Thank you for joining!
We will get started promptly at 8:35 am

MICMT

Michigan Institute for Care Management & Transformation

2021 Annual Meeting

October 8, 2021

Welcome

Agenda

8:35 AM - 8:50 AM
Welcome
Scorecard Discussion

8:50 AM- 9:50 AM
PDCM Updates & PO Success Spotlights

9:50 AM – 11:05 AM
Expansion of Team-Based Care
Break - Approximately 10:25 AM

11:05 AM – 11:55 AM
MICMT Program Evaluation & Team-Based Care Data Analysis

11:55 AM – 12:00 PM
Closing Remarks

2020 MICMT Scorecard

- Thanks for your patience as we worked through some iterations of the final 2020 Scorecard payments.
- Payment should come in November.
- The positive: part of the reason for the changes is that we paid out what wasn't earned to POs.

2021 MICMT Scorecard

2021 Provider Delivered Care Management Funding will be distributed to Physician Organizations through two avenues, with different payment timelines:

1. Training Reimbursement → BCBSM will reimburse for care team member training at a flat rate of $500 per person who passes the test for full-day approved training courses and $250 per person who passes the test for half-day approved training courses for licensed and unlicensed care team members. This reimbursement will occur in the January, 2022 PGIP check and include those trainings that occur between November 2020 and October 2021.

2. Scorecard Distribution
   The following scorecard shows the infrastructure elements that MICMT / BCBSM consider fundamental for care management program success. This distribution will occur in the October 2022 PGIP check to allow time for outcomes evaluation.

NOTE: The % of PDCM offices will be assessed using the 2021 1% Threshold List from 2020 Claims.

2021 MICMT Scorecard

2021 Scorecard				
Measure #	Weight	Measure Description	Points	Data Source
1	50	**Outcomes:**		
		Consistently follow the process for sharing all payer (including BCBSM) clinical data in the appropriate format to MiHIN in coordination with PPQC throughout 2021. • PO should send clinical data on all patients and all payers. • Expectation is that the PO is sending info from, at minimum, all PDCM-defined offices.	**10** **% of PDCM offices** / **# of points** **90%** / **10** **75%** / **8** **50%** / **5** **25%** / **3**	MiHIN report (shared with MICMT when permission granted by PO)
		Points for the below outcomes measures are earned based on the PO performance with the PDCM Outcomes VBR. *(See Appendix A for more information)*		Aligns with BCBSM outcomes reporting for POs/sub-POs. If sub-POs apply, points

2021 Scorecard				
Measure #	Weight	Measure Description	Points	Data Source
		A1c performance	**10**	distributed using a weighted average based on Sub-PO population.
		BP Performance	**10**	
		ED Utilization	**10**	
		IP Utilization	**10**	

2021 MICMT Scorecard

2	25	**Health Disparities**		
		Unconscious Bias Training: Percentage PDCM offices that attested to **both** of the Unconscious Bias training PCMH/PCMH-N capabilities by the first 2022 snapshot .	**10 total** **% of PDCM offices** / **# of points** **90%** / **10** **75%** / **8** **50%** / **5** **25%** / **3**	SAD tool report used to assess capabilities in place by end of calendar year 2021.
		Expand the PO process for having a registry that collects SDoH. Points provided for the percentage of PDCM-defined practice units with PCMH/PCMH-N capability 2.25 in place by the first 2022 snapshot.	**10 total** **% of PDCM offices** / **# of points** **90%** / **10** **75%** / **8** **50%** / **5** **25%** / **3**	SAD tool report used to assess capabilities in place by end of calendar year 2021.
		Develop/expand the PO process for creating a feedback loop for social needs among Practice Units. Points provided for the percentage of PDCM-defined practice units with PCMH/PCMH-N capabilities 10.7 in place by the first 2022 snapshot.	**5 total** **% of PDCM offices** / **# of points** **90%** / **5** **75%** / **4** **50%** / **3** **25%** / **2**	SAD tool report used to assess capabilities in place by end of calendar year 2021.

2021 MICMT Scorecard

<table>
<tr><td>3</td><td>5</td><td colspan="3">Care Management Operations (Note: this will not impact VBR)</td></tr>
<tr><td colspan="2"></td><td>Clinic Dedicated Care Management:
The BCBSM PDCM program is different from other care management programs, such as payer or vendor-based care management, because of the direct connection to the provider and point of care.
POs should support practices to develop dedicated care management.
• For small practices with less than 2.0FTE or fewer providers, there should be at least 4 hours / week of dedicated</td><td>5<table><tr><th>% of PDCM offices</th><th># of points</th></tr><tr><td>90%</td><td>5</td></tr><tr><td>75%</td><td>4</td></tr><tr><td>50%</td><td>3</td></tr><tr><td>25%</td><td>2</td></tr></table></td><td>Care manager attestation process completed in 2021. Number of providers at a practice will be determined using the Fall</td></tr>
</table>

<table>
<tr><th colspan="5">2021 Scorecard</th></tr>
<tr><th>Measure #</th><th>Weight</th><th>Measure Description</th><th>Points</th><th>Data Source</th></tr>
<tr><td></td><td></td><td>time, through a single or combination of care team members.
• For practices with greater than or equal to 2.0 FTE of providers, dedicated care team member time should minimally be 4 hours per week, per individual care team member.</td><td></td><td>2021 snapshot.</td></tr>
</table>

2021 MICMT Scorecard

4	20	**Engagement:**		
		Care Team Survey & Attestation / Verification	**9**	MICMT reporting
		At least 3 scheduled phone conferences (30 minutes) with the MICMT to review scorecard performance and program updates	**5**	MICMT reporting
		Participation in a Regional MICMT meetings by at least 1 PO representative.	**3**	MICMT reporting
		Participation in the Annual MICMT meeting by at least 1 PO Representative with a leadership role in Care Management activity at the PO level.	**3**	MICMT reporting

**DRAFT ** 2022 MICMT Scorecard

2022 Scorecard - DRAFT

2022 Provider Delivered Care Management Funding will be distributed to Physician Organizations through two avenues, with different payment timelines:

1. Training Reimbursement → BCBSM will reimburse for care team member training at a flat rate of $500 per person who passes the test for full-day approved training courses and $250 per person who passes the test for half-day approved training courses for licensed and unlicensed care team members. This reimbursement will occur in the January, 2022 PGIP check and include those trainings that occur between November 2020 and November 2021.

2. Scorecard Distribution
   The following scorecard shows the infrastructure elements that MICMT / BCBSM consider fundamental for care management program success. This distribution will occur in the October, 2022 PGIP check to allow time for outcomes evaluation.

2022 Scorecard				
Measure #	Weight	Measure Description	Points	Data Source
1	81	**Outcomes:**		
		Points for the below outcomes measures are earned based on the PO performance with the PDCM Outcomes VBR. *(See Appendix A for more information)*		PCMH Capabilities will be measured at the first snapshot of 2023.
		Patient Satisfaction Outcomes: PCMH Capability 4.4 (and???) 4.23 in place	**9**	
		Peds: IP Utilization	**9**	Outcomes measures align with BCBSM outcomes reporting for PDCM practices.
		Peds: ED Utilization	**9**	
		Peds: Composite Metric	**18**	
		Adult: A1c performance	**9**	
		Adult: BP Performance	**9**	
		Adult: ED Utilization	**9**	
		Adult: IP Utilization	**9**	

2022 Scorecard				
Measure #	Weight	Measure Description	Points	Data Source
2	4	**Care Management Operations (Note: this will not impact VBR)**		
		Clinic Dedicated Care Management: The BCBSM PDCM program is different from other care management programs, such as payer or vendor-based care management, because of the direct connection to the provider and point of care. POs should support practices to develop dedicated care management. • For small practices with less than 2.0FTE or fewer providers, there should be at least 4 hours / week of dedicated time, through a single or combination of care team members. • For practices with greater than or equal to 2.0 FTE of providers, dedicated care team member time should minimally be 4 hours per week, per individual care team member.	5 **% of PDCM offices** / **# of points** 90% / 4 75% / 3 50% / 2 25% / 1	Care manager attestation process.
3	15	**Engagement:**		
		Billing SME Identified	**3**	MICMT Reporting
		Billing Training Completed	**4**	MICMT Reporting
		Billing Meeting Participation (All meetings)	**4**	MICMT Reporting
		Care Team Survey & Attestation / Verification	**2**	MICMT reporting
		At least 3 scheduled phone conferences (30 minutes) with the MICMT to review scorecard performance and program updates	**2**	MICMT reporting
		Participation in a Regional MICMT meetings by at least 1 PO representative.	**1**	MICMT reporting
		Participation in the Annual MICMT meeting by at least 1 PO Representative with a leadership role in Care Management activity at the PO level.	**1**	MICMT reporting

MICMT

PDCM Updates & PO Success Spotlights

PO Spotlight Success

Physician Organization	Presenters	Success
United Physicians	Mary Ellen Turk, RN, CPHQ, ACM	Improved
Livingston Physician Organization (LPO)	Renea Clark, MA	Improved
Integrated Health Partners (IHP)	Stacey Duncan-Jackson, MPA, RN	Sustained
Holland PHO	Gina Shutter, CPHQ	Sustained
MedNetOne Health Solutions	Erica Ross	Sustained

Region: Southeast
PO Type: Independent

Number of Practices 2020 Fall Snapshot	
Primary Care	168
Mixed	6
PDCM Eligible	80

Claims Activity		
Year	PDCM Eligible Members	Percent of Engagement
2019	146154	3.2%
2020	151354	5.7%

Number of Care Team Members 2021 CM Attestation	
Nurse	12
Social Worker	10
Dietitian	6
Nurse Practitioner	4
Community Health Worker	4
Pharmacist	1
Pharmacist Tech	1

Outcomes Points Achieved 2020 MICMT Scorecard	
A1C	5
BP	0
ED	10
IP	10

Livingston Physician Organization

Region: Central/MidMichigan
PO Type: Independent

Number of Practices 2020 Fall Snapshot	
Primary Care	16
Mixed	0
PDCM Eligible	6

Claims Activity		
Year	PDCM Eligible Members	Percent of Engagement
2019	4359	1.0%
2020	5700	6.1%

Number of Care Team Members 2021 CM Attestation	
Medical Assistant	10
Nurse	2
Nurse Practitioner	1

Outcomes Points Achieved 2020 MICMT Scorecard	
A1C	0
BP	10
ED	10
IP	10

Integrated Health Partners

Region: Western
PO Type: Independent

Number of Practices 2020 Fall Snapshot	
Primary Care	17
Mixed	6
PDCM Eligible	16

Number of Care Team Members 2021 CM Attestation	
Nurse	33
Pharmacist	2
Social Worker	2
Medical Assistant	1
Non-Clinical Community Health Worker	1

Claims Activity		
Year	PDCM Eligible Members	Percent of Engagement
2019	19238	4.4%
2020	18968	6.1%

Outcomes Points Achieved 2020 MICMT Scorecard	
A1C	6
BP	6
ED	10
IP	10

MICMT

holland pho
Physician Hospital Organization

Region: Western
PO Type: Independent

Number of Practices
2020 Fall Snapshot

Primary Care	9
PDCM Eligible	9

Claims Activity

Year	PDCM Eligible Members	Percent of Engagement
2019	10357	4.2%
2020	10913	5.8%

Number of Care Team Members
2021 CM Attestation

Nurse	16
Medical Assistant	6
Social Worker	6
Dietitian	4
Behavioral Health Care Manager	1
Licensed Counselor	1
Non-Clinical Care Manager	1
Pharmacist	1

Outcomes Points Achieved
2020 MICMT Scorecard

A1C	10
BP	10
ED	10
IP	10

MICMT

MedNetOne HEALTH SOLUTIONS

Region: Southeast
PO Type: Independent

Number of Practices 2020 Fall Snapshot	
Primary Care	57
Mixed	3
PDCM Eligible	16

Claims Activity		
Year	PDCM Eligible Members	Percent of Engagement
2019	15384	6.2%
2020	19740	8.3%

Number of Care Team Members 2021 CM Attestation	
Nurse	14
Medical Assistant	7
Social Worker	3
Dietitian	3
Nurse Practitioner	1
Non-Clinical Community Health Worker	1

Outcomes Points Achieved 2020 MICMT Scorecard	
A1C	0
BP	10
ED	10
IP	10

MICMT

PO Spotlight Q&A

Expansion of Team-Based Care

Program Overview

Program/Initiative	Presenters
BCBSM Specialty Team-Based Care	Sheri Lee
Pharmacist Optimizing Oncology Care Excellence in Michigan (POEM)	Emily Mackler, PharmD
Integrated Michigan Patient-Centered Alliance in Care Transitions (I-MPACT)	Grace Jenq, MD
Michigan Collaborative for Type 2 Diabetes (MCT2D)	Caroline Richardson, MD

Specialist Team-Based Care

MICMT Annual Meeting

October 8, 2021

Sheri R. Lee

Senior Health Care Analyst

Value Partnerships

Specialist Team-Based Care Presentation Agenda

Specialist Team-Based Care: Goals

Encourage more specialists to adopt a team-based care approach focused on care management

Engage specialists with a VBR opportunity based on activities within their control

Leverage existing and developing HIE capabilities to facilitate team-based care

Increase coordination of care among PCPs and specialists

Reduce unnecessary hospital admissions

Specialist Team-Based Care: Eligibility Requirements

Physician Organizations

Must:

- Be onboarded to the following statewide HIE use cases:
  - Active Care Relationship Service (ACRS)
  - Admission, Discharge, Transfer (ADT)
  - Exchange C-CDA (formerly Medication Reconciliation)
- Participate in STBC workgroup meetings

Participating Specialists

Must:

