Michigan Summary of Care Report

Patient-Centered Medical Home Neighborhood Approaches to Chronic Disease Care

4th Edition

Presented by

SANOFI

2014–2015
**Purpose:**
To focus on the specific patient care strategies used by physician groups that have implemented a patient-centered medical home delivery model. This 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.

**Introduction**
The *Michigan Summary of Care Report*, now in its fourth edition, highlights the care management strategies implemented by three leading physician groups across the state of Michigan. These featured medical groups operate as patient-centered medical homes (PCMHs), using coordinated care models and other strategies to improve health care delivery and outcomes through enhanced access, care management and monitoring.

The groups participating in this 2014–2015 report use a range of tools—from high-tech patient tracking, reporting and registries to a more traditional, personalized doctor-patient relationship—all to improve the health and health care for chronic disease patients in their practices. Although the traditional focus of PCMHs is on primary care, in order to form the broader PCMH neighborhoods (PCMH-Ns), provider groups must integrate a number of community resources, including:

- Specialists
- Acute, post-acute and ambulatory care
- Pharmacy and diagnostic services
- State and local public health and other community resources

The success of the PCMH-N model depends on (1) ensuring effective communication, coordination and integration with PCMH practices, including the flow of patient care information; (2) providing appropriate and timely consultations and referrals that complement and advance the aims of the PCMH practices; and (3) clearly defining roles and responsibilities of primary care physicians and specialists in caring for the patient. This report showcases the steps these innovative practices are taking to ensure success in this emerging model of patient care.
Welcome

At Blue Cross Blue Shield of Michigan (BCBSM) our 10-year partnership with primary care physicians (PCPs) and specialists under the Physician Group Incentive Program (PGIP) continues to transform the delivery of primary health care in Michigan. But our work is not done. We are increasingly expanding our focus to PCPs’ relationships with specialists and their vital role in the delivery of specialty health care as patient-centered medical home neighbors (PCMH-Ns).

Physician organizations play a key role in engaging specialists in PGIP. Physician organizations are tasked with educating their specialists on how to participate further as active members of the community of caregivers, how to achieve clinical integration, and how to share accountability for population management.

There are abundant opportunities for specialists to collaborate with their PCP and specialist peers in the development and implementation of structured approaches to referrals and information sharing. In addition to several specialist-focused PGIP performance initiatives like Cardiac Care, Radiology Management and Emergency Department Utilization, the PCMH program has recently expanded to integrate the role of specialists and sub-specialists into the PCMH-Neighbor (PCMH-N) model—a cornerstone of building Organized Systems of Care (OSCs).

Goals

The goals of the PCMH-N model are for PGIP-participating specialists to:

- Clearly define roles and responsibilities of primary care physicians and specialists in caring for the patient
- Ensure effective communication, coordination and integration with PCMH practices, including appropriate flow of patient care information
- Provide appropriate and timely consultations and referrals that complement and advance the aims of the PCMH practices

Performance-Based Fees

BCBSM initially introduced performance-based specialist fee uplifts in 2012. The specialist fee uplifts are designed to:

- Take steps toward further transformation of reimbursement from traditional fee-for-service to fee-for-value
- Accelerate specialist engagement in PGIP
- Encourage conversations and collaboration between specialists and PCPs
- Accelerate the adoption of PCMH-N principles
- Support and promote OSCs
- Assess and improve population-based metrics of performance

The number of specialty types eligible for fee uplifts has expanded significantly since 2012. As of February 2015, over 95% of specialty types were eligible for a fee uplift. Specialist fee uplifts reward specialty practices that are associated with communities of caregivers who provide high-value care to shared populations of patients.

Total Health

At BCBSM, we believe in increasingly rewarding providers for managing the total health of individuals in a manner that is patient-centered, highly coordinated and cost-effective. Through our PCMH and PCMH-N programs, our value-based provider contracting strategy and other initiatives, we are supporting the transformation of health care delivery to achieve these goals, strengthening the doctor-patient relationship, and avoiding decisions that lead to fragmented care and poor outcomes—all with a well-informed, and increasingly engaged, consumer leading the way.

