VALUE Partnerships
Improving Health Care in Michigan

The Continued Evolution of the Patient Centered Medical Home: Provider Delivered Care Management and the Patient Centered Medical Neighborhood - An Update from Michigan

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Overview of BCBSM

- Serving **4.4 million** Michigan members and over **1.2 million** out of state members
- More than **7,000** employees state-wide

- Michigan Blues have largest network in the state
  - More than **156 hospitals** *(100% of all MI hospitals)*
  - Nearly **30,000 physicians** *(95% of all MI physicians)*

- In 2012, BCBSM paid **$18.6 million** in claims to doctors, hospitals and health care providers

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Our Goal: Improve Care for Members and Increase Value for our Customers

$$\text{Value} = \frac{\text{Patient Experience} + \text{Quality}}{\text{Cost}}$$

Phase I: PGIP (2005- present)
"Building the PCP Foundation"

BCBSM infrastructure support: "pay for participation"

Initial focus

- ✓Connect physicians with Physician Organizations
- ✓Engage POs in PGIP
- ✓Address chronic care challenges
- ✓Increase generic Rx use
- ✓Implement e-Prescribing
- ✓Improve performance on HEDIS measures
- ✓Address excessive radiology use

Phase II: PCMH (2008 - present)

"Transforming Primary Care to Focus on Population Health"

PCPs across Michigan rewarded for developing practice-level infrastructure to support PCMH model via **12 PCMH Domains of Function** (140 capabilities) which leads to:

Improved Quality,
Reduced Inefficiency
and
Improved PMPM

What is a Patient Centered Medical Home in 20 Words or Less?

Core Features

- Personal Physician
- Physician-directed Medical Practice
- Whole Person Orientation
- Care is Coordinated and Integrated
- Quality and Safety
- Enhanced Access
- Payment Reform

BCBSM's PCMH Program Goals

#1 Reward implementation of PCMH capabilities

PCMH Domains of Function (and number of associated capabilities)
Patient-provider partnership (8)
Patient registry (18)
Performance reporting (13)
Individual care management (18)
Extended access (9)
Test tracking and follow-up (9)
Electronic prescribing
Preventive services (8)
Linkage to community services (8)
Self-management support (8)
Patient web portal (12)
Coordination of care (9)
Specialist referral process (10)

#2 Reward performance that comes from successful implementation

Quality

- **Evidence Based Care and Preventive Services** – reflects use of patient registries and proactive practice teams

