Successful Strategies in Continuity of Care

Jean Malouin MD MPH
August 5, 2014

Agenda

• Health Care: What’s all the fuss?
• Population Management: The evolving landscape
• Michigan Primary Care Transformation Project
• What does the future hold?
• Questions

Health Care: What’s all the fuss?
Average Health Spending Per Capita ($US): The ubiquitous and non-sustainable cost curve

<table>
<thead>
<tr>
<th>Health Care Waste</th>
<th>Excess Cost Estimates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unnecessary Services</td>
<td>$210B</td>
</tr>
<tr>
<td>Inefficiently Delivered Services</td>
<td>$130B</td>
</tr>
<tr>
<td>Excess Administrative Costs</td>
<td>$190B</td>
</tr>
<tr>
<td>Prices That Are Too High</td>
<td>$105B</td>
</tr>
<tr>
<td>Missed Prevention Opportunities</td>
<td>$55B</td>
</tr>
<tr>
<td>Fraud</td>
<td>$75B</td>
</tr>
<tr>
<td><strong>Total Estimated Excess Costs:</strong></td>
<td><strong>$765B</strong></td>
</tr>
</tbody>
</table>

Source: Institute of Medicine, 2011

U.S. Health Care: A system perfectly designed to get the results it does
“...in much of the country, no one is in charge. And the result is the most wasteful and the least sustainable health-care system in the world.”

- Atul Gawande MD MPH

Source: "The Cost Conundrum: What a Texas town can teach us about health care". The New Yorker, June 1, 2009

Current Fragmentation of Care

• Patients experience and clinicians operate in “silos” of care
• Referral networks are large\(^1\) and often depersonalized


Patients Report Experiencing Poor Coordination

Percent U.S. adults reported in past two years:

- Your specialist did not receive basic medical information from your primary care doctor: 13%
- Your primary care doctor did not receive a report back from a specialist: 15%
- Test results/medical records were not available at the time of appointment: 19%
- Doctors failed to provide important medical information to other doctors or nurses you think should have it: 26%
- No one contacted you about test results, or you had to call repeatedly to get results: 45%
- Any of the above: 47%

Michigan: Some sobering statistics

- 45th (of 50 states) in heart disease deaths
- 43rd in percent of obese adults
- 40th in breast cancer death rate
- 38th in infant mortality rate
- 37th in percent of adults who smoke
- 35th in overall cancer death rate
- 30th in colorectal cancer death rate
- 28th in stroke-related deaths

Proposed Solutions...

- Accountable Care Organizations?
- Patient Centered Medical Homes?
- Health Care Reform?
- All/None of the above?
Continuity of Care: Brewing the Secret Sauce

- Definition
  - Primary care literature: Relationship between a single practitioner and a patient that extends beyond specific episodes of care
  - Broader scope: Coordination of care relationships between all members of the health care team, across disciplines, over time

Three types of continuity

- **Informational continuity**: the use of information to make current care appropriate
- **Management continuity**: consistent, coherent approach to the management of a health condition over time
- **Relational continuity**: ongoing therapeutic relationship between a patient and one or more providers

Haggerty et al, BMJ 2003;327:1219-21

- While continuity of care is defined at the *individual* patient level, the strategies for improving continuity of care must be defined at the *population* level
Population Management:  
The Evolving Landscape

Accountable Care Organizations (ACOs):  
A Key Concept in Healthcare Reform

- Health care reform includes provisions for creating “Accountable Care Organizations” for Medicare beneficiaries
- ACOs are organized provider groups, including physicians, hospitals, and post-acute providers, responsible for health care of a population
- Centers for Medicare & Medicaid Services (CMS) is leading this but commercial insurance is also involved
- Goal: Deliver care in a less costly and more coordinated, efficient and patient-centered manner

Important Components of an ACO

- Provider structure and organization – Governance
- Financial model – cost, growth
- Comparison group - local or national
- Patient attribution – in FFS, who are our patients?
- Case mix adjustment, or risk adjustment - how sick are the patients?
- Quality Measures - how good are they, what is the burden
- Health Information Technology (HIT) – EHR, registries, HIE
ACO Primary Care Components (CHQPR, 2009)

1. Complete and timely information about patients and the services they are receiving
2. Technology and skills for population management and coordination of care
3. Adequate resources for patient education and self-management support
4. A culture of teamwork among the staff of the practice
5. Coordinated relationships with specialists and other providers
6. The ability to measure and report on the quality of care
7. Infrastructure and skills for management of financial risk
8. A commitment by the organization's leadership to improving value as a top priority, and a system of operational accountability to drive improved performance

How will ACO success be measured?