Tom Leyden, MBA
Director II, Value Partnerships
Blue Cross Blue Shield of Michigan
MedNetOne Health Solutions

Based in Michigan, serving Southeast Michigan

MedNetOne Health Solutions is a full-service health care provider group with nearly 800 provider members, including primary care physicians (PCPs) and behavioral health and other specialists. MedNetOne facilitates a patient-centered medical home neighborhood (PCMH-N) focus among physician member practices to advance the care of chronic disease patients through a variety of initiatives, one of the most successful being the incorporation of behavioral health services into primary care. To that end, two MedNetOne physician practices have partnered with psychologist Michelle McGarrity, MA, LLP, an on-site behavioral health specialist, to help identify and remove barriers to effectively care for patients with diabetes and other chronic illnesses. This PCMH neighborhood, much like others, uses a registry to track disease-condition specific individual and population-based information, which helps identify gaps in care and supports care management.

Incorporating Behavioral Health

- Physicians and the care team use a non-threatening, “warm hand-off” to introduce McGarrity and her services, framing the encounter as routine and something done with all patients. This shared medical visit approach translates to improved care management and coordination.
- McGarrity evaluates patients for depression and other behavioral health issues, and incorporates “motivational interviewing”—ensuring that patients are motivated intrinsically to work on self-care, adherence and other health care decisions.
- Team “huddles” bring together the physician, the medical assistant, the behavioral health specialist and other care support members to develop a patient-centered plan that addresses each individual case.

Results

- Of MedNetOne diabetes patients with an A1c level at or above 8%, the average A1c level before such patients’ first behavioral health intervention was 9.3%; after behavioral health intervention, this average A1c level declined to 8.8%.

Michigan Type 2 Diabetes Patients

In 2013, the percentage of Michigan Type 2 diabetes patients who received at least one A1c test (77.0%) topped that of the nation (74.2%). These patients were also significantly less likely to have at least one emergency department (ED) visit from 2011 to 2013 (9.0%) than those nationally (15.9%). Similarly, the average number of ED visits per Type 2 diabetes patient during the same time was 50% higher across the nation (2.4) than it was in Michigan (1.6). Despite this progress, Michigan still faces challenges. For instance, from 2011 to 2013, the shares of patients with uncontrolled A1c levels grew to 18.1% from 16.3% and exceeded the national averages in each of the three profiled years.

<table>
<thead>
<tr>
<th>Percentage of Type 2 Diabetes Patients, by A1c Level Range¹</th>
<th>≤7.0%</th>
<th>7.1–7.9%</th>
<th>8.0–9.0%</th>
<th>&gt;9.0%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Michigan</td>
<td>50.3%</td>
<td>48.8%</td>
<td>48.6%</td>
<td>20.3%</td>
</tr>
<tr>
<td>Nation</td>
<td>51.1%</td>
<td>50.6%</td>
<td>49.5%</td>
<td>20.7%</td>
</tr>
</tbody>
</table>

¹ The A1c test measures how much glucose has been in the blood during the past 2-3 months. Figures reflect the percentages of Type 2 diabetes patients who have had at least one A1c test in a given year.
The average A1c level of MedNetOne diabetes patients over 50 years old was 9.7% before their first behavioral health encounter. Six months and more after this first behavioral health encounter, the average A1c level for these patients fell to 8.1%.

**Program Highlights**
- Benefits of On-Site Interventions— MedNetOne serves patients from diverse backgrounds, so removing logistical barriers (for example, not requiring patients to travel to a separate location for behavioral health interventions) improves patient care.
- Hard Targets— MedNetOne compares the metrics of their diabetes patients with HEDIS and other measures, and works to achieve those goals at the same time as they make progress with behavioral health measures.

**Data source:** MedNetOne Health Solutions, 2015

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**Michigan Type 2 Diabetes Patients (cont.)**

<table>
<thead>
<tr>
<th>Market</th>
<th>A1c Testing</th>
<th>Blood Glucose Testing</th>
<th>Serum Cholesterol</th>
<th>Urine Microalbumin</th>
<th>Ophthalmologic Exam</th>
</tr>
</thead>
<tbody>
<tr>
<td>Michigan</td>
<td>76.1%</td>
<td>76.8%</td>
<td>77.0%</td>
<td>85.8%</td>
<td>85.9%</td>
</tr>
<tr>
<td>Nation</td>
<td>73.2%</td>
<td>74.1%</td>
<td>74.2%</td>
<td>86.2%</td>
<td>86.7%</td>
</tr>
</tbody>
</table>

**Hospital Readmission Rates and Emergency Department (ED) Utilization for Patients with Type 2 Diabetes, by Type of Therapy, 2011-2013**