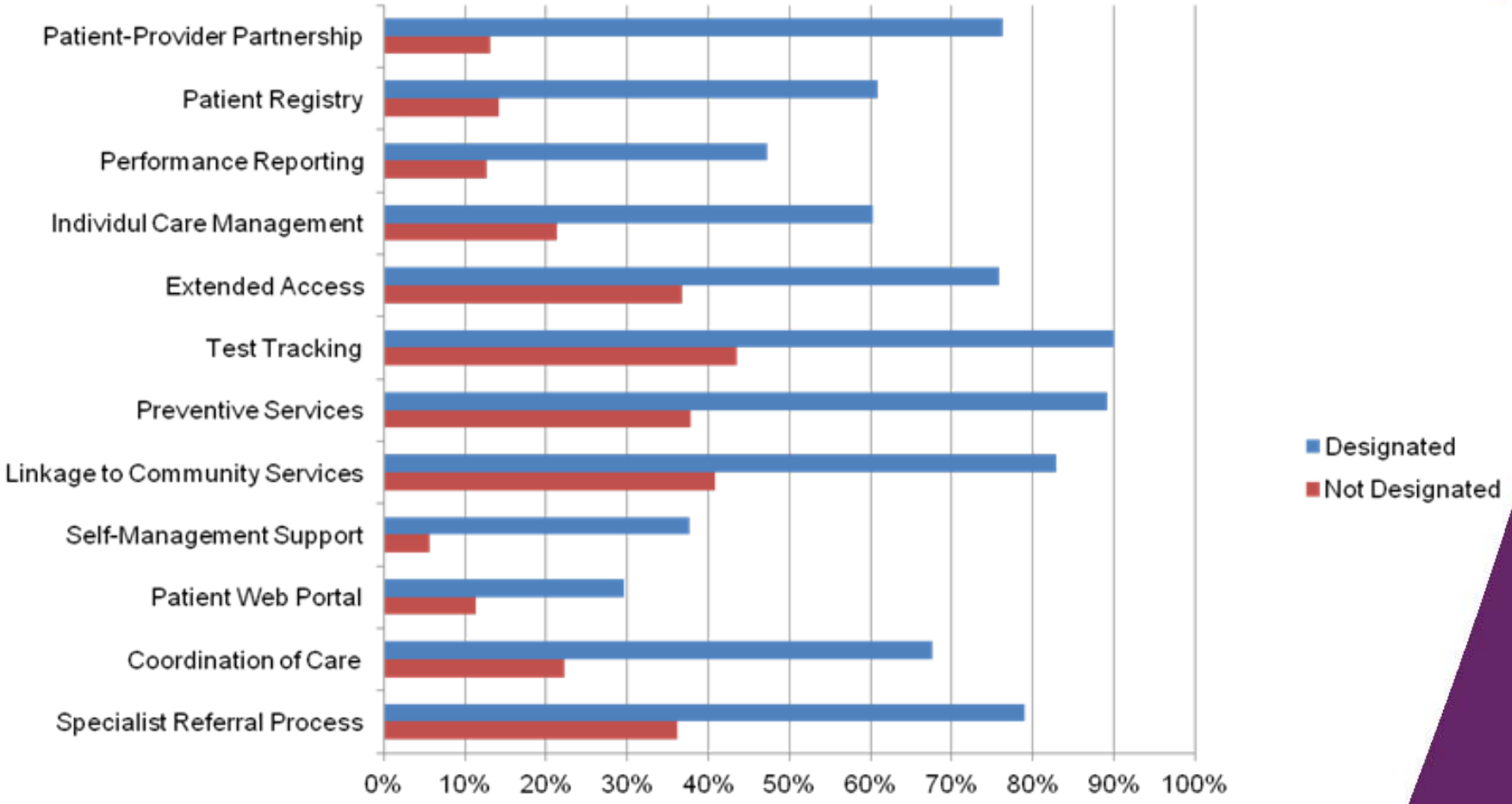
Use

- **Emergency Department (ED) Visits for Primary Care Sensitive Conditions** – reflects improved patient access to care
- Imaging Use – reflects judicious use of ancillary services

Efficiency

- **Generic Drug Use** – reflects efforts to better manage healthcare resources

Percent of PCMH Capabilities Fully in Place by Initiative for Designated and Not-Designated Practice Units in 2013



*For the "not designated" cohort, only PCMH Designation eligible practice units were included in the analysis; practices not functioning as primary care providers are excluded.
**SOURCE: Winter 2012 SRD

PCMH Designated Practices = High Performing Practices

Metric	PCMH Designees Compared to Non-PCMH Practices		
	Year 3 Designation (2011)**	**Year 4 Designation*** (2012)**	**Year 5 Designation**** (2013)**
	776 practices **2,552 designated physicians** **820,000 attributed BCBSM members** *(54.6% increase in practices and 39.0% increase in physicians over 2010)*	**995 practices** **3,017 designated physicians** **1.08M attributed BCBSM members** *(28.1% increase in practices and 18.2% increase in physicians over 2011)*	**1,244 practices** **3,624 designated physicians** **1.12M attributed BCBSM members** *(24.6% increase in practices and 19.8% increase in physicians over 2012)*
Adults (18-64)	**2010 Data°**	**2011 Data°**	**2012 Data°**
Emergency department visits (per 1,000)	**-9.7%**	**-9.3%**	**-8.8%**
Primary care sensitive emergency department visits (per 1,000)	**-11.2%**	**-11.3%**	**-11.2%**
Ambulatory care sensitive inpatient discharges (per 1,000)	**-22.1%**	**-23.8%**	**-19.1%**
High tech radiology services (per 1,000)	**-7.5%**	**-8.3%**	**-7.3%**
High tech radiology standard cost PMPM	**-5.0%**	**-4.3%**	**-3.1%**
Low tech radiology services (per 1,000)	**-4.9%**	**-7.3%**	**-6.7%**
Low tech radiology standard cost PMPM	**-5.1%**	**-7.4%**	**-5.6%**