• Payments linked to both quality and reduction of cost growth
• Reliable and progressively more intricate performance measurement to drive improvements in care
  — Initially, pay for reporting
  — Gradual shift to pay for performance over time

ACO Guiding Principle: The IHI “Triple Aim”
The Triple Aim means Accountability for Outcomes and Patient Experience, not just Cost.

CMS Strategies to Achieve Triple Aim Goals

- Bundled Payments
  - Inpatient physician & hospital
  - Inpatient and post acute care
  - Post acute care
- Pay-for-Performance
  - Value-based purchasing
  - Readmission penalties
- Shared Savings
  - Medicare Shared Savings Program (MSSP)
  - Pioneer ACO Program
- Electronic Health Record/meaningful Use

Four key elements of successful ACOs:

- Care Coordination
- Better Access to Care
- Health IT
- Payment Reform

Better to Best: Value Driving Elements of the Patient Centered Medical Home and Accountable Care Organizations
March 2011, Washington DC
Health IT: Challenges remain

- Electronic Health Records
- Population-based Registries
- Health Information Exchanges

Primary Care: The Foundation for ACO Population Management

Primary Care and Health Outcomes (1)

- Evidence for the benefits of primary care oriented health systems is robust across a wide variety of types of studies:
  - International comparisons
  - Population studies within countries
    - Across areas with different PCP:population ratios
    - Across different types of practitioners

Source: Starfield et al, Milbank Q 2005; 83:457-502
Primary Care and Health Outcomes (2)

- Primary health care oriented countries:
  - Have more equitable resource distributions
  - Have health insurance of services provided by the government
  - Have little or no private health insurance
  - Have no or low co-payments for health services
  - Are rated as better by their populations
  - Have primary care that includes a wider range of services and is family oriented
  - Have better health at lower costs

Sources: Starfield and Shi, Health Policy 2002;60:201-18
van Doorslaer et al, Health Econ 2004;13:629-47
Schoen et al, Health Aff 2005;24:509-25

Patient-Centered Medical Home: The Silver Lining?

What exactly is a “Medical Home”?

- Whose definition do we use?
  - Professional physician societies (AAFP, AAF, ACP, AOA)
  - National Committee for Quality Assurance (NCQA)
  - Payers (CMS, BCBSM, Aetna, etc.)
- Skepticism about differences from usual practice
  - “Don’t we already do this?”
- Uncertainty about what patients really want
  - A place where everyone knows your name…?
  - A free market?
- With medical care, one size does not fit all
Joint Principles of the Patient-Centered Medical Home (AAFP, AAP, ACP, AOA)

• Personal physician
• Physician directed medical team
• Whole-person orientation
• Integrated, coordinated care
• Quality and safety as hallmarks
• Enhanced access
• Payment structure for added patient value

How is this model different from what’s been tried before?

• Early HMO model (1980-1990)
  – Primary care physician as “gatekeeper”
  – Focus on decreased utilization, not improved outcomes
• Chronic care management models
  – Payer-based programs
  – Disease-based programs
• PCMH concept originated with physicians
• Added payment for added value

Challenges with Medical Home Implementation

• Multiple definitions for PCMH model (NCQA, BCBSM, URAC, etc.)
• Multiple payer reimbursement strategies
  – Per member per month (PMPM) patient fee
  – Increase E & M reimbursement
  – Payment for telephone care, electronic visits
• Incentives not always aligned across the healthcare continuum
• Difficult to quantify long-term outcomes
• Declining student interest in primary care
PCMH: Results and Evidence (1)
- Alaska Native Medical Center, Anchorage, AK
  - 50% fewer urgent care and emergency room (ER) visits
  - 53% fewer hospital admissions
  - 65% reduction in specialist utilization
- Capital Health Plan, Tallahassee, FL
  - 40% fewer inpatient stays
  - 37% fewer ER visits
  - 18% lower health care claims costs
- Geisinger Health System, Danville, PA
  - 25% fewer hospital admissions
  - 50% fewer hospital readmissions
  - 7% lower cumulative total spending
- Group Health of Washington, Seattle, WA
  - 15% fewer inpatient stays
  - 15% fewer hospital readmissions
  - Estimated cost savings of $15 million (2009-10)
  - 18 - 65% improvements in medication management

