination, improved quality, and decreased costs in the context of fee-for-service reimbursement model for Medicare beneficiaries
- Large, multi-specialty group practices selected for participation
- Sites eligible for savings bonus of up to 80% of total cost savings over 2% if quality targets met with variable cost / quality weighting over the duration of the project
  - Year 1 cost/quality weighting 70%/30%; Year 2 - 60%/40%; Years 3 to 5 - 50%/50%
- PGP demonstration sites serves as a model for ACO structure and reimbursement
- 5,000 Physicians and 224,000 Medicare Beneficiaries
## PGP & Transition Demonstration Results

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<tr>
<th></th>
<th>PGP Demo</th>
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<tbody>
<tr>
<td></td>
<td>2006</td>
<td>2007</td>
</tr>
<tr>
<td>Total Target Expenditures</td>
<td>$11,881</td>
<td>$12,679</td>
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<tr>
<td>Total Actual Expenditures</td>
<td>$11,473</td>
<td>$12,344</td>
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<tr>
<td>Total Target Minus Actual</td>
<td>$408</td>
<td>$334</td>
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<tr>
<td>Percent Savings</td>
<td>3.40%</td>
<td>2.60%</td>
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Reasons to Pursue Pioneer ACO

- Multiple care coordination and quality interventions in place due to experience in PGP and Transition Demo
  - Transitional Care program
  - Complex care management
  - Post-acute clinical programs
  - Strong primary care medical home effort (MIPCT)
  - Quality Management Program

- Strong institutional leadership support; ACO is key component of UMHS strategic plan

- Strong physician/institutional culture supporting evidence-based care

- Partnership with high quality regional PO: will improve care of co-managed patients and IHA will manage their aligned patients well

- Blue Cross of Michigan is interested in the ACO concept – developing an Organized System of Care concept
UMHS Accountable Care Organization Development

- Home Care Services
  - Sub-acute care
- Public Health Safety Net Clinics
- Hospital Care
- Specialty Care
- Patient Centered Medical Home
- Primary Care
- Data and Analytics
UM Initial Focus

• Target the highest cost, most complex cases first
  – Complex Care Management Program
  – Outpatient Case Management
  – Inpatient-Outpatient Transition Management
  – Mental Health Care Coordination

• Primary Care Engagement
  – Patient Centered Medical Home
Improving Care Coordination Across UMHS

**Michigan Primary Care Transformation Project (MIPCT)**

- Embedded Care Navigators in all primary care ACUs
  - Follow patients as they transition from hospital to home
  - Work closely with complex patients to manage their chronic illnesses

**Inpatient care management initiative**

- UMHS is transitioning from a centrally-based discharge planning program to a unit-based discharge planning program

**Complex care management program**

- Case managers work with the most complex patients in UM (uninsured, homeless, physically and psychologically impaired, etc.)
Engaging UMHS Providers to Transform Care Delivery (1)

Specialty Engagement

• Cardiology
  – Improving rates for cholesterol screening (BPA, external lab process, reporting)
  – Collaborating with existing workgroups to offer PM or analytic assistance (Heart Failure re-admissions, Arrhythmia coordinated management and Cardiology care management)

• Nephrology
  – Improving primary care utilization and decreasing inappropriate ED utilization for dialysis patients

• Oncology
  – Develop a process for chemotherapy consents
  – Code status conversations with patients
Engaging UMHS Providers to Transform Care Delivery (2)

Clinical decision support for population management

• Optimize decision support tools in MiChart to improve chronic care management and preventive services

• Provide supportive mechanisms for providers, panel managers and support staff to remind of care needs

• Maximize financial incentives for delivery of evidence based care

• Continue to educate physicians to use clinical decision support
Engaging providers external to UMHS

Skilled nursing facility collaboration
- Establish relationships with local SNFs to reduce LOS and increase quality, communication

Collaboration with local providers
- Collaborative relationship through ACO, OSC
- Identifying opportunities for community advance care planning collaboration

Acute Care for Elders (ACE) Unit
- Specialized inpatient unit at local community hospital for UMHS geriatric patients
  - Run by UM geriatricians, staffed by local hospital clinicians
Collaborating with payers on payment reform efforts

**PremierCare**
- Currently working with PremierCare to take on full responsibility/risk for the health and outcomes of all University of Michigan employees

**SilverScript Partnership**
- Collaboration with SilverScript (CVS) on a Part D shared savings project
UMHS ACO Future

• Continue to engage specialists
  – Geriatrics
  – Psychiatry
  – Pulmonology
  – Emergency physicians

• Continue to work with community partners
  – Subacute rehab/skilled nursing
  – Hospice/Palliative Care
  – Homecare agencies

• Initiate homecare visit for Complex care management program

• Transition to POM ACO starting 1.1.14
Physician Organization of Michigan Accountable Care Organization (POM ACO)

**POM-ACO Medical Groups (2013)**
- Advantage Health Physicians (386)
- Crawford PHO (77)
- Lakeshore Health Network (356)
- Oakland Southfield Physicians (233)
- Olympia Medical (191)
- United Physicians (805)
- Physicians of West Michigan (344)
- Wexford PHO (395)
- University of Michigan (Specialists)

* Not part of an ACO / Shared Savings Program

- Medicare Pioneer ACO (UM and IHA)
- BCBSM Organized Systems of Care (UM, IHA and HVPA)
- CMS Shared Savings Program (POM-ACO)
- Mid-Michigan Health Plan * (UM and Mid-Michigan)
Transition from Pioneer to MSSP

- UMHS fully supports transformation efforts by CMS
- Administratively align UM ACO programs
- Benefits:
  - Risk adjusted methodology
  - No IME costs included in performance measures
  - No impact on institutional strategy to develop capability to compete in alternative payment contracts
  - Increases partnership with physicians across MI
Lessons Learned

- **Culture** – change in mindset from project to new way of delivering care

- **Leadership** – buy-in and prioritization of efforts & corresponding resources

- **Communication** – leaders and local providers

- **Implementation** – data perfection limits operational performance

- **Patient Engagement** – develop mechanisms to reach out to patients (e.g. opt outs)

- **Analytics** – must be capable of processing data & develop leadership and actionable reports
Suggested Initial Areas of Focus for MSSP

- Readmissions
  - Duals
  - Disabled
- High utilizers
- Sub-acute facilities
- Home Health
- Hospice
- Ambulance expenses
Contact Information

Linnea C. Chervenak, MHA
Administrative Director, Population Health Office
University of Michigan

Phone: (734) 647-7493
Email: linneac@umich.edu