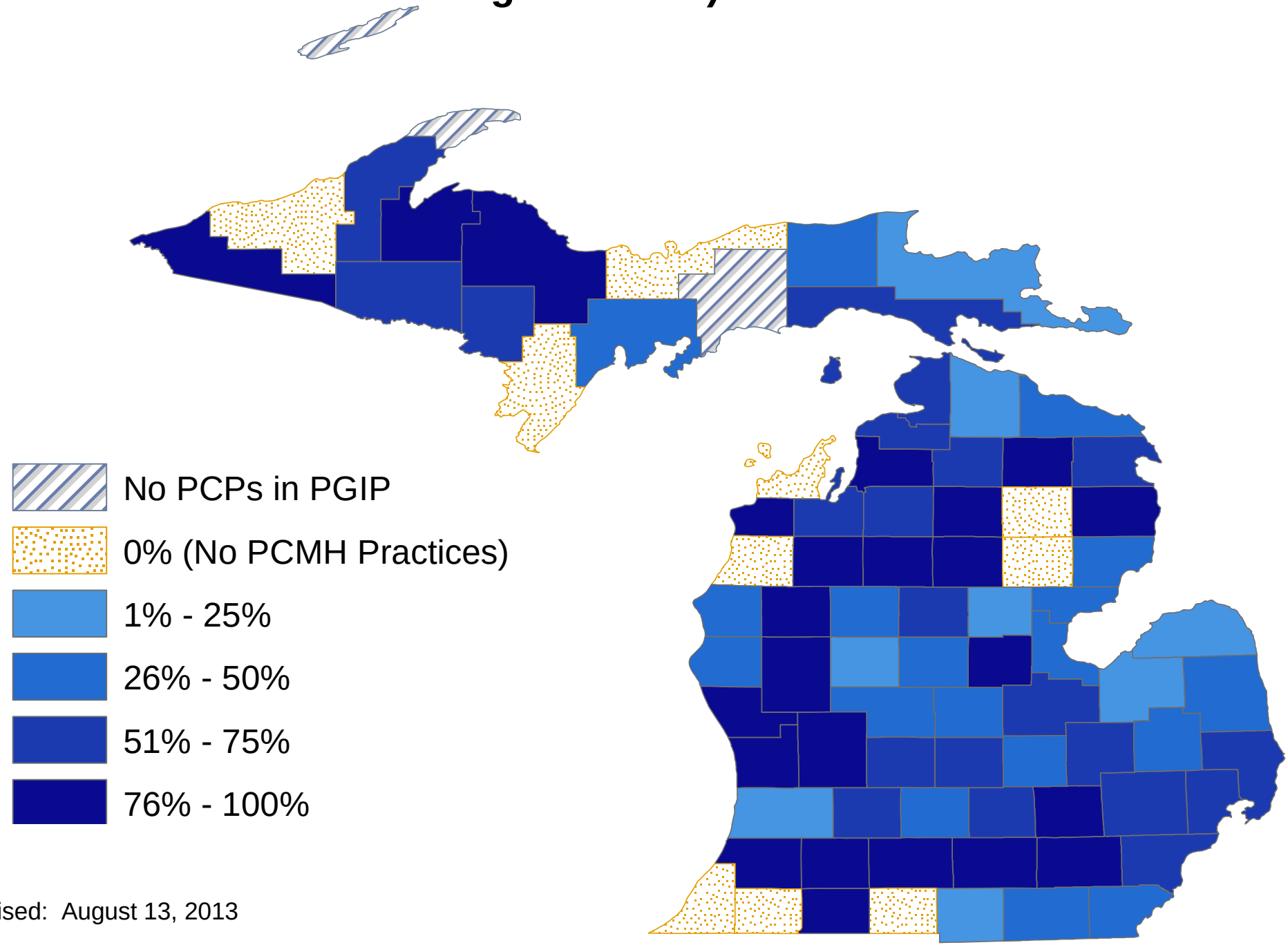
**Year 3 Designation: July 2011 – June 2012
***Year 4 Designation: July 2012 – June 2013
****Year 5 Designation: July 2013-June 2014
°Same time period of claims data used for determining designation

Designated Practices: Impact on Patient Experience

When PCMH program began, majority of PUs started with minimal level of PCMH capabilities in place. PCMH Designated practices have made great progress in implementing capabilities that support patients.

- **Over 99% of PCMH designated practice units have**:
  - All test tracking steps documented in the patient's medical record
  - Patients informed about abnormal test results
  - Medication review and management for all patients with chronic conditions
  - Directories of specialists and community resources are kept up-to-date for patient referral purposes
  - Staff training about PCMH/practice transformation concepts
  - 24-hour access to a clinical decision-maker
  - Systematic approach to providing tobacco use assessment tools and smoking cessation advice
  - And many more….

Percent of PCPs in 2013 PCMH-Designated practice units (as a percent of total participating Physician Group Incentive Program PCPs)

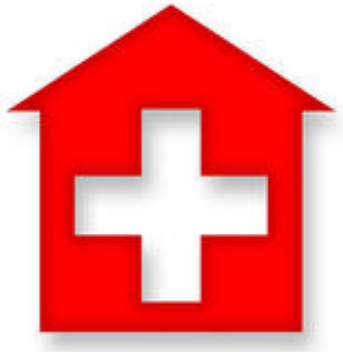


Revised: August 13, 2013

Phase III: Provider Delivered Care Management (2010 - present)

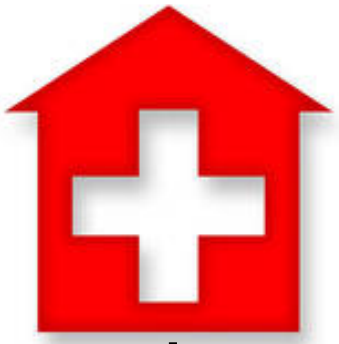
"Enhancing PCP care by expanding services"

PCMH designated



PCMH + PDCM

PCMH designated



PCMH + PDCM

PCMH designated

PCMH + PDCM

PDCM = Care mgt. delivered in PCPs office by highly-qualified **care managers** in conjunction with PCP & clinical care team

Non-PGIP PCPs

PGIP PCPs

Provider Delivered Care Management

Overview

- PDCM is rooted in the BCBSM Patient Centered Medical Home program
- Care management traditionally delivered by the health plan; now also available in the office setting for select PCMH designated homes
  - Patients have trusted relationship with PCP
  - Literature suggests favorable outcomes and engagement
- Proactive approach to managing patients with chronic conditions
- Projected ROI of 1:1 in year one, increasing to 2:1 (or better) in years two and three (no performance guarantees available because program is so new)

PDCM: Real World Impact

- Dawn K., actual PDCM Care Manager
- Working with “Mr. M,” a patient with type 2 diabetes
  - Did not follow diet or check glucose levels;
  - minimal social supports;
  - condition was uncontrolled
- Dawn worked 1:1 to provide basic diabetes education, followed up on glucose testing and med reconciliation to ensure compliance
- Mr. M has since lost weight, regularly checks glucose, and takes medications
  - Improved quality of life
  - Less risk of having a critical health event
- Quote from Mr. M:

  “This is exactly what I needed to get and stay on track!”