<table>
<thead>
<tr>
<th>Market</th>
<th>30-Day Readmissions</th>
<th>Any Insulin Products</th>
<th>Three Insulin Antidiabetic Products</th>
<th>Percentage of Unique Patients with at Least One ED Visit</th>
<th>ED Visits per Patient</th>
<th>Percentage of Unique Patients with at Least One ED Visit</th>
<th>ED Visits per Patient</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Any Insulin Products</td>
<td>Three Non-Insulin Antidiabetic Products</td>
<td>Percentage of Unique Patients with at Least One ED Visit</td>
<td>ED Visits per Patient</td>
<td>Percentage of Unique Patients with at Least One ED Visit</td>
<td>ED Visits per Patient</td>
</tr>
<tr>
<td>Michigan</td>
<td>20.8%</td>
<td>28.3%</td>
<td>9.0%</td>
<td>1.6</td>
<td>8.7%</td>
<td>1.0</td>
<td></td>
</tr>
<tr>
<td>Nation</td>
<td>18.9%</td>
<td>23.9%</td>
<td>15.9%</td>
<td>2.4</td>
<td>18.1%</td>
<td>2.6</td>
<td></td>
</tr>
</tbody>
</table>

Data source: IMS Health © 2015

1. The A1c test measures how much glucose has been in the blood during the past 2-3 months. Figures reflect the percentages of Type 2 diabetes patients who have had at least one A1c test in a given year.
2. Figures reflect the percentages of Type 2 diabetes patients who were readmitted to an inpatient facility in the three-year period between 2011 and 2013. These percentages include patients who filled multiple prescriptions. Readmissions are not necessarily due to Type 2 diabetes.
3. Figures reflect the percentages of and the visits and charges for Type 2 diabetes patients who visited an emergency department in the three-year period between 2011 and 2013. These include patients who filled multiple prescriptions.
4. Patients who filled prescriptions for any insulin products may have also filled prescriptions for products in the non-insulin category, and vice versa.
Integrated Health Partners

Based in Michigan, serving a six-county area in Mid-Michigan

As part of its approach to patient-centered medical homes (PCMHs), Integrated Health Partners’ (IHP’s) Learning Collaboratives (LCs) bring together primary care and specialty physicians, including, most recently, chiropractic and behavioral health providers, to enhance care coordination. New processes focusing on communication, efficiency and effectiveness of care are tested throughout the year and tracked before being fully implemented in an office. LC-participating physicians report higher shares of diabetes patients receiving eye exams, foot exams and depression and HbA1c screenings than their non-LC counterparts and primary care physicians (PCPs) overall.

Coordination Methods

- Coaching—Each office has a practice coach who works directly with providers to develop and refine internal processes related to patient care, practice efficiencies and quality improvement.

- Care Coordination Agreements—Coaches bring specialists and primary care physicians together to enter into a care coordination agreement that establishes standards for communication and information sharing for mutual patients.

- In-Person Collaboration—PCPs and specialists (including chiropractors and ophthalmologists) have face-to-face meetings to coordinate care for shared patients, developing uniform patient education material for prevention and self-care, as well as recommendations for when and where to seek professional medical treatment. Further, PCPs and specialists share patient self-management goals, a process originating from a recent Learning Collaborative.

- Information Sharing—An area urgent care center (UCC) and a primary care practice have developed a process for the UCC to obtain vital patient data within minutes if needed to make patient care decisions. This pilot program is one of the innovative practices being promoted at additional IHP offices.

- Community Collaboration—IHP creates opportunities for provider offices to learn about support services provided by local agencies, such as the Area Agency on Aging, translation services, transportation, aid for needy families and more.
Wayne State University Physician Group

Based in Michigan, serving Southeast Michigan

The Wayne State University Physician Group (WSUPG) is a large, nonprofit multispecialty physician practice in southeast Michigan with the goal of fostering healthier patients and communities. Supported by a large network of physicians representing nearly every specialty, WSUPG is developing a patient-centered approach to care through collaboration, communication and data-driven decisions.

Improving Communication and Integrating Technology

- **Collaboration**—WSUPG has integrated multiple specialties, including behavioral health and ophthalmology, to provide a complete approach to chronic disease management. An in-house pharmaceutical dispensary at the Troy Campus addresses medication noncompliance and nonadherence and increases patient convenience.
- **Communication**—A Patient Advisory and Representative Council was formed in October 2013 to better understand patients’ health care experience through personal stories and open feedback. Multiple initiatives, including a 24-hour response time to routine calls, have been implemented or evaluated as a result. The second session began in April 2015 and is focused on internal medicine.
- **Integrating Technology**—Population health software was implemented in WSUPG general medicine practices in March 2015, and in family medicine practices in April 2015. The software helps maximize the patient visit by providing support for planned appointments and disease management. A color-coded dashboard allows clinical staff and providers to quickly analyze needed tests and referrals, improving coordination of care.
- **Access**—WSUPG multispecialty clinics in Troy and Southfield operate as “neighborhoods,” providing a one-stop shop approach for patient care.