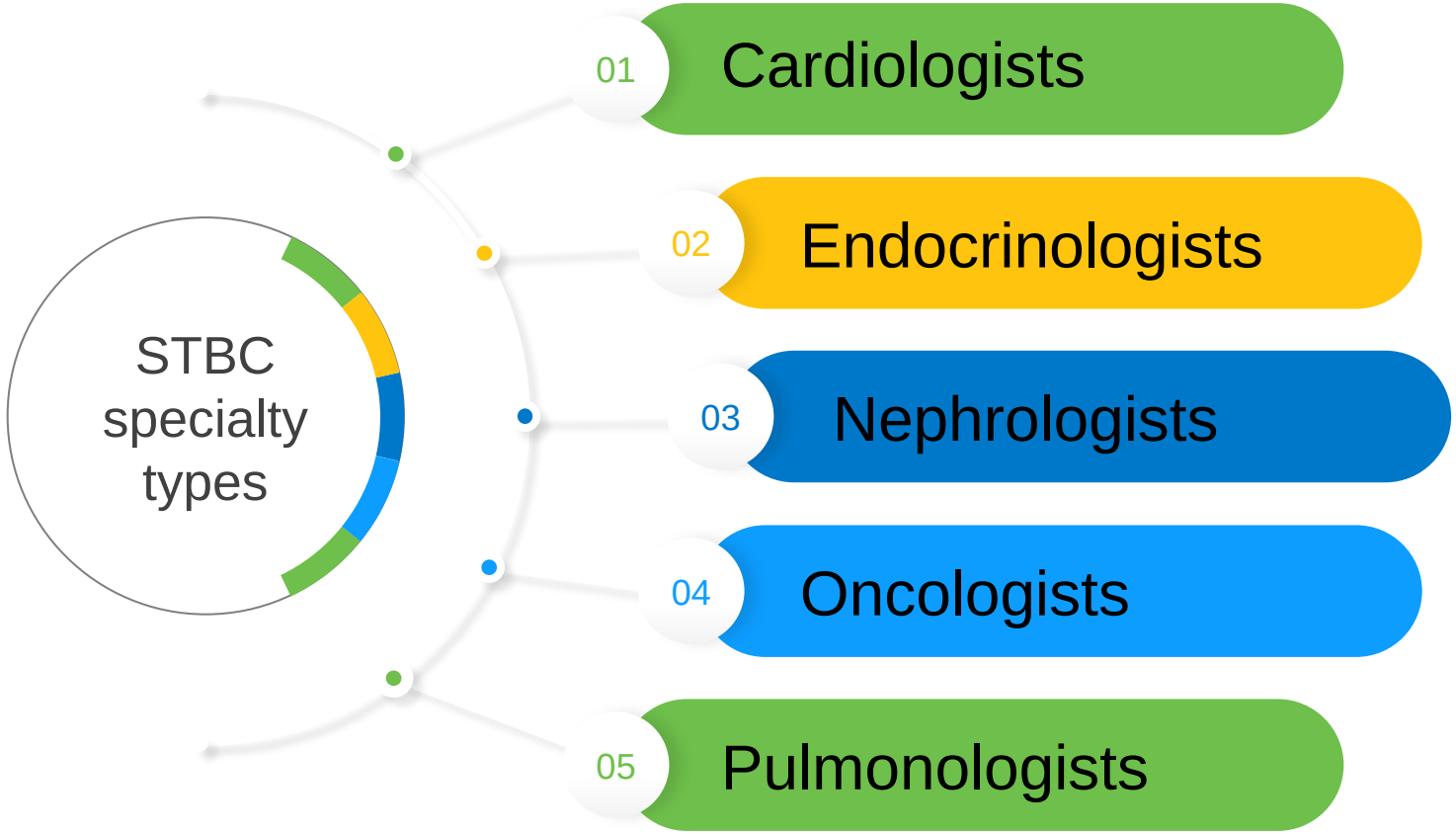
- Secure a care manager
- Identify their high-risk population
- Have a mechanism for receiving real-time ADT alerts via a mobile device
- Participate in one STBC workgroup meeting annually

Care Manager / Team

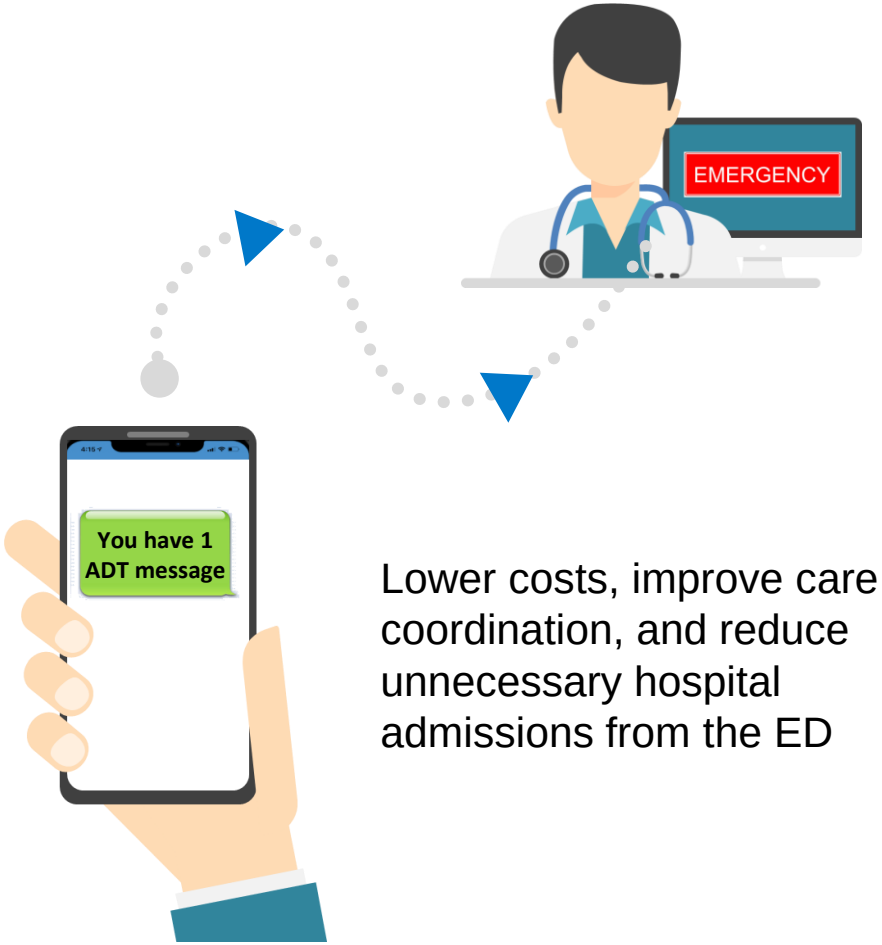
Must:

- Be supported by a licensed health care professional that:
  - Provides care management services
  - Complete required training
  - Participates in STBC workgroup meetings

Eligible Specialists



Improve integration of HIE data to improve care processes to facilitate specialist communication



Lower costs, improve care coordination, and reduce unnecessary hospital admissions from the ED

Real-time alerts

Develop and implement integrated solutions for using HIE and mobile health technology

Avoid unnecessary inpatient admissions

Facilitate real-time communications between PCPs/Specialists and EDs

Coordinate appropriate follow-up ambulatory care

Improve integration of ADTs and other HIE data to improve care processes

Specialist Team-Based Care: Statistics

STBC	Cohort 1 (started in 2020)	Cohort 2 (started in 2021)	Total Specialists in STBC	Percent from PGIP in STBC
Cardiology	41	84	125	14.9%
Endocrinology	12	44	56	28.3%
Nephrology	55	35	90	32.0%
Oncology	39	1	40	8.7%
Pulmonology	5	44	49	15.2%
Total	**152**	**208**	**360**	**17.1%**

Participating Physician Organizations

	Cohort 1	Cohort 2
Answer Health Physician Organization	✓	✗
Beaumont ACO	✓	✗
Integrated Health Partners	✓	✗
Oakland Physician Network Services	✓	✓
Olympia Medical PLLC	✓	✓
The Physician Alliance LLC	✓	✗
United Physicians	✓	✓
University of Michigan	✗	✓
Upper Peninsula Health Group	✗	✓

STBC Training Statistics

Average Test Score

Average Learning Outcomes Evaluation

Number of Trainings Offered

Number of Attendees

Number of Trainers

VBR & HIE Reward Eligibility

Cohort Start Year	2020	2021	2022	2023
Cohort 1	PO attestation of meeting program requirements		PDCM codes billed for 4% of eligible population*	TBD
Cohort 2	N/A	PO attestation of meeting program requirements		PDCM codes billed for 4% of eligible population*
Cohort 3	N/A		PO attestation of meeting program requirements	

*The eligible population is determined by the number of patients who had at least two or more E&M visits with the specialist within the practice unit during the measurement period (November 1, 2020 through July 31, 2021). The population includes all BCBSM PGIP Attributed Commercial and MA members.

Care Management Works

PDCM is an important program in helping in controlling costs through lower emergency department visits and inpatient stays

PEDIATRIC	2020		
	PCMH only	PCMH+ PDCM	Difference
Emergency department visits (per 1,000)	202.62	177.80	**-12.2%**
Primary care sensitive emergency department visits (per 1,000)	82.32	66.78	**-18.9%**
Low tech radiology services (per 1,000)	402.77	396.30	-1.6%
Low tech radiology standard cost PMPM ($)	2.99	2.97	-0.7%

A population level analysis shows that the subset of practices engaged in PDCM, as a group, perform better on key utilization metrics than PCMH designated practices who are not engaged in PDCM. This trend is further magnified for ED visits when practices are enabled with HIE.

ADULT	2020		
	PCMH only	PCMH + PDCM	Difference
Emergency department visits (per 1,000)	209.97	198.84	**-5.3%**
Primary care sensitive emergency department visits (per 1,000)	91.92	85.88	**-6.6%**
Ambulatory care sensitive inpatient discharges (per 1,000)	3.74	3.40	**-9.3%**
High tech radiology services (per 1,000)	264.67	263.25	-0.5%
High tech radiology standard cost PMPM ($)	13.46	13.53	0.5%
Low tech radiology services (per 1,000)	1131.94	1139.93	0.7%
Low tech radiology standard cost PMPM ($)	11.01	11.04	0.2%

PDCM Procedure Codes

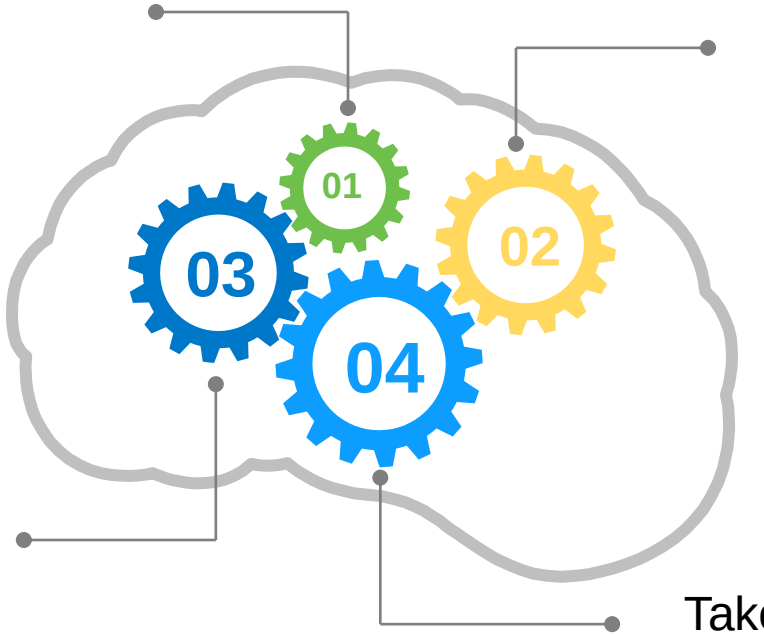
- G9001* - Coordinated Care Fee – Initial
- G9002* - Coordinated Care Fee – Maintenance
- 98961* - Group Education 2–4 patients for 30 minutes
- 98962* - Group Education 5–8 patients for 30 minutes
- 98966* - Phone Services 5-10 minutes
- 98967* - Phone Services 11-20 minutes
- 98968* - Phone Services 21-30 minutes
- 99487* - Care Management Services 31-75 minutes per month
- 99489* - Care Management Services, every additional 30 minutes per month
- G9007* - Team Conference
- G9008* - Physician Coordinated Care Oversight Services (Enrollment Fee)
- S0257* - End of Life Counseling

Specialist Team-Based Care: Lessons learned from the pilot

- At least half of the practices high-risk group should be made-up of BCBSM members.
- POs should include the new specialist care managers in meetings with the PCP care managers.
- ED physicians will avoid an admission if there is a viable care plan in place; it is important for the care managers to be involved prior to an ED visit so a plan can be in place about follow-up care.
- Each practice must carve out enough time for the care manager to actively manage their patients; this role should not be added to an already full workload.
- Ensure the office staff is aware of the available codes and how to bill them. Even if you think you understand the billing, it is important to continuously review it.