CMS Demonstration Project: MiPCT

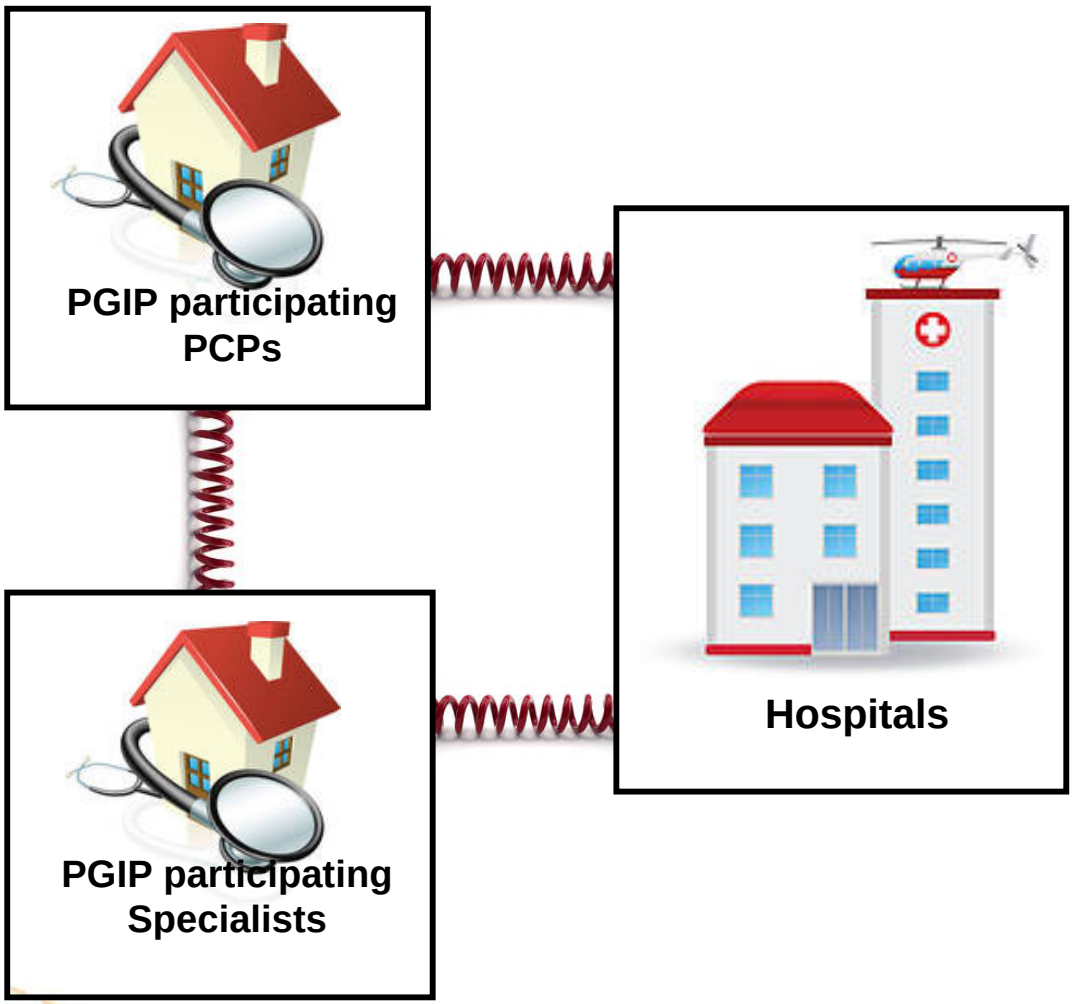
- PDCM was piloted for 2 years ("Phase I") then linked to MiPCT project ("Phase II")
- Phase I (5 POs) ran from 2010-2012; Phase II runs from 2012-2014
- Michigan Primary Care Transformation project (MiPCT)
  - CMS-supported *Multi-Payer Advanced Primary Care Practice* demonstration project
  - Michigan one of eight states participating; *our cohort comprises 50% of participants nationally*
- Phase II includes approx. 1,560 physicians in 380 practices across MI
  - All practices have been "PCMH Designated" for past four years
  - Providers working with care managers tend to be more sophisticated
    - More PCMH capabilities in place, strong performance on Q/U/E
- PDCM *will continue* even when MiPCT project ends on 12/31/14

PCMH & PDCM: Results Overview

- PCMH Designated physicians consistently perform well on measures of quality, utilization, and efficiency
- PCMH demonstrated savings of $155M over first three years of program
  - 2008-2011 program years certified by BCBSM Actuary
  - 2012 data will be certified later in 2014 (lag time due to claims run-out and publishing restrictions from academic journals)
- For a practice that has fully implemented PCMH, expected cost savings of $26.37 lower PMPM adult medical costs
  - Per *Health Services Research* article (July 2013)
  - Caveat: No practice has yet accomplished full capability implementation
- PDCM practices have 6% lower cost for adult population compared to non-PDCM practices

Paustian et al. "Partial and Incremental PCMH Practice Transformation: Implications for Quality and Costs." *Health Services Research*. 2013 Jul 5. Epub