PCMH: Results and Evidence (2)
- HealthPartners, Bloomington, MN
  - 39% fewer ER visits
  - 40% fewer hospital readmissions
  - Reduced appointment wait time from 26 days to 1 day
- Horizon Blue Cross Blue Shield of New Jersey
  - 25% fewer hospital readmissions
  - 21% fewer inpatient admissions
  - 31% increase in self-management of blood sugar
- Maryland CareFirst Blue Cross Blue Shield
  - 4.2% reduction in patients' overall health care costs
  - Estimated cost savings of $40 million (2011)
- Vermont Medicaid
  - 31% fewer ER visits
  - 21% reduction in inpatient services
  - 22% lower per member per month costs (2008-10)

BCBSM PCMH Designation Program
Results: Michigan’s BCBSM PCMH Program

PCMH savings $ millions

2009: $14
2010: $67
2011: $89
2012: $116

Improved outcomes from PCMH practices

- Improved quality for chronic illness: 12.2%
- Increase in adult preventive care: 5.1%
- Increase in pediatric preventive service: 12.2%

The Michigan Primary Care Transformation Project

Where We Started: The Vision for a Multi-Payer Model

- Use the CMS Multi-Payer Advanced Primary Care Practice demo as a catalyst to redesign MI primary care
  - Multiple payers will fund a common clinical model
  - Allows global primary care transformation efforts
  - Support development of evidence-based care models
- Create a model that can be broadly disseminated
  - Facilitate measurable, significant improvements in population health for our Michigan residents
  - Bend the current (non-sustainable) cost curve
  - Contribute to national models for primary care redesign
- Form a strong foundation for successful ACO models
- Demonstration period: January 2012 – December 2014
**MAPCP Demo: Participating States (2014)**

- **Maine** 70 practices, 122,420 patients
- **Michigan** 358 practices, 1,109,926 patients
- **Minnesota** 282 practices, 1,013,545 patients
- **New York** 41 practices, 99,019 patients
- **North Carolina** 47 practices, 83,553 patients
- **Pennsylvania** 51 practices, 163,670 patients
- **Rhode Island** 16 practices, 57,676 patients
- **Vermont** 123 practices, 272,324 patients

**TOTAL** 988 practices, 2,922,151 patients

---

**MiPCT Participants**

- 358 practices
- 37 POs
- 1,800 physicians
- 1.1 million patients
  - Medicare
  - Medicaid managed care plans
  - BCBSM
  - BCN
  - Priority Health (7/13)

---

**Michigan Primary Care Transformation Project**

**Advancing Population Management**

<table>
<thead>
<tr>
<th>Services</th>
<th>Infrastructure</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Complex Care Management</strong></td>
<td>Health IT: - Disease registry functionality *</td>
</tr>
<tr>
<td>Tier 1</td>
<td>- Care management documentation **</td>
</tr>
<tr>
<td><strong>Care Management</strong></td>
<td>- Payer portal (optional)</td>
</tr>
<tr>
<td>Functional Tier 2</td>
<td>- Community prescriber enrollment (optional)</td>
</tr>
<tr>
<td><strong>Transition Care</strong></td>
<td>- Emergency care (optional)</td>
</tr>
<tr>
<td>Functional Tier 2</td>
<td>- Pathway planning and medication reconciliation</td>
</tr>
<tr>
<td><strong>Navigating the Medical Neighborhood</strong></td>
<td>- 24/7 access to decision maker **</td>
</tr>
<tr>
<td>Functional Tier 1</td>
<td>- 30% open access slots **</td>
</tr>
<tr>
<td><strong>Prepared Practice Healthcare Team</strong></td>
<td>- Extended hours</td>
</tr>
</tbody>
</table>