Necessities for the STBC Care Manager

Wants to work with patients on self management



Must have time to actively manage their patients

Focuses on care management and not other practice activities

Take the appropriate care manager training and continue training requirements on an annual basis

STBC – PDCM Comparison Table

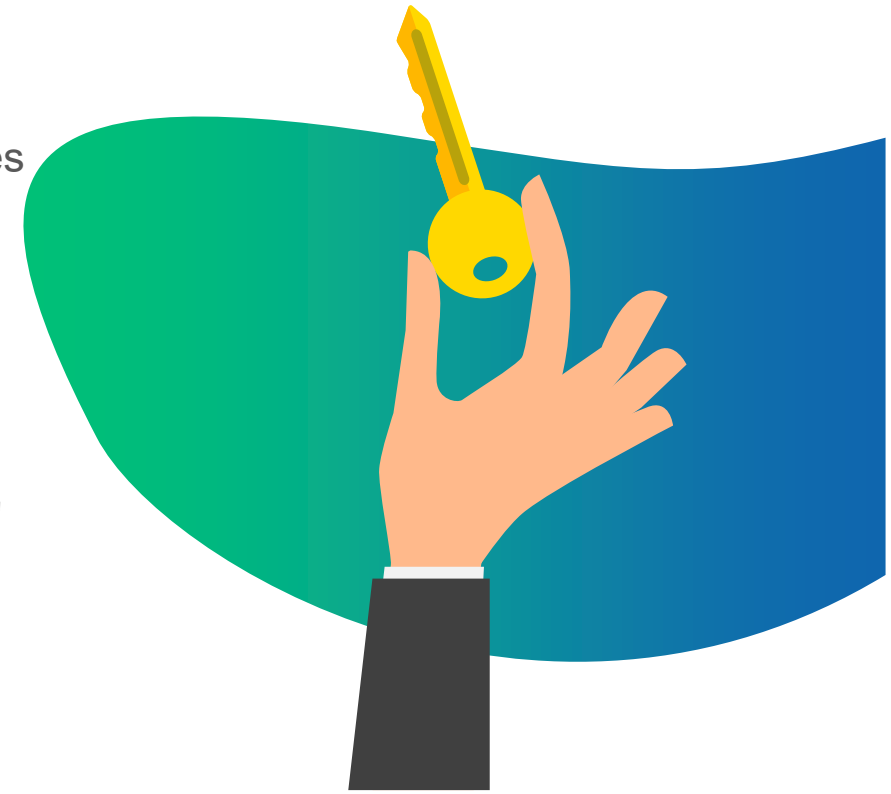
Requirements	STBC	PDCM
Care management services are available through the doctor's office	✓	✓
Care team members bill the PDCM codes and the rules regarding who can bill the codes are the same as in PDCM	✓	✓
Care managers (and care team members) must take the online PDCM billing course	✓	✓
Specialists must identify their high-risk patients through an ACRS file	✓	✗
Specialists must have a mechanism for receiving real time ADTs via a mobile device	✓	✗
A licensed care manager is required	✓	✗
Relevant PCMH-N capabilities are not required, although they are recommended	✓	✗
Specialists that agree to the program requirements are eligible for 105% VBR (ultimately eligibility is based on measurement)	✓	✗
HIE rewards are available to POs that participate	✓	✗

Specialist practices that meet PDCM requirements can continue to bill the PDCM codes without going through this program, but the specialists will not be eligible for VBR and the POs will not receive the related HIE rewards

Communication is key

Key Takeaways

- In order to succeed in the STBC program, the specialists must be on-board with the program requirements.
- Care managers in the specialists' offices need to be seeing patients and billing PDCM codes via the rendering physician's NPI.
- Including care managers in specialists' offices will lead to positive outcomes, such as fewer ED visits and inpatient admissions.



Preparation for POs interested in participating in STBC

Next Steps

POs should be prepared to help the specialists on-board to the program

POs should meet with practices, administration and clinical staff to explain the care management, IT, and real-time ADT notification requirements to make sure they can meet the program expectations

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More STBC Coming Soon

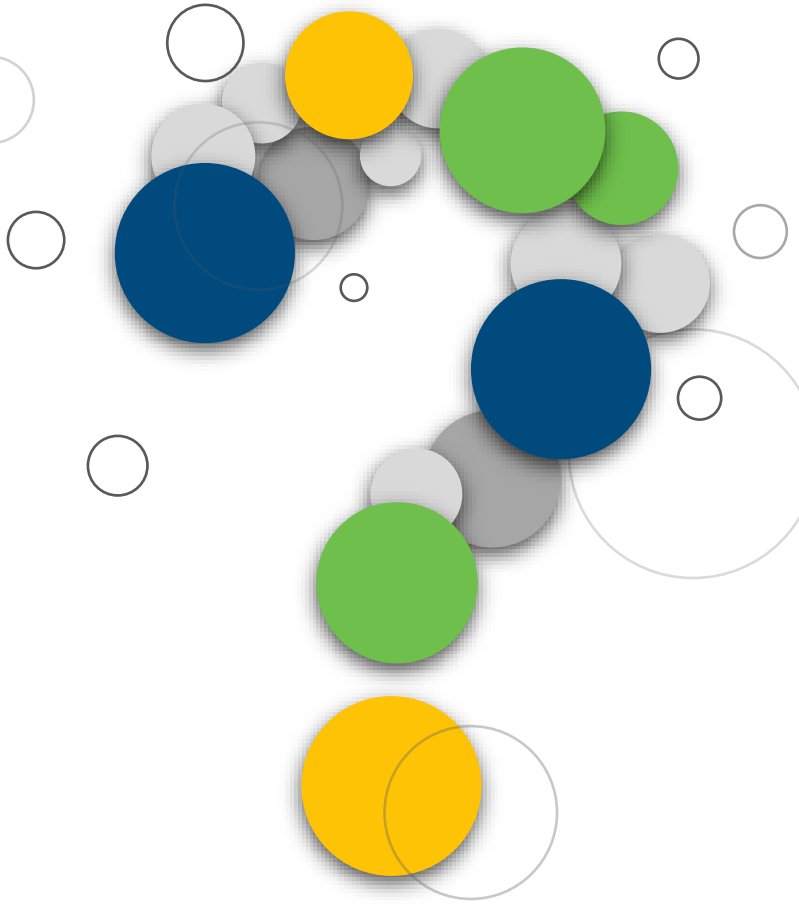
Next Steps

01 Details regarding plans for 2022 are being finalized

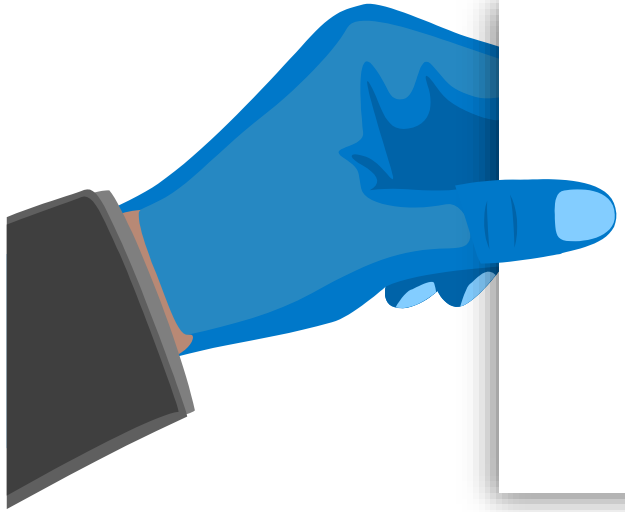
02 There will be opportunities for new POs to join the program and for existing POs to add more specialists

03 Information will be shared via the PO Collaboration site

Questions



Contact Information



Sheri Lee
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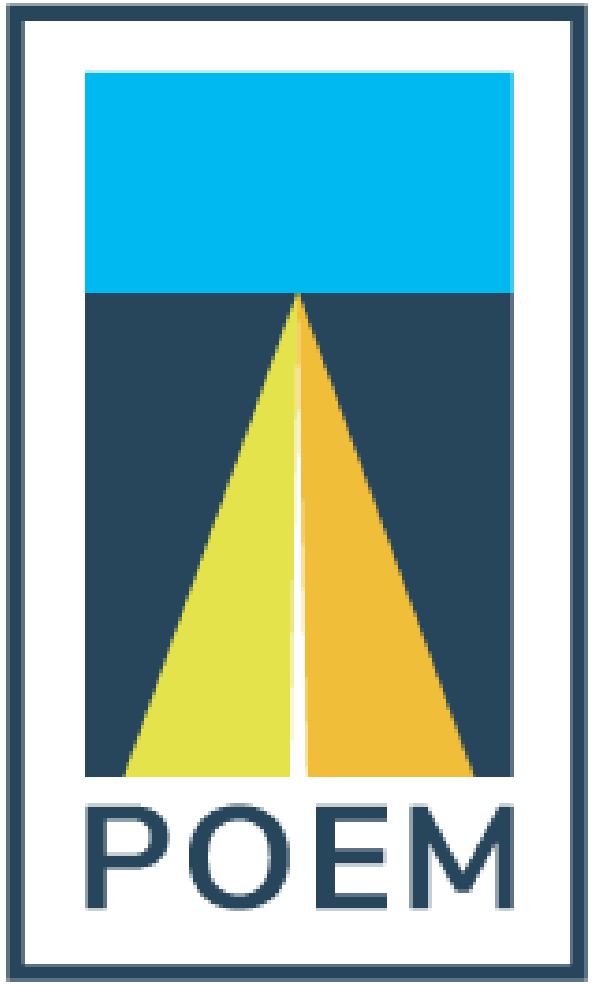
Value Partnerships
Blue Cross Blue Shield of Michigan



Pharmacists Optimizing Oncology Care Excellence in Michigan (POEM)

Emily Mackler, PharmD, BCOP

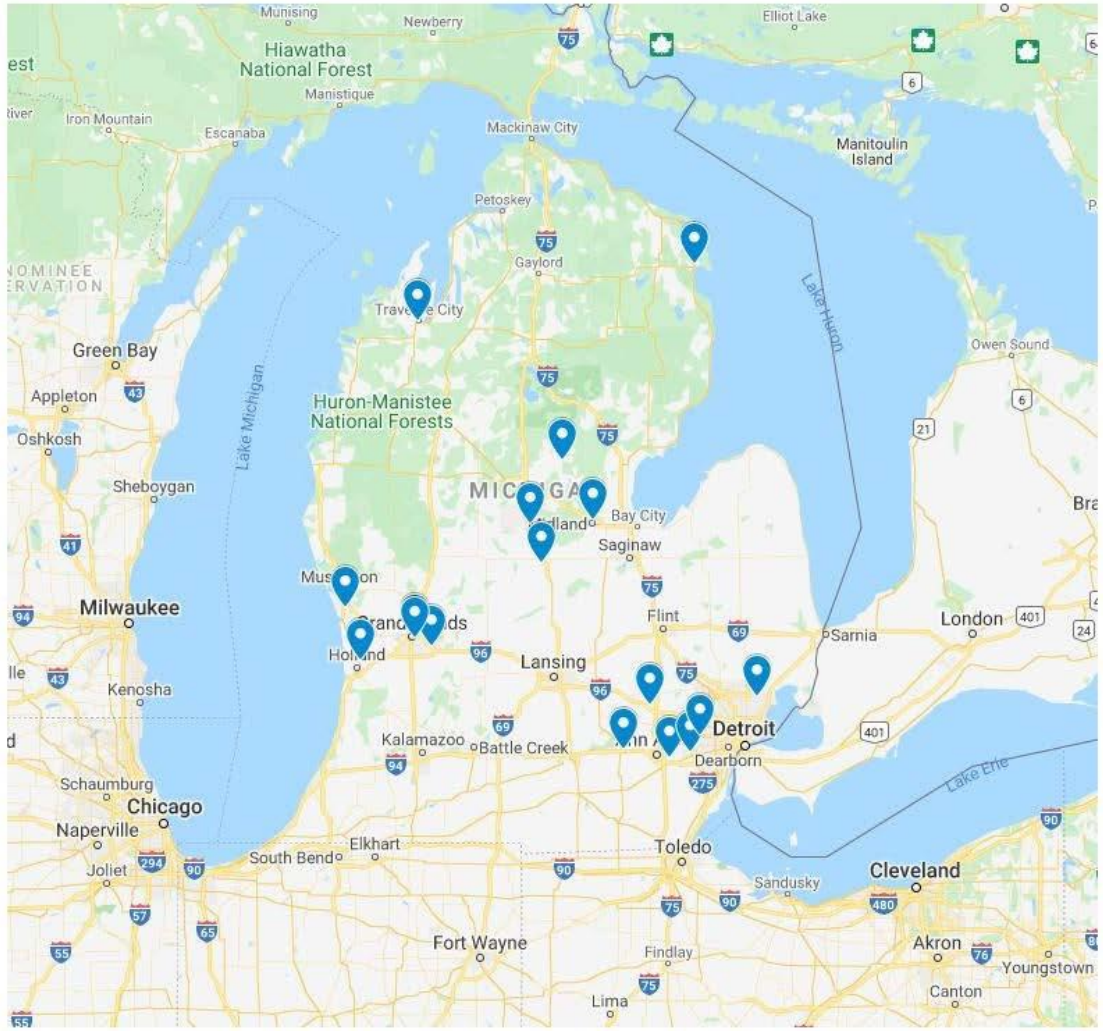
POEM Director

MICMT and MOQC (MI Oncology Quality Consortium)

moqc.org/poem

POEM Information

- Collaboration between MICMT and MOQC
- Integration of clinical oncology pharmacists in direct patient care → improve patient care and outcomes
- Clinical focus areas:
  - Oral anticancer agents
  - Immunotherapy
  - Symptom management and optimization
  - Patients with multiple co-morbidities
- Practice Support:
  - Pharmacist salary
  - Value-based reimbursement



Launched October 2020

- 6 Clinical Oncology Pharmacists
- 8 Physician Organizations
- 24 Oncology Sites
- 72 Physicians