Phase IV: PCMH-N + Organized Systems of Care (2012 - present)
"Building Connectivity to Improve Population Health"



PCMH – Neighborhood
(the Specialists)
• 140 PCMH Capabilities

Organized Systems of Care Initiatives (3)
•Integrated Patient Registry
• Integrated Performance Measurement
• Integrated Processes of Care

Hospital
•Admission, Discharge & Transfer (ADT) Initiative
(2013 - present)

BCBSM's PCMH Neighbor Efforts

1. Incorporates American College of Physicians et al concept of "PCMH Neighbor". PCMH-N:
   - Ensures **effective communication**, **coordination**, and **integration** with PCMH practices
   - Provides **appropriate** and **timely consultations** and **referrals** that complement and advance the aims of PCMH practices
   - Defines **roles** and **responsibilities** of PCPs and specialists in caring for patient
2. Expanded PCMH Interpretive Guidelines to incorporate specialist-specific expectations
   - PCMH Initiatives have always been open to participation by specialists, new Guidelines explicitly address specialist role in each domain
3. Developed sample Primary Care-Specialty Care Agreement

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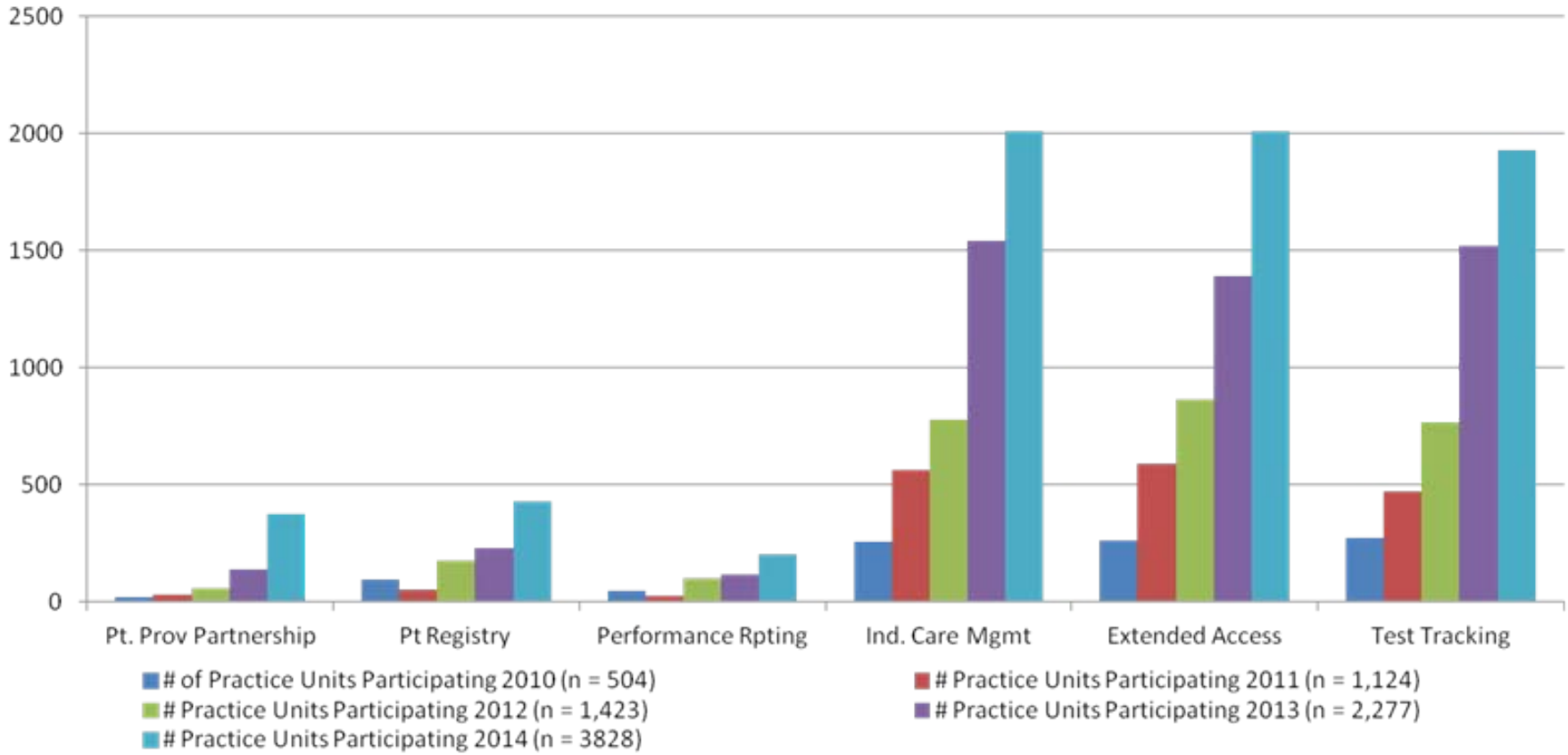
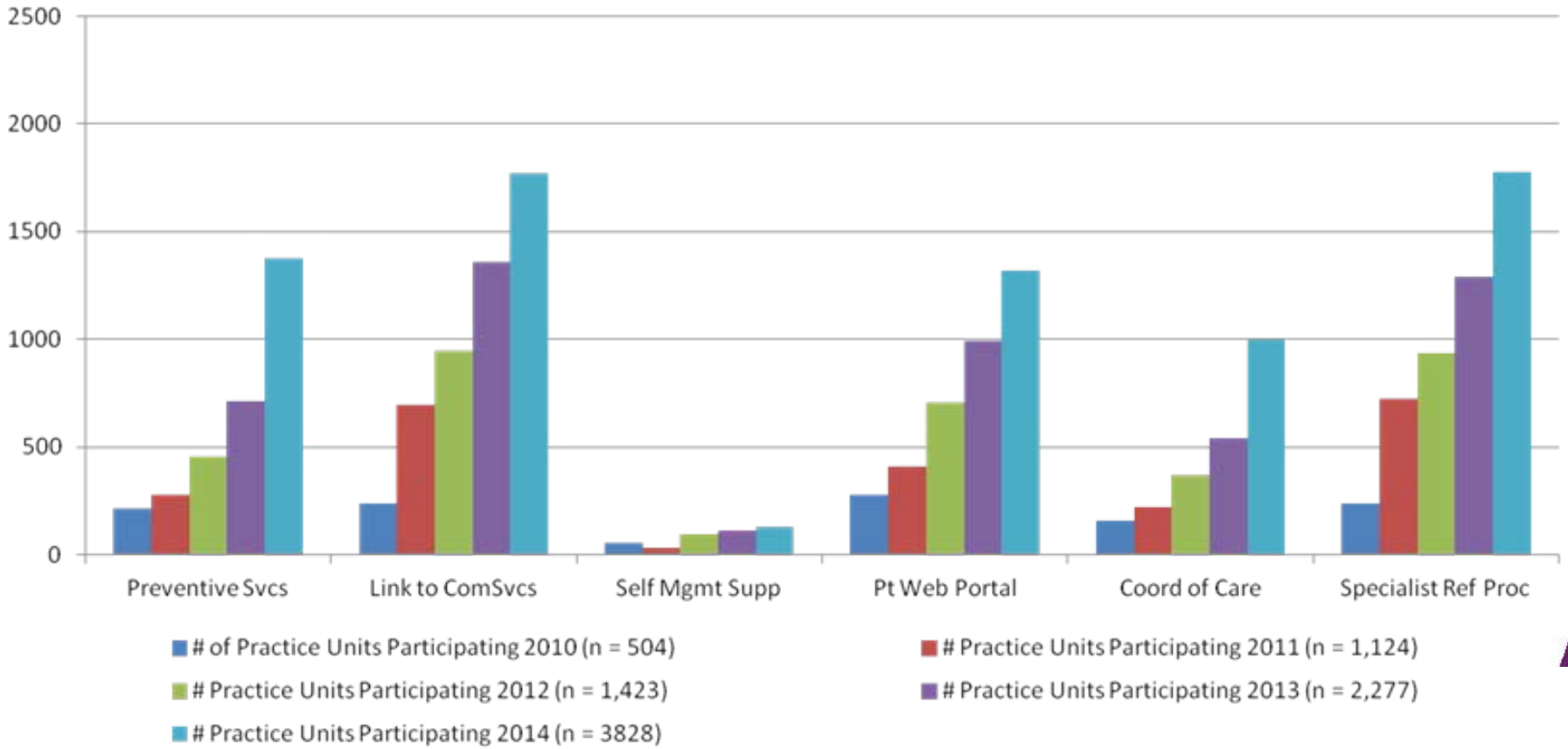
Specialist Engagement in PCMH-N