*denotes requirement by end of year 1

---

**PO P U L A T I O N  M A N A G E M E N T**
Population Management 101: Maximizing everyone’s health

I. Healthy Population

II. Mild-moderate illness
Well-compensated multiple diseases
Single disease

III. Complex illness
Multiple Chronic Disease
Developmental, social, financial

IV. Most complex
(e.g., Homeless, Schizophrenia)

MiPCT Statewide Progress to Date

- Statewide infrastructure including Steering Committee, subcommittees, administrative and clinical leadership
- Over 350 Care Managers hired and trained
  - Building caseloads of targeted high-risk patients
- Building infrastructure in partnership with participating Physician Organizations and practices
  - Ongoing Care Manager training, coaching, mentoring
  - Team-based learning collaboratives
  - Town Hall dinners

MiPCT Focus:
PCMH Care Management Components Associated With Positive Outcomes

- Care delivery by multidisciplinary teams
- Care delivery in collaboration with physician’s office
- Attention to care transitions
- Medication reconciliation
- In-person visits along with telephonic encounters
- Patient selection important - risk stratification plus physician input important to successful interventions
Care Manager Survey Findings

Physicians that Care Managers work with support the concepts of the MiPCT care management team-based care

<table>
<thead>
<tr>
<th></th>
<th>May 2013</th>
<th>December 2013</th>
<th>June 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly agree</td>
<td>48</td>
<td>59</td>
<td>72</td>
</tr>
<tr>
<td>Agree</td>
<td>107</td>
<td>32</td>
<td>83</td>
</tr>
<tr>
<td>Neither agree nor disagree</td>
<td>39</td>
<td>56</td>
<td>20</td>
</tr>
<tr>
<td>Disagree</td>
<td>2</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Strongly disagree</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>

Multi-Payer Claims Database

- Collect data from multiple Payers and aggregate it together 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

MDC: MiPCT Dashboards

- Population Information
  - Attributed members by Payer
  - # of members by Risk Level
  - # patients by Chronic Condition (Asthma, CKD, CHF, etc)

- Quality Measures
  - Screening and Test Rates
    - Diabetes, Cancer Screen, etc
  - Immunization Rates, Wellness Visits, etc.
  - Comparison to Benchmarks

- Utilization Measures
  - ED Use, Admission, Re-admissions, etc.
  - Comparison to Benchmarks
How will CMS define success?

The tie to budget neutrality and ROI

Key factors for ongoing success:

Practice Level

• Optimize partnership with care managers/PCPs
  – Team meetings/Communication
  – Participate in identification of high-risk patients
• Optimize use of registries
  – population management between visits
  – Point-of-care alerts
  – chronic conditions
• Optimize primary care patient access

Key factors for ongoing success:

Health System Level

• Optimize coordination of care between specialists and PCPs
• Optimize communication between inpatient and outpatient settings during patient transitions
• Look for ways to decrease waste
• Use resources wisely – soon we’ll all be more accountable for costs
MiPCT: What happens after 2014?

- Options being explored
  - Demonstration extension additional 1-2 years
  - Ongoing funding for care management
  - Ongoing funding for MDC database and other administrative costs
  - Coordination with State Innovation Model (SIM)

www.mipctdemo.org

Health Care:
What does the future hold?
Ultimately, need system redesign

• Manage populations, not encounters
  – Registry-based panel management
• More team-based care
• More non-traditional care
  – Telephonic, electronic

• WHAT WOULD YOUR IDEAL DAY LOOK LIKE?

Hopefully, a chance to hop off the wheel

How would this care be reimbursed?

• Various models proposed (none really new!)
  – Fee for service
  – Capitation
  – Bundled, episodic payments
  – Pay-for-performance (quality)
  – Care management fees
• Likely, some combination will emerge
• Ideally, all payers use the similar models
CMS – Desperately Seeking Solutions

• Areas of promise – what we’re doing!
  – PCMH models
  – Care coordination
  – Population management
• Question on the table - Can primary care redefine care delivery?
  – This is our best chance to provide the answer
  – If successful, can lead to new funding models

“Primary Care is HOT right now, but it won’t last forever”

• David Meyers, MD
  Director, Center for Primary Care, Prevention and Clinical Partnerships, AHRQ

Closing thought...
Ultimately - It’s still all about the patient
Questions?