- 874 Patients
- 1695 Encounters
- 1854 Interventions

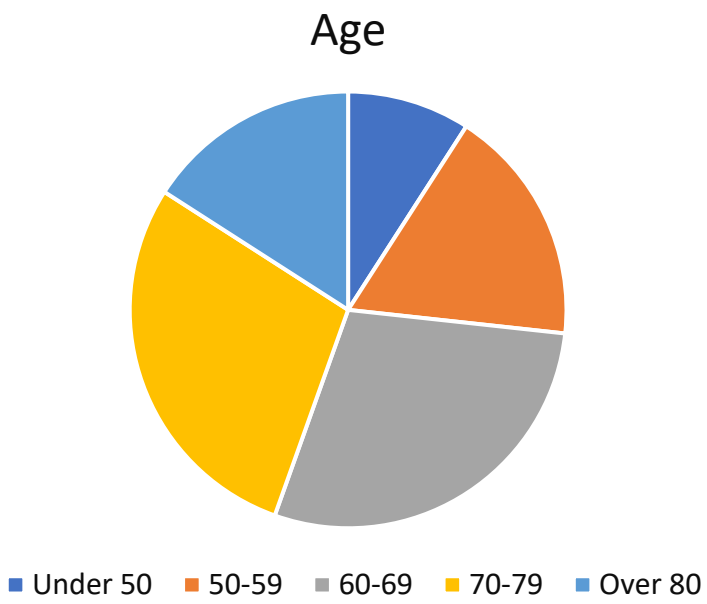
POEM

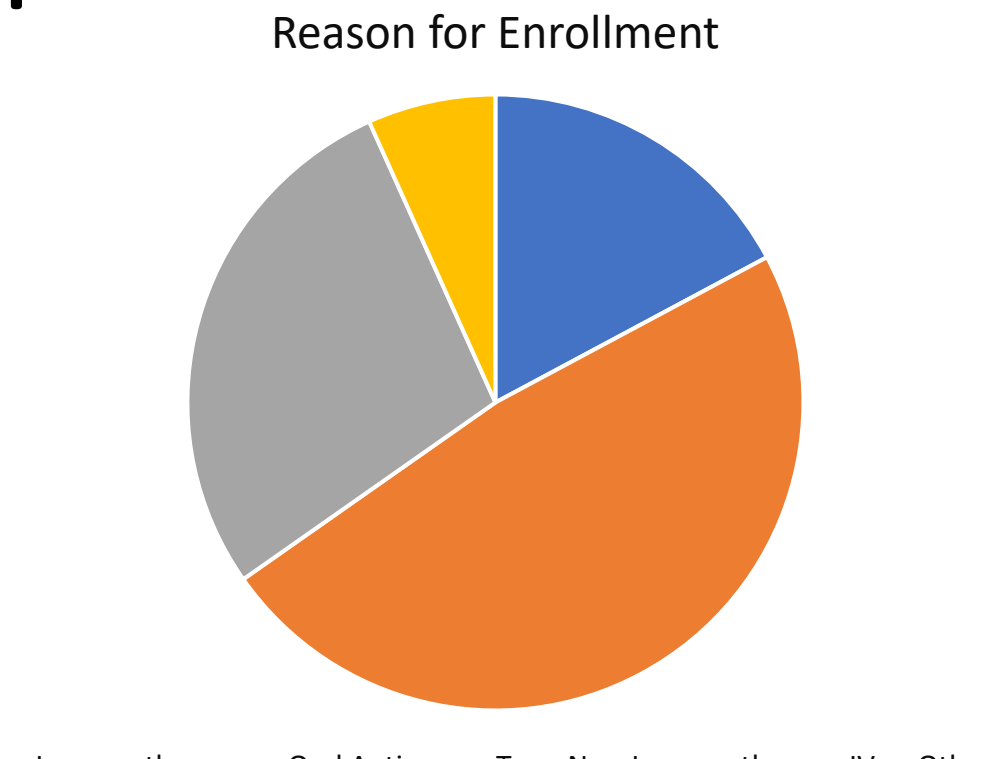
Outcome Assessment

- Pharmacist report – RedCap
  - Patient demographics
  - Encounters
  - Interventions
- Patient satisfaction
- Care management billing optimization
- Site-specific metrics and outcomes

Data – Demographics

- Female: 48.4%
- White: 85.1%



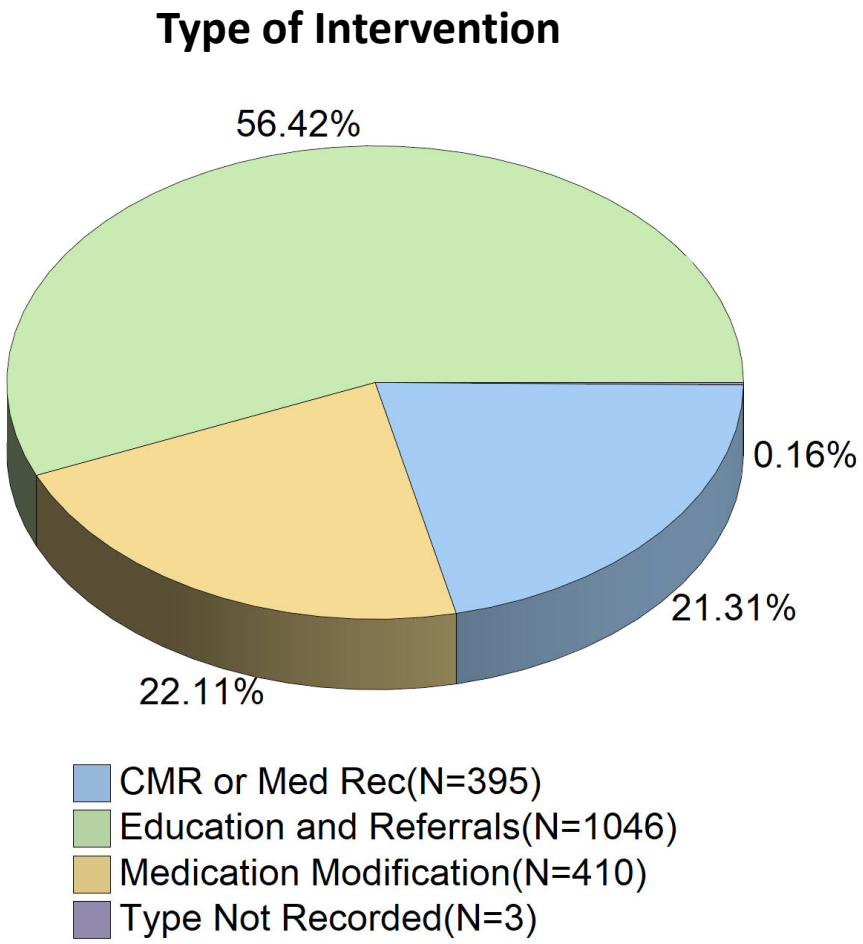


POEM

Data – Outcomes

- Encounters per week
  - 36 over the last year
  - 58 over the past quarter
- 66% of encounters billed a care management code

- Interventions per week
  - 39 over the last year
  - 67 over the past quarter



Improvement in Time to Oral Anticancer Agent Follow-Up

Johengen, E., PharmD, BCACP; Davidson, A., BS; Hecht, K., PharmD, BCPS, BCACP; Beekman, K., MD; Reyes-Gastelum, D., MSc; Mackler, E., PharmD, BCOP

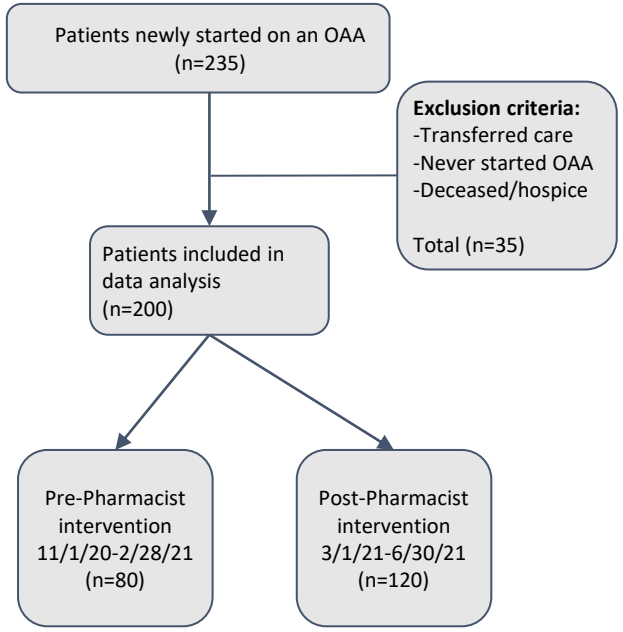
INTRODUCTION

* Cancer treatment management has evolved from infusions that are supervised by a healthcare provider to oral medications taken at home.
* While oral anticancer agents (OAA) are more convenient for patients, more responsibility is put on them to manage their own treatment.
* Pre-intervention: OAA monitoring was shared between team members (nurse, physician, advanced practice provider) and a consistent process for patient identification did not exist.
* Post-intervention: A dedicated oncology pharmacist position was added for patient education and follow-up.

OBJECTIVES

* To demonstrate the impact of an oncology pharmacist on the time to follow-up for patients initiating treatment with OAAs

METHODS



Abstract #235

Pharmacist involvement improves time to oral anticancer agent follow up.

CONCLUSIONS

* Adding a dedicated pharmacist to a community cancer center for OAA education and ongoing monitoring improved the proportion of patients whose follow up met institutional and national guidelines for OAA monitoring frequency.
* Future directions for this research include identifying the impact of the dedicated pharmacist on clinical outcomes such as healthcare resource utilization, toxicity, and adherence.

REFERENCES

1. Ribeiro TB, et al. *Int J Technol Assess Health Care*. 2020;36(1):20-28
2. Mackler E, et al. *J Oncol Pract*. 2019 Apr;15(4):e346-e355
3. Aisner J. *American Journal of Health-System Pharmacy*. 2007; 64(9).
4. Dürr P, et al. *Journal of Clinical Oncology*. 2021 Apr 6:JCO2003088. Epub ahead of print.

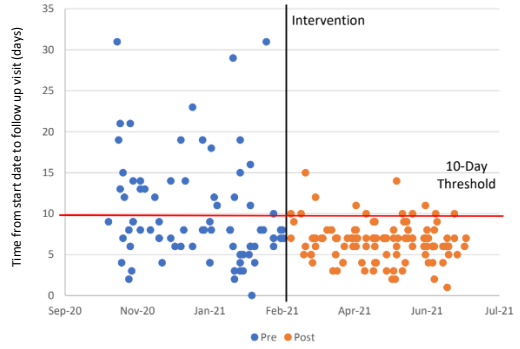
RESULTS

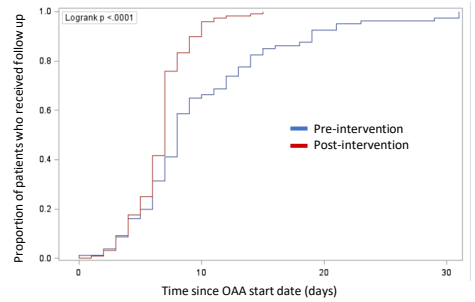
Table 1. Percent of OAA follow up within 10 days and 14 days, pre-intervention vs. post-intervention

	New Starts	Follow up within 10 days, n (%)	Follow up within 14 days, n (%)	Median time to follow up, days (range)
Pre-intervention	80	51 (63.8)	66 (82.5)	8 (2 to 31)
Post-intervention	120	115 (95.8)	119 (99.2)	7 (2 to 15)
p-value		<0.001	<0.001	<0.001

A Wilcoxon test was performed to compare the follow-up days between the pre- and post-interventions. There is a significant statistical differences between them ($p < 0.001$).

Figures 1 and 2. Time to first OAA follow up





Support for the Michigan Oncology Quality Consortium is provided by Blue Cross and Blue Shield of Michigan as part of the BCBSM Value Partnerships program.

Contact: Emily_Johengen@ihacares.com

Patient Experience

- “The pharmacist was kind and knew everything we needed to know. We are always grateful for the hard truths. She covered those with professional grace. Thank you.”

- “The pharmacist was fantastic! I seriously consider this time with her extremely helpful!”

Conclusion

- Early data from our pilot year indicates positive patient experiences, multiple education sessions, and several medication interventions to improve symptoms and treatment-related side effects.
- Our first site-specific analysis indicates an improvement in time to patient follow-up.
- We continue to recruit practices for participation with availability for 6 practices in 2022

Thank you – POEM team

Michigan Institute for Care Management & Transformation Annual Meeting

October 8, 2021

Objectives

- Describe I-MPACT
- Show trends of PCP, Cardiologist, Pulmonologist, Other Follow-up post discharge
- Describe association of Cardiologist appointment post-discharge with 30-day readmission
- Describe impact of care management, education, standardization of workflow on CHF 30-day readmission
- Illustrate post Skilled Nursing Facility readmissions
- Demonstrate Care Management association with decreased readmission for SNF patients
- Describe Patient Reported Outcome Survey Results

Mission

I-MPACT is a patient-centered, data-driven collaborative that engages healthcare organizations and patients throughout Michigan in developing and implementing innovative approaches for improving care transitions.