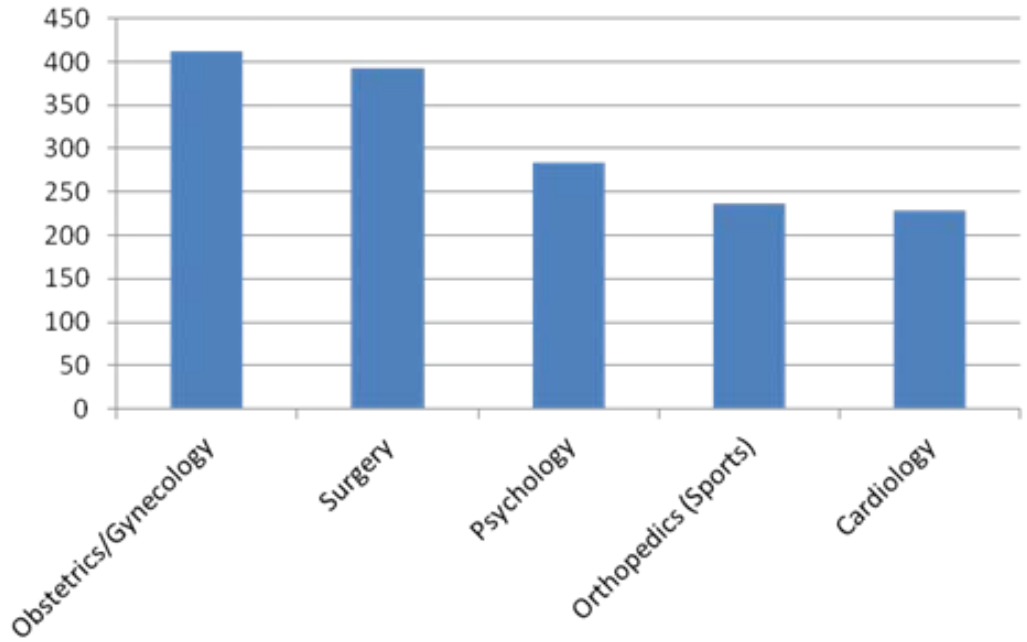


Specialist Engagement in PCMH-N *contd*



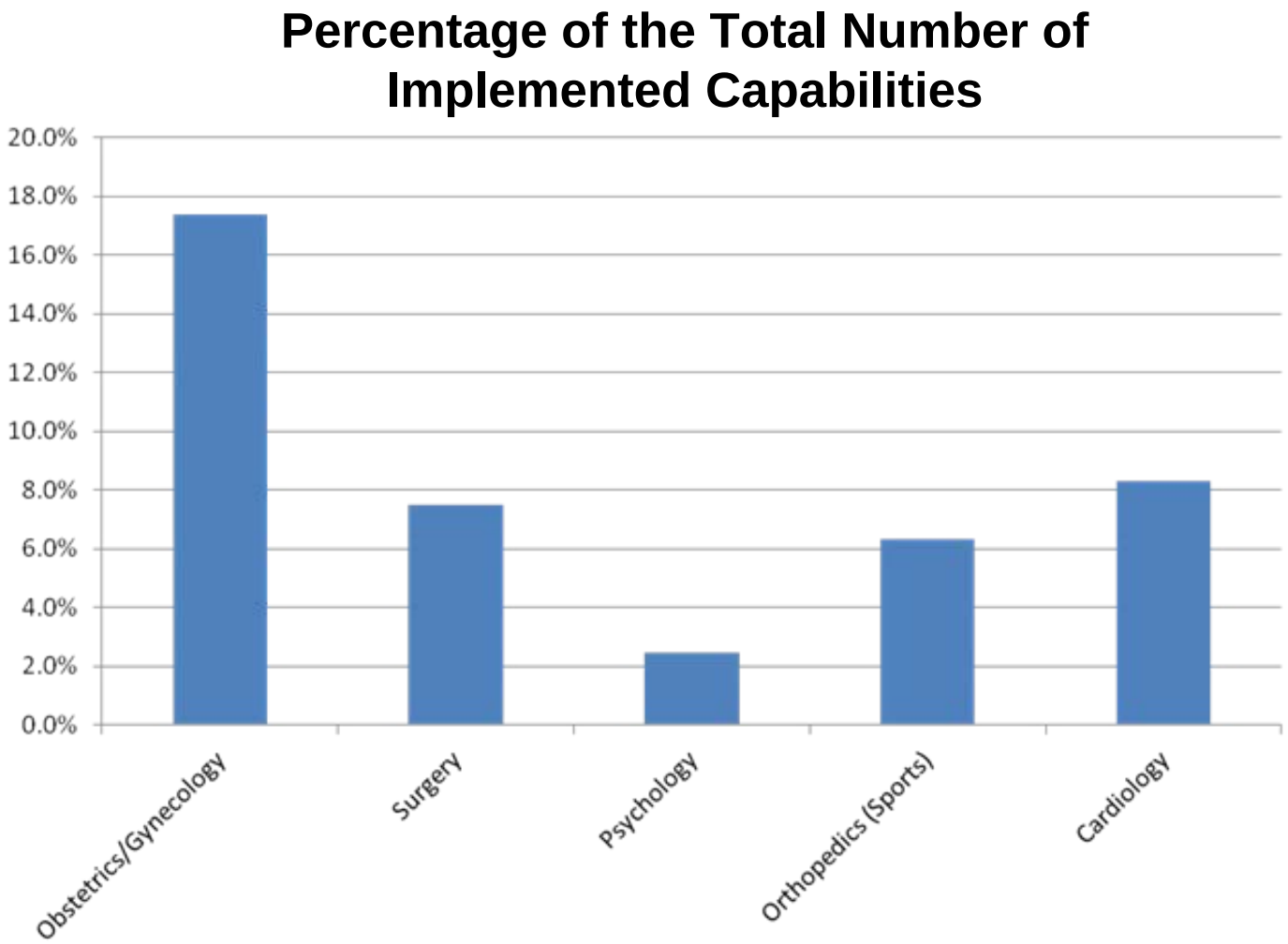
Five Highest PCMH-N Participating Specialty Types in 2014

1. Obstetrics/Gynecology
2. Surgery
3. Psychology
4. Orthopedics (Sports)
5. Cardiology



* Used total count of PGIP specialists (n = 12,085) as denominator

Capability Implementation by Highest Participating Specialty Types



Organized Systems of Care

- Goal: Decrease fragmentation of care and encourage communities of caregivers to provide integrated, coordinated, efficient care to a PCP-attributed patient population
- 39 OSCs in Michigan comprised of 4,300 PCPs and 9,500 specialists caring for 1.3 million BCBSM members
- Similar to PCMH, there is significant need for infrastructure development. 42 possible OSC capabilities to implement
- Since data collection began in 2012, all of the OSCs have begun implementing OSC capabilities
- Percent of OSCs Implementing at least one capability:

Integrated Patient Registry (23 capabilities)	Integrated Performance Measurement (7 capabilities)	Integrated Processes of Care (12 capabilities)
100%	70%	16%

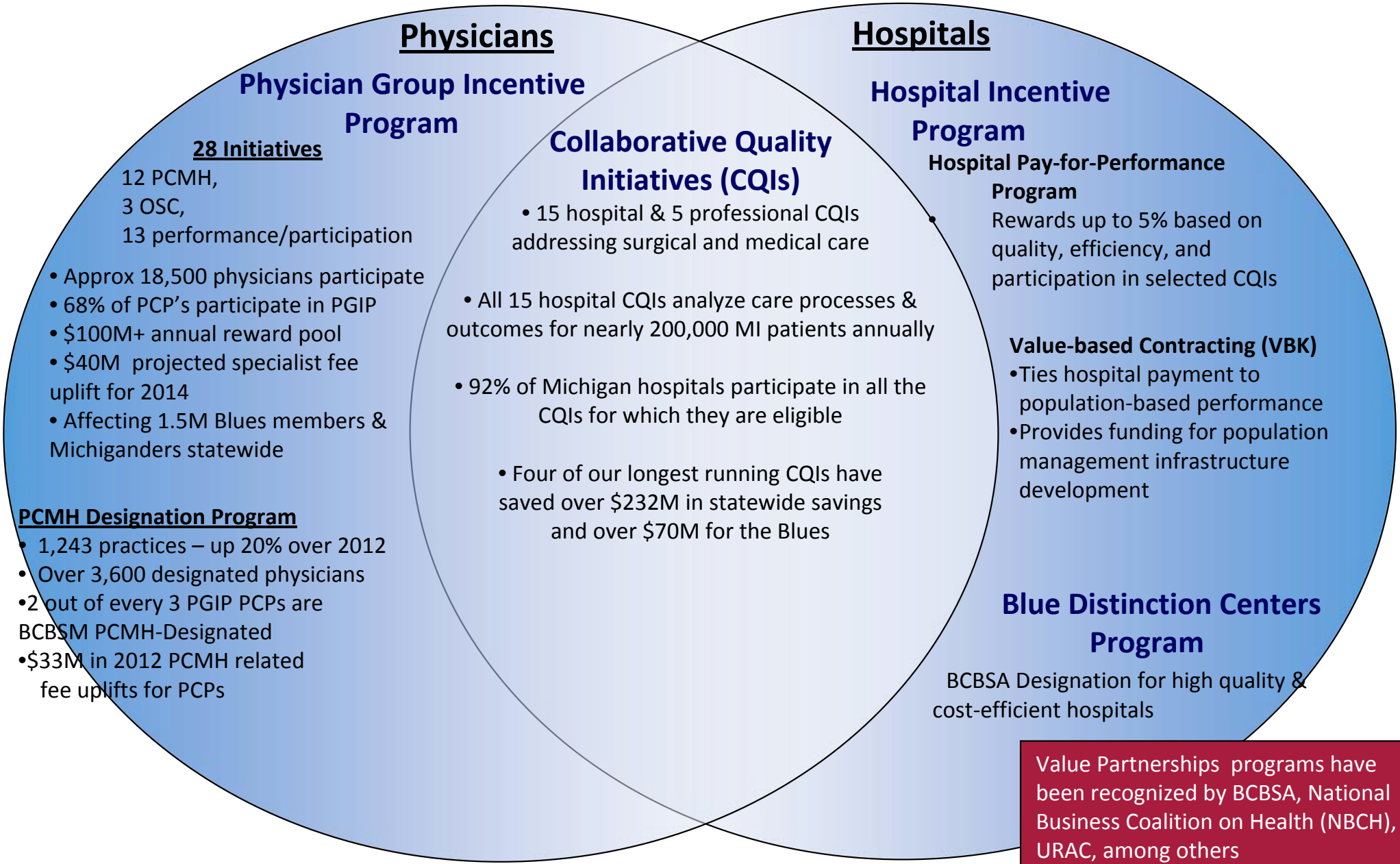
Statewide Notification Service for Admission, Discharge, Transfer and ER Visits

- Uses existing health information exchange capabilities to
  - Receive all-patient, real-time ADT notifications from each hospital
  - Match each notification against a patient-provider relationship file
  - Send the notification to the patient's caregivers
- Blue Cross incentive payments used to promote provider participation
  - Support to hospitals sending all-patient notifications
  - Support to physician organizations sending updated patient-provider lists
- Practitioners are able to receive a comprehensive daily census report for their patients, regardless of payer or hospital the patient uses
- Expected outcomes include improved care transitions and reduced readmissions
- Current and projected hospital participation rates*

Feb 2014	Jul 2014	Dec 2014	Mar 2015
13 hospitals 28% of admits	35 hospitals 67% of admits	48 hospitals 82% of admits	82 hospitals 100% of admits*

*Excludes small rural hospitals

In Closing: Value Partnerships, Moving from a FFS to Fee For Value Environment



Value Partnerships programs have been recognized by BCBSA, National Business Coalition on Health (NBCH), URAC, among others

Questions?

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