**Program Highlights**

- A patient-centered approach to care is being implemented through various efforts, including the use of technology, increased communication and collaboration between specialists and PCPs.
- WSUPG truly listens to patients through standardized feedback mechanisms, including patient satisfaction surveys and the Patient and Representative Advisory Council.

“WSUPG has shown me they are investing in their patients by closing the communication gap and improving the overall health care experience.”

—WSUPG patient and member of the Patient and Representative Advisory Council

**Specialist Focus: Ophthalmologist’s View**

**WSUPG Diabetic Eye Exam Initiative: Q&A With Dr. Asheesh Tewari**

**Q:** Dr. Tewari, what is the Diabetic Eye Exam Initiative, and how has it benefitted your practice?

**A:** In July 2014, WSUPG and the Kresge Eye Institute conducted an outreach effort to improve diabetic eye exam testing rates for patients. The initiative integrated EMRs and other software into a standardized referral process to identify gaps in care. For instance, diabetes patients who did not have a current eye exam were contacted and referred to an ophthalmologist. As a result, we have experienced higher patient volume, in addition to an incremental rise in the numbers of diabetic patients who received eye exams. We are now better equipped to help patients manage their disease more proactively.

**37.7%** of patients contacted as part of this initiative made and kept a diabetic eye exam appointment.

**Q:** Why is this so important? How does getting an eye exam benefit the patient?

**A:** Diabetes is a leading cause of preventable blindness. The two main causes of vision loss from diabetes (macular edema and proliferative retinopathy) are preventable and, when caught early, can be treated and stabilized to preserve sight and even recover some vision. If diabetic eye disease is left untreated, the resulting blindness may be a barrier to optimal care for these high-risk patients: travel to and from appointments, for example, or proper administration of medications becomes a real challenge. Early intervention is key, and greater communication among providers and patients helps ensure that patients receive the care they urgently need.

**Q:** Have the PCMH-N model and these initiatives changed how you communicate with PCPs?

**A:** Certainly. Technology has helped us to communicate better with PCPs in real-time, through instant access to the same information. We can see their instructions to each patient and follow up accordingly. This concept has helped to streamline patient appointments, while establishing useful new channels of communication within our medical neighborhood for better coordination of care.
Methodology

Chronic disease measures for the physician groups featured in the Michigan Summary of Care Report (pp. 4-7) are self-reported. The analyses and findings herein do not intend to imply that any physician group, either collectively or individually, correlates to overall group results.

Type 2 diabetes data for Michigan and national markets (pp. 4-5) were generated by IMS Health out of health care professional (837p) and institutional (837i) insurance claims, representing more than 7.7 million unique patients nationally in 2013 with a diagnosis of Type 2 diabetes (250.00-250.92). Data from physicians of all specialties and from all hospital types are included.

IMS Health also gathers data on prescription activity from the National Council for Prescription Drug Programs (NCPDP). These data account for some 2 billion prescription claims annually, or more than 50% of the prescription universe. These prescription data represent the sampling of prescription activity from a variety of sources, including retail chains, mass merchandisers and pharmacy benefit managers. Cash, mail order, Medicaid and third-party transactions are tracked. Data arriving into IMS Health are put through a rigorous process to ensure that data elements match to valid references, such as product codes, ICD-9 (diagnosis) and CPT-4 (procedure) codes, and provider and facility data.

Claims undergo a careful de-duplication process to ensure that when multiple, voided, or adjusted claims are assigned to a patient encounter, they are applied to the database, but only for a single, unique patient.

Through its patient encryption methods, IMS Health creates a unique, random numerical identifier for every patient, and then strips away all patient-specific health information that is protected under the Health Insurance Portability and Accountability Act (HIPAA). The identifier allows IMS Health to track disease-specific diagnosis and procedure activity across the various settings where patient care is provided (hospital inpatient, hospital outpatient, emergency rooms, clinics, doctors’ offices and pharmacies), while protecting the privacy of each patient.