I-MPACT Goals

High Level:

- Reduce readmissions
- Reduce ED utilization
- Increase post-discharge 7-day follow-up appointments
- Improve transitions of care:
  - Communication between providers
  - Communication between providers and patients
  - Increased patient satisfaction with care transitions
- Three (3) target populations to choose from:
  - COPD
  - CHF
  - Patients transitioning into and out of a SNF

I-MPACT Current State

I-MPACT launched in April 2016

- 5 Cohorts – 20 hospitals; 15 Physician Organizations; 20+ SNFs

Data registry launched 2017

- Demographics
- Documentation of Transition of Care Communication
  - between Inpatient and Outpatient provider (Discharge Summary)
  - Between Providers and Patients (Discharge Instructions)

Focusing on finding interventions or combinations of interventions that are most effective

- Literature says patients will require more than one intervention to make a difference
  - Interventions need to be multi-faceted; cross multiple clinical disciplines; patient-centered
  - Care Management, Medication Reconciliation, Standardization of discharge process, Consultation, Patient Education

I-MPACT

CHF POPULATION – POST-DISCHARGE FOLLOW-UP AND CARE MANAGEMENT TO PREVENT READMISSIONS

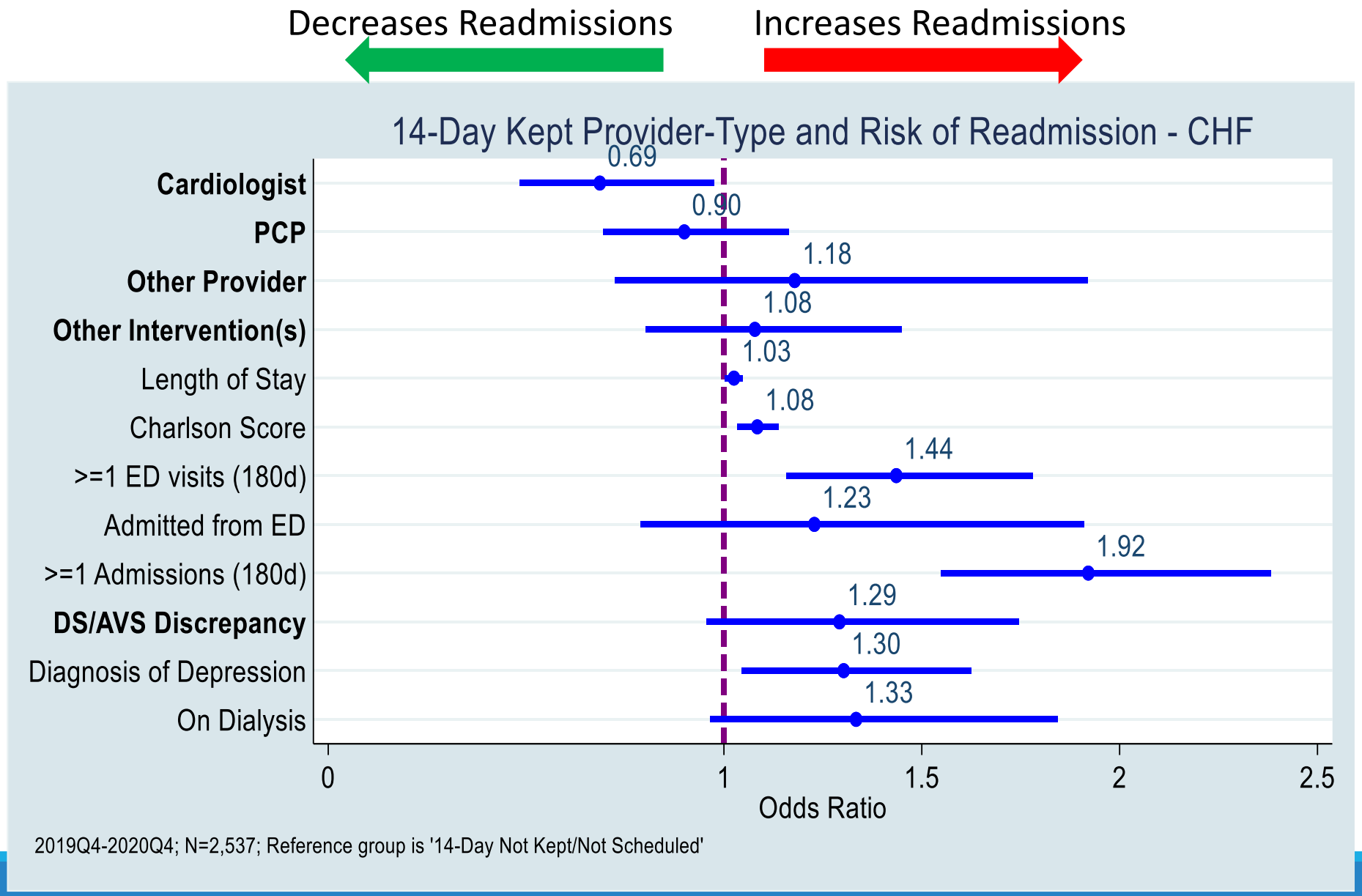
Follow-up Appointments by Provider Type*

	PCP		CARD		PULM		OTHER	
	% of patients who sched. appt.	Of sched. appt. % kept	% of patients who sched. appt.	Of sched. appt. % kept	% of patients who sched. appt.	Of sched. appt. % kept	% of patients who sched. appt.	Of sched. appt. % kept
f/u 0-7 days only	30.3%	60.1%	9.3%	69.4%	1.3%	74.7%	7.5%	66.6%
f/u 8-14 days only	7.9%	64.0%	3.4%	73.1%	0.6%	75.0%	2.6%	61.3%

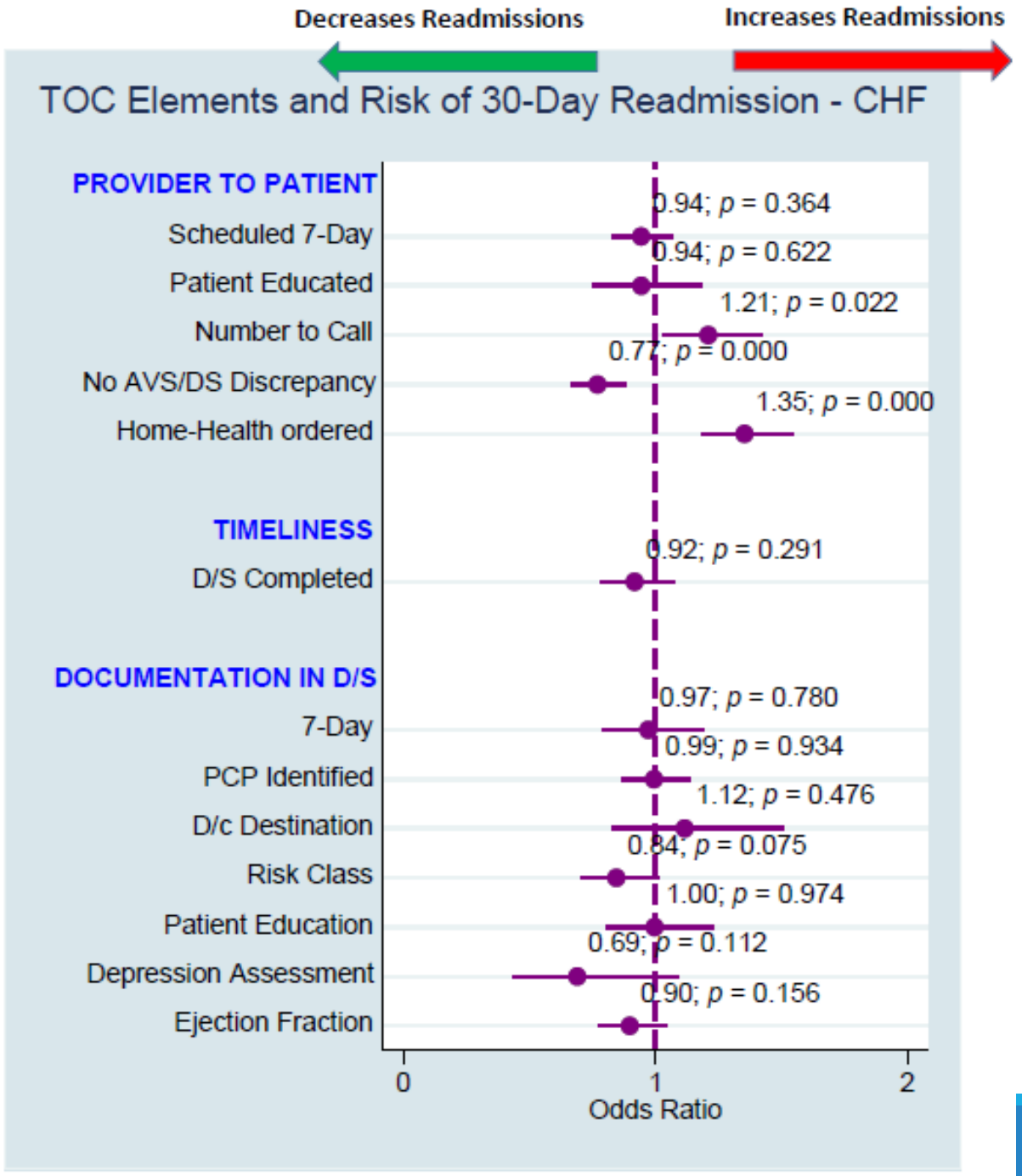
*Patients discharged to home/assisted living only – Data from Q4 2019 – Q2 2021

*A patient may be counted under multiple provider types depending on the number of appointments scheduled

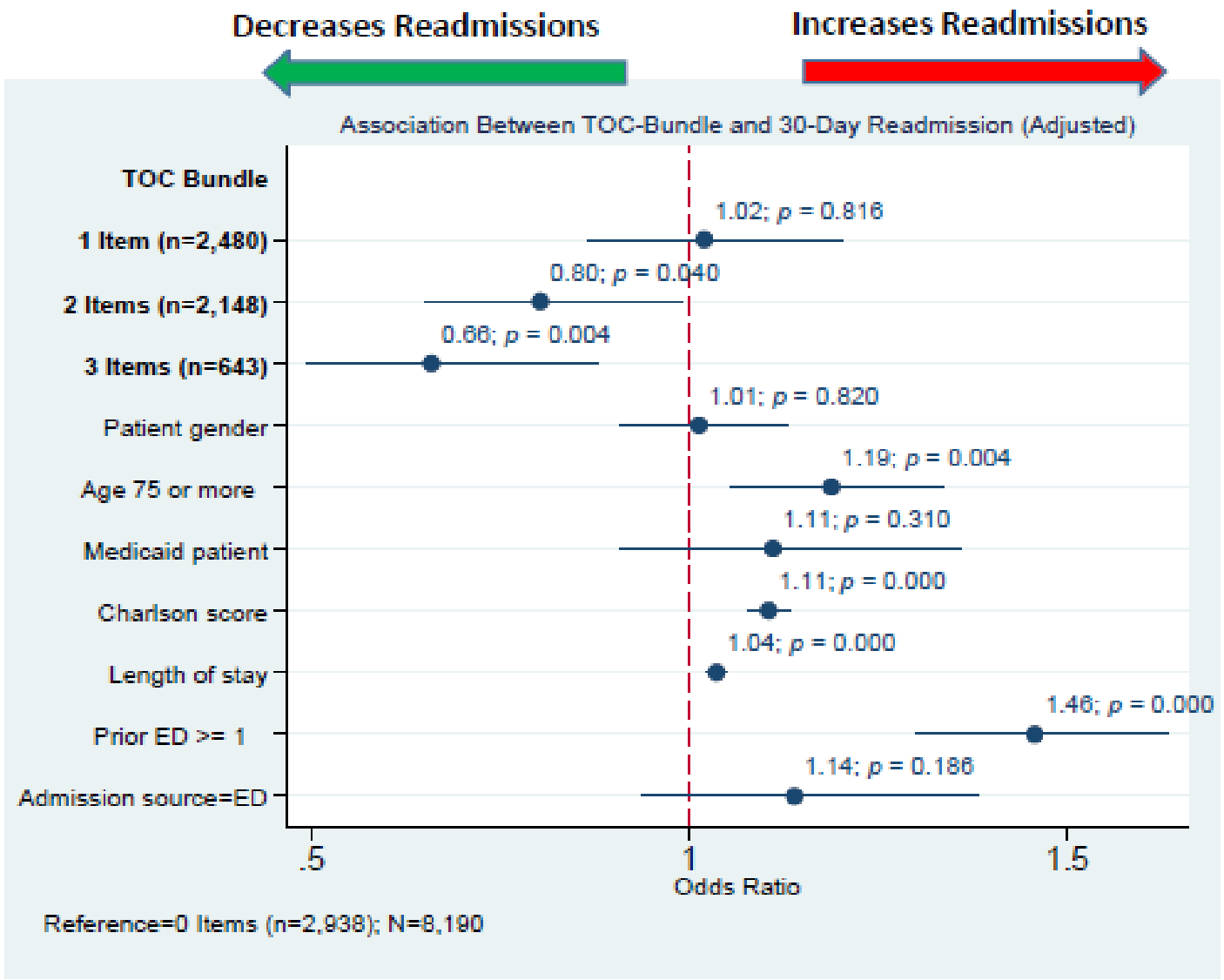
14-day Post-discharge Follow-up



CHF Transition of Care (TOC) Elements

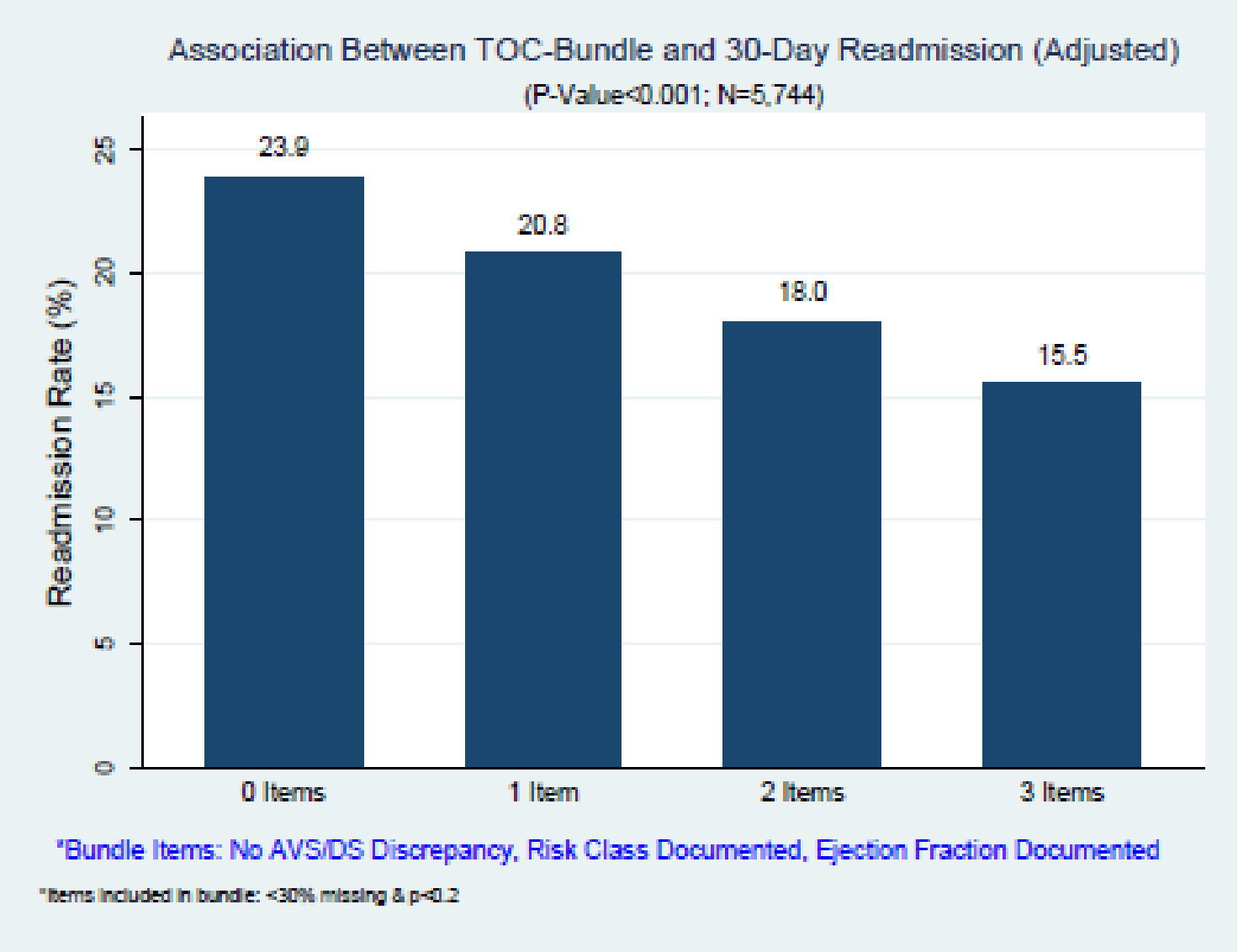


CHF Transition of Care (TOC) Elements



Bundle Items: No AVS/DS discrepancy, Risk Class Documented, Ejection Fraction Documented

CHF Transition of Care (TOC) Elements

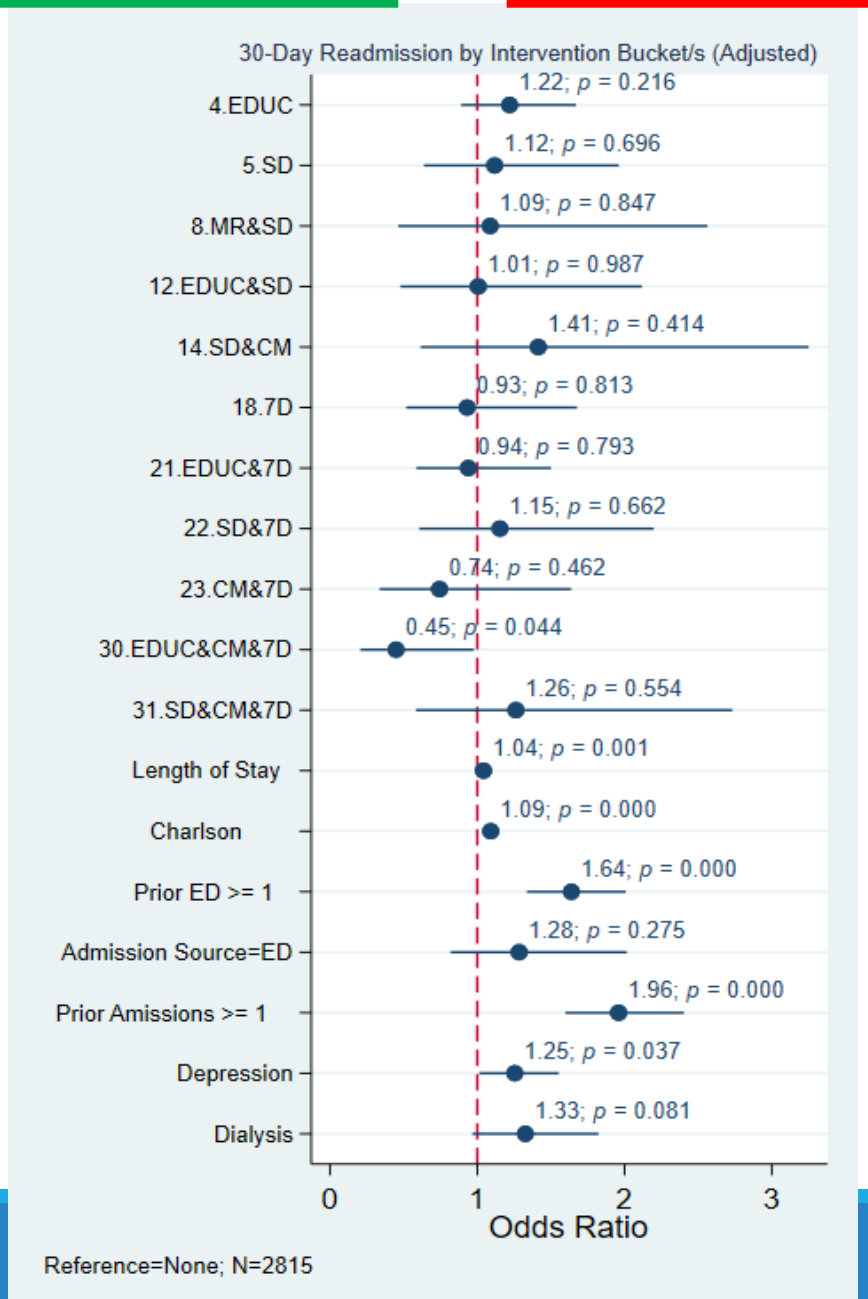


Including all three items from the bundle potentially reduces readmissions by 35%.

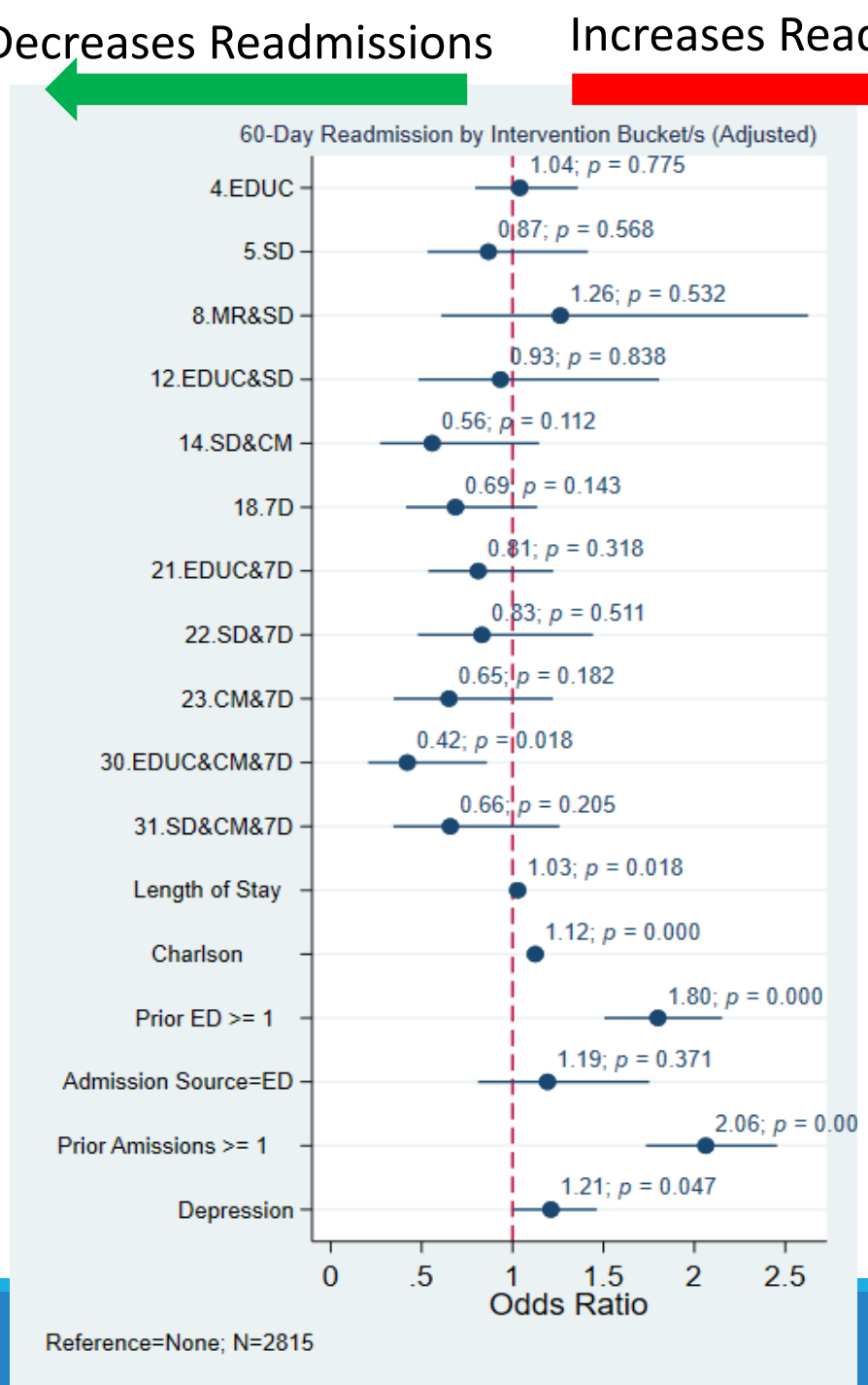
CHF Interventions & 30-day Readmissions

Decreases Readmissions

Increases Readmissions



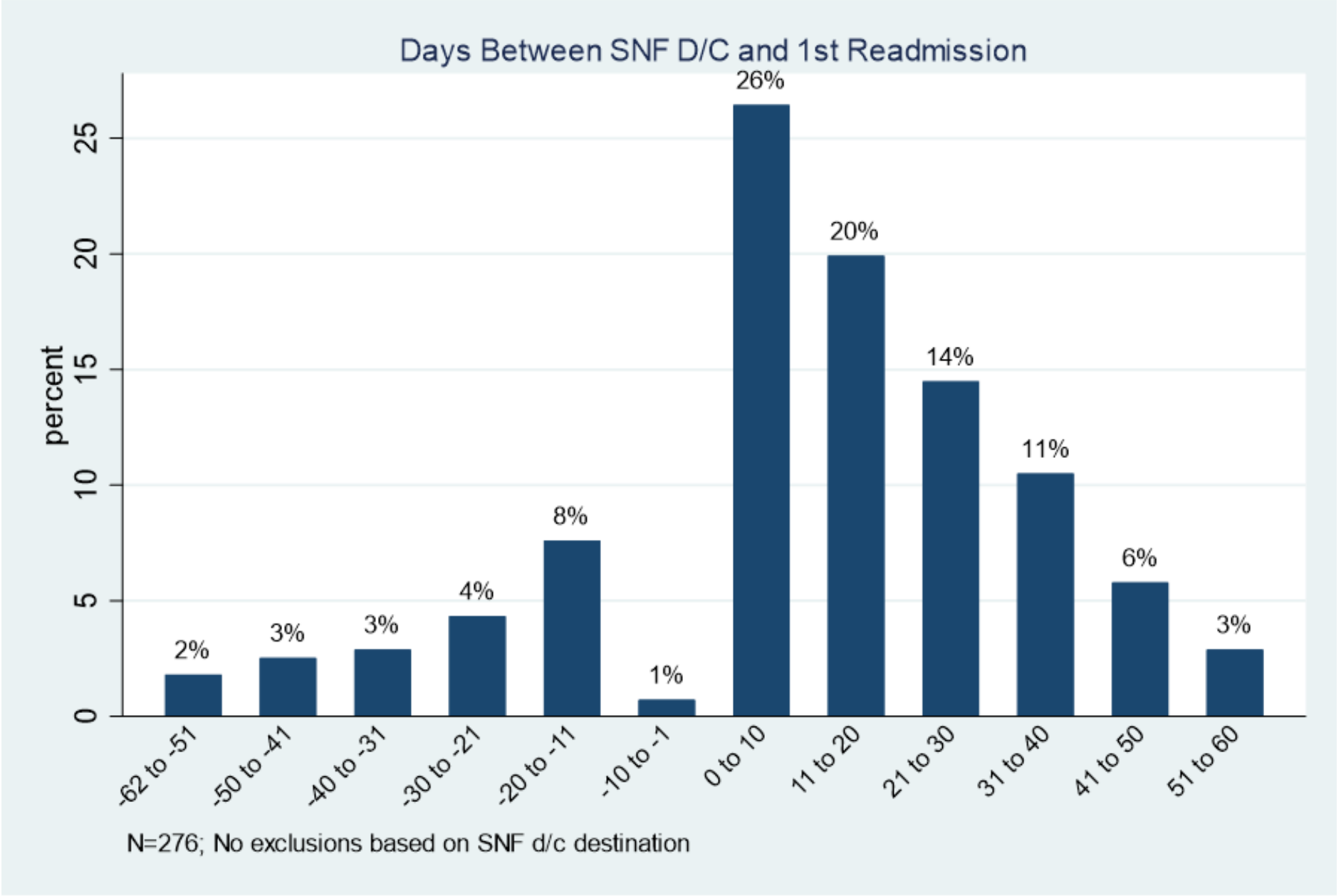
CHF Interventions & 60-day Readmissions



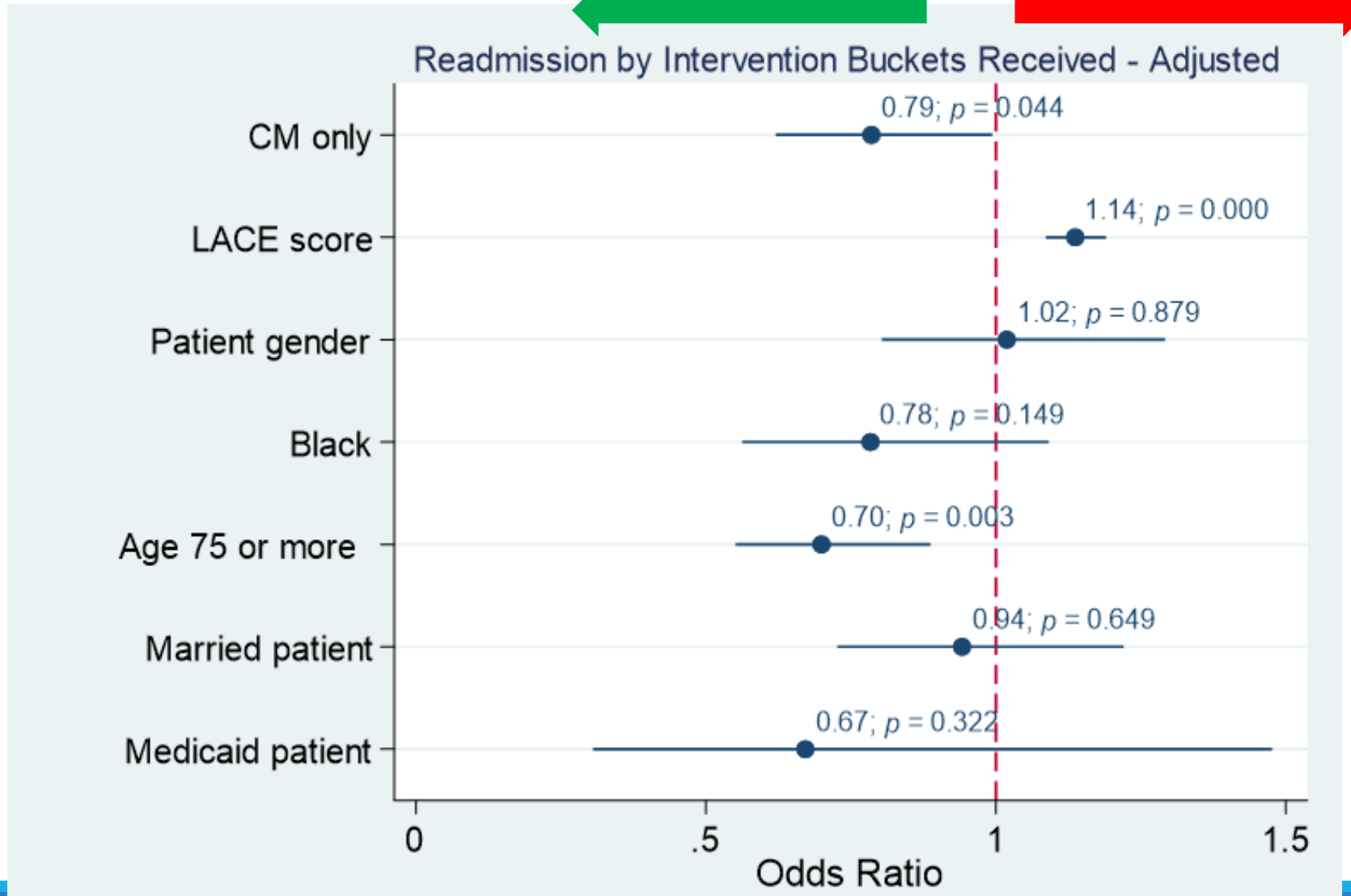
I-MPACT

SNF POPULATION & CARE MANAGEMENT

Time to 1st Readmission SNF Patients



SNF Population Readmissions Within 60 Days of Hospital Discharge – Care Management Only vs No Intervention



I-MPACT

PATIENT REPORTED OUTCOMES

I-MPACT PROS Project

Data Collected from October 2018 through December 2019

Key Points

Question: What are patients' perspectives about their care transition experience from hospital or skilled nursing facility to home?

Findings: Black/African American patients are more likely to report:

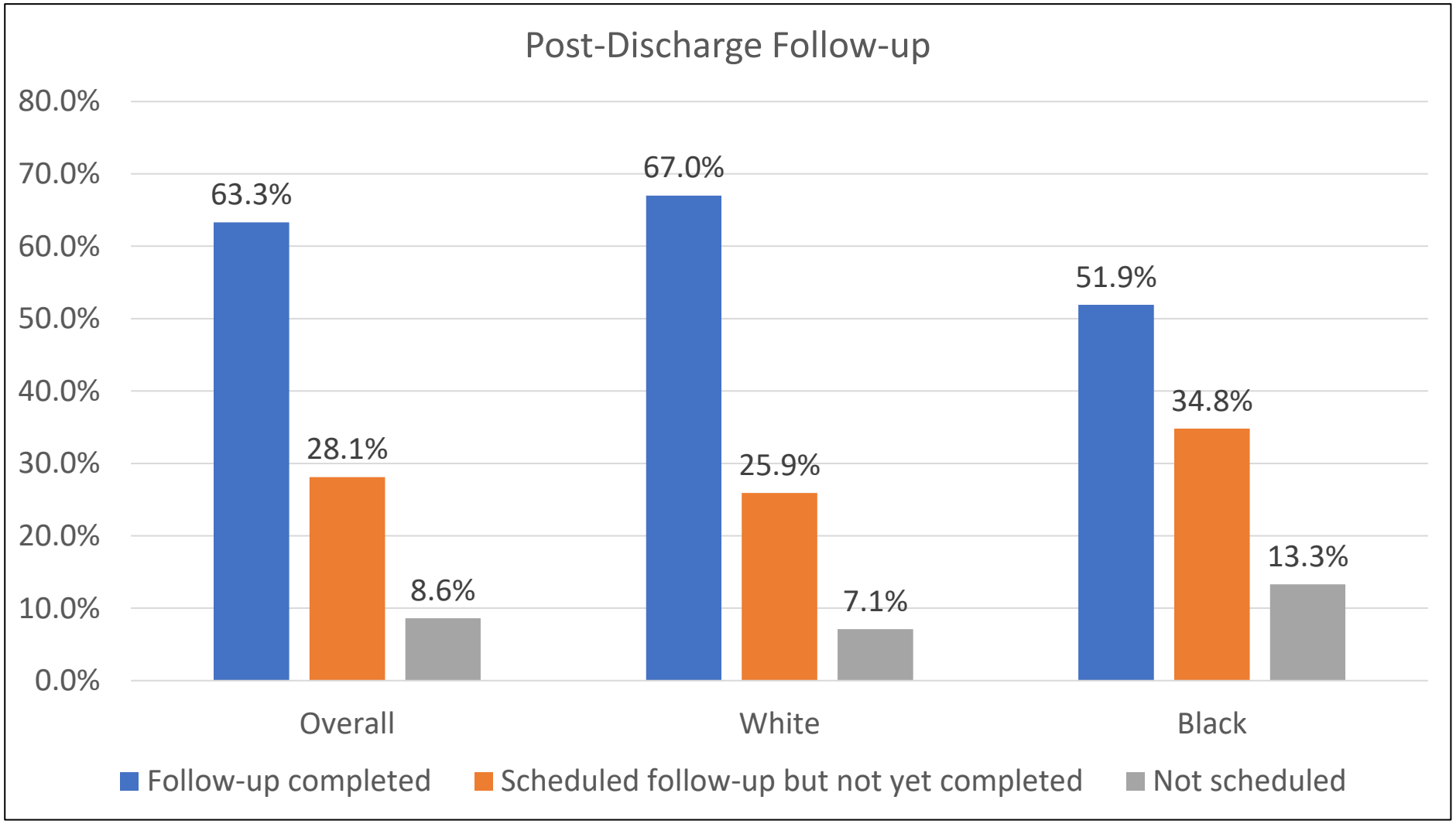
(1) Concerns related to affording their most basic needs, doctors' visits, and copays;

(2) A lack of confidence using or receiving necessary home medical equipment;

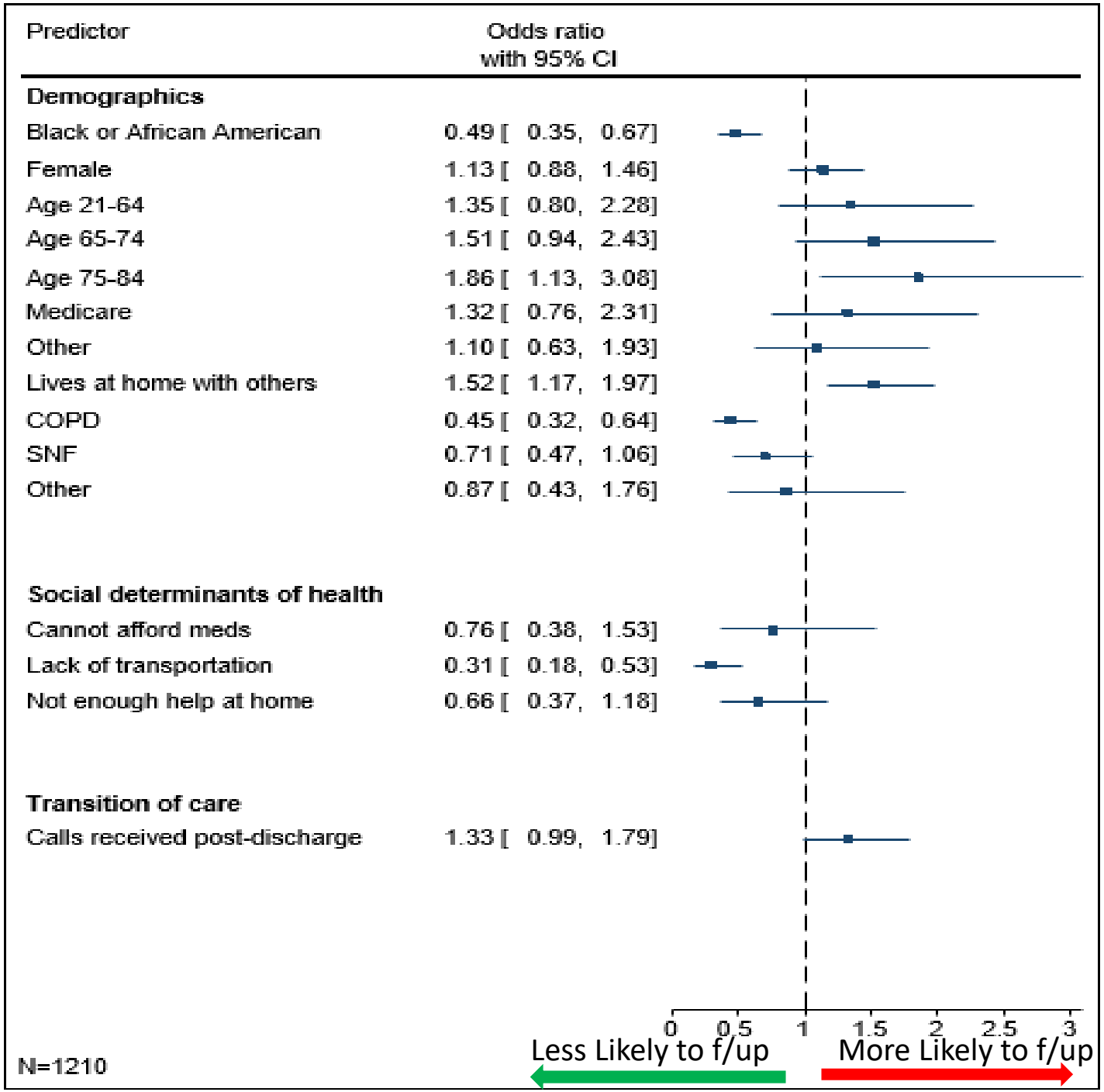
(3) Not attending follow-up appointments after discharge to home. Black patients are less likely to attend early post-discharge follow-up appointments and receive follow-up calls.

Meaning: Patients may experience disparities in their care transition experience based on their race.

PROs Data


Post-Discharge Follow-up
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
63.3%
28.1%
8.6%
67.0%
25.9%
7.1%
51.9%
34.8%
13.3%
Overall
White
Black
Follow-up completed
Scheduled follow-up but not yet completed
Not scheduled

Adjusted associations between patient characteristics and completion of post-discharge follow-up



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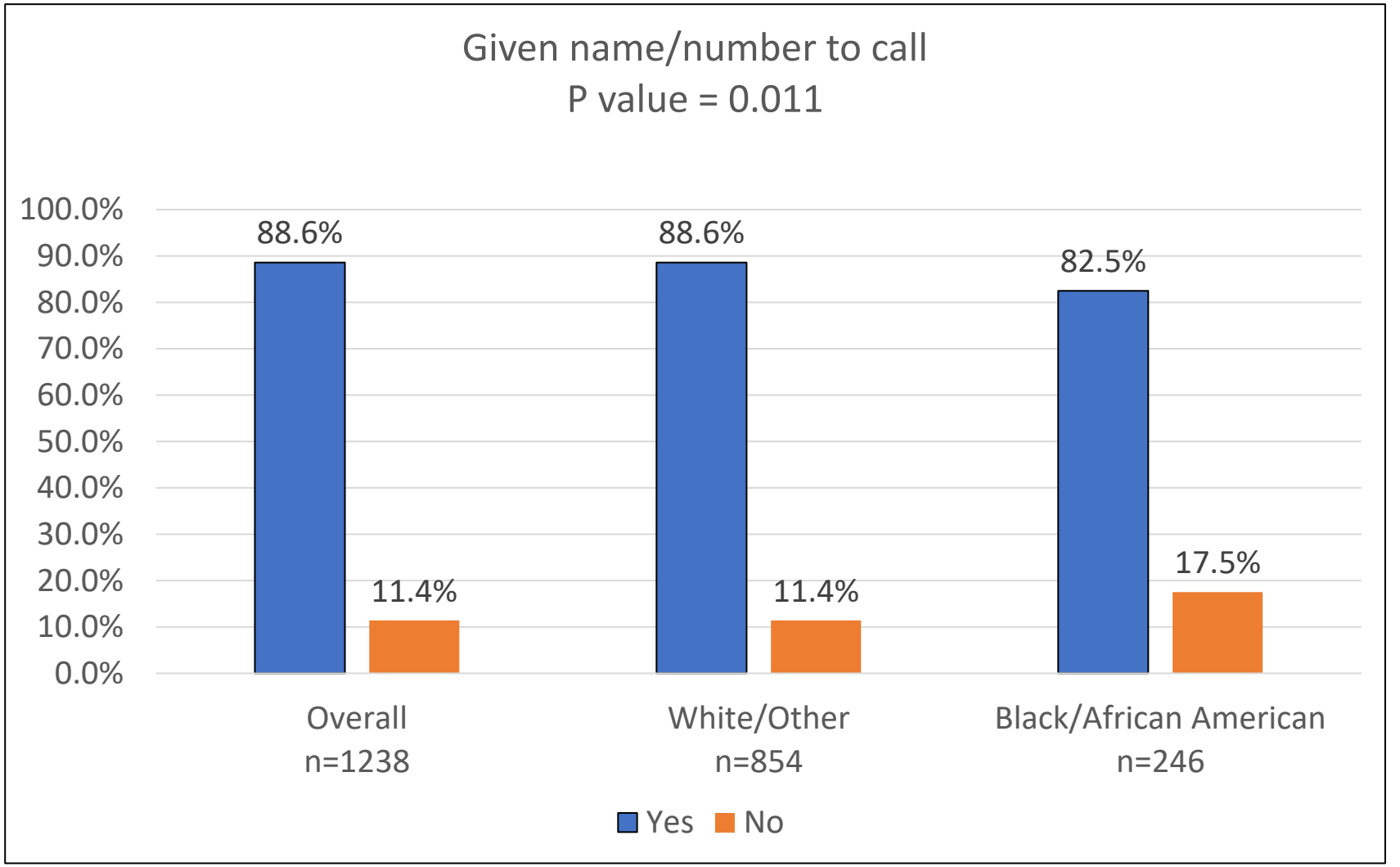
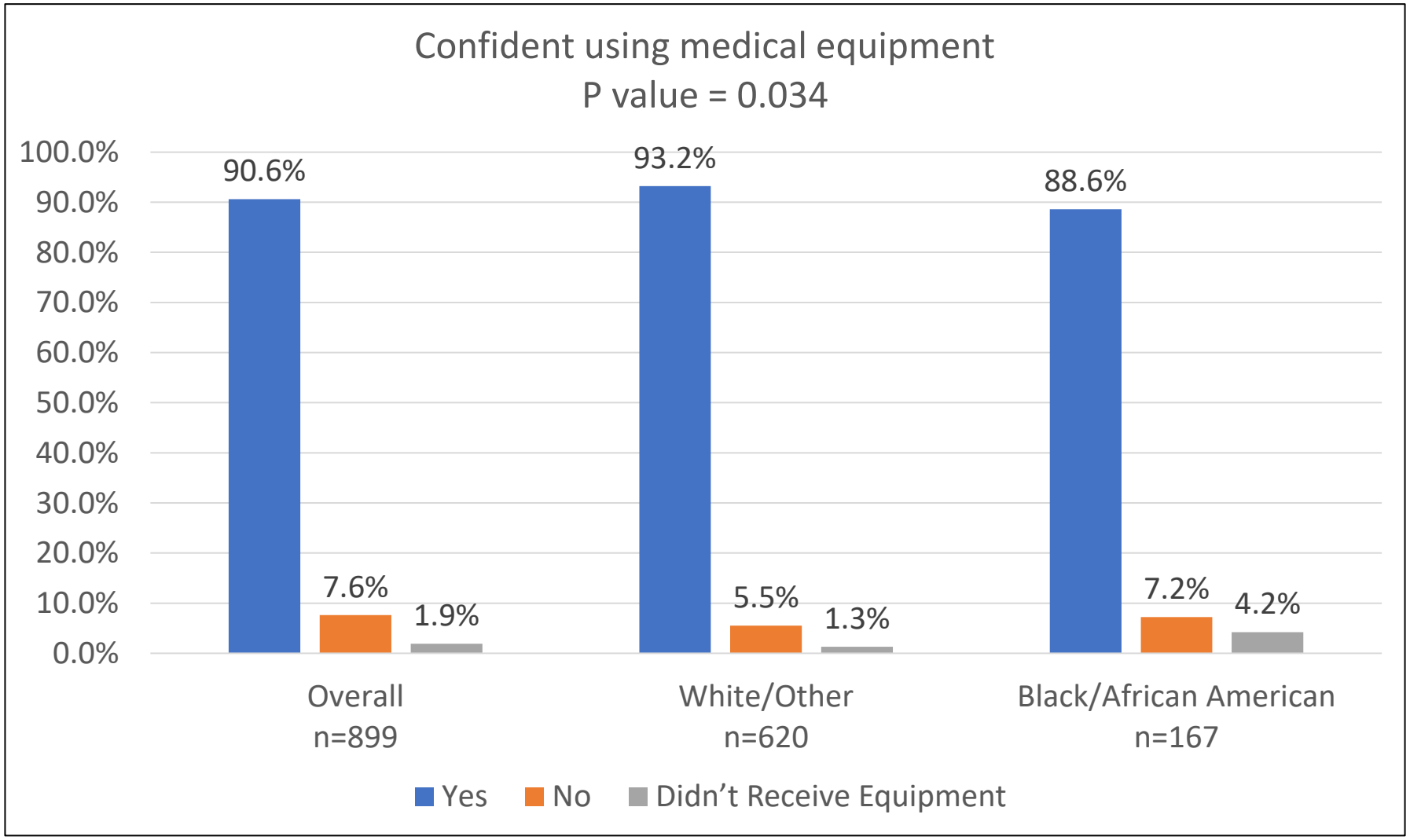
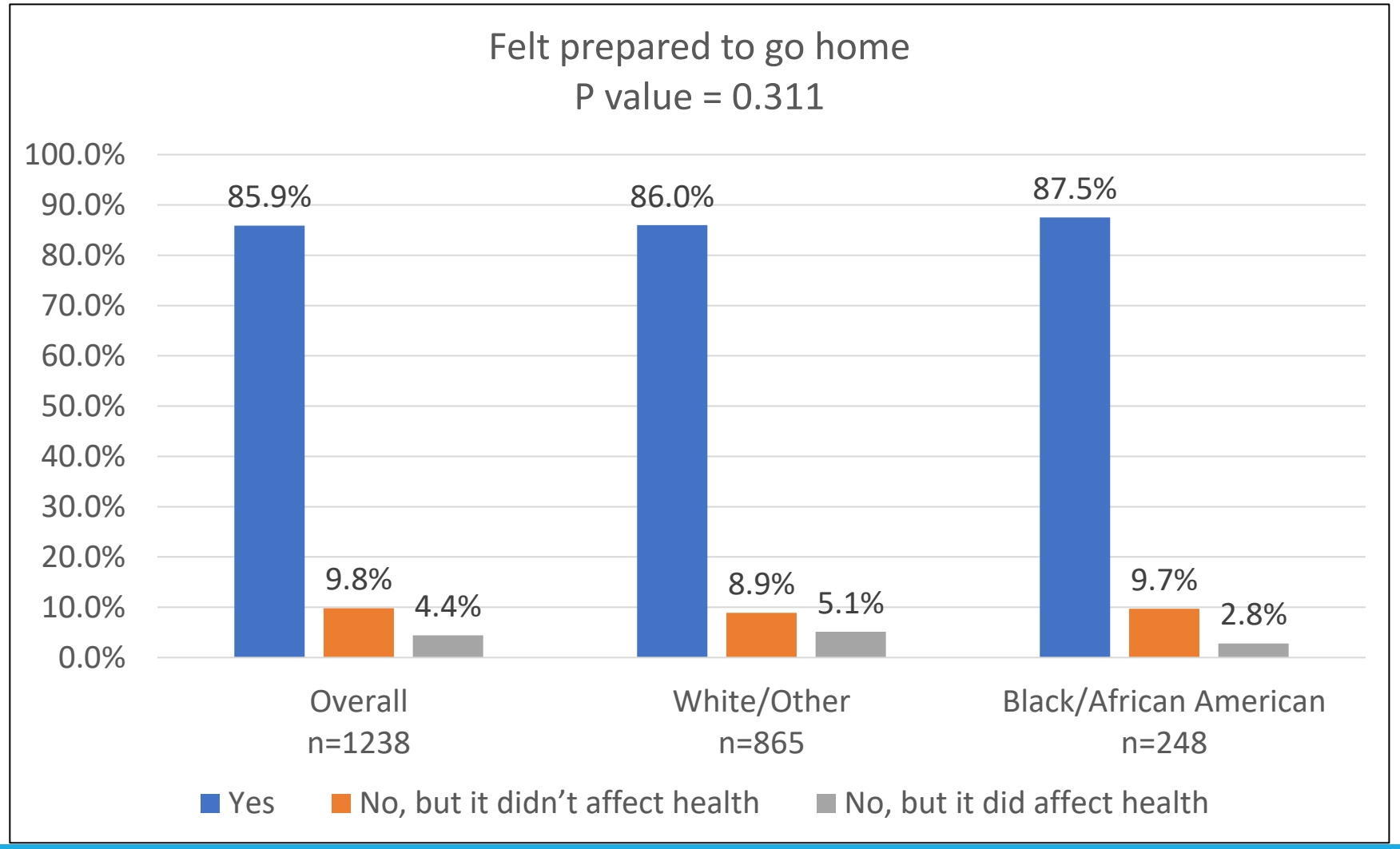

Given name/number to call
P value = 0.011
100.0%
90.0%
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
88.6%
11.4%
88.6%
11.4%
82.5%
17.5%
Overall
n=1238
White/Other
n=854
Black/African American
n=246
Yes
No

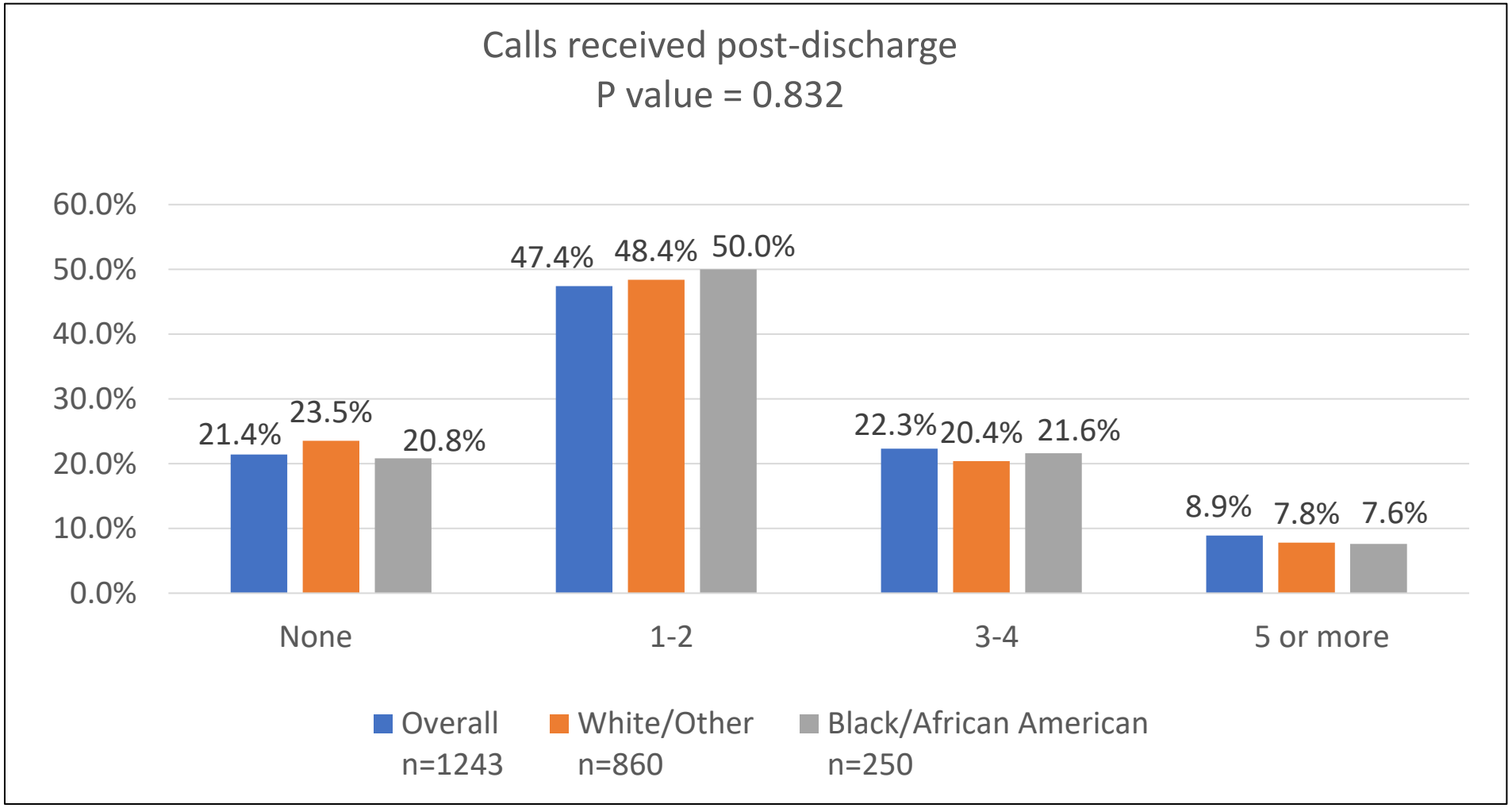
PROs Data


Confident using medical equipment
P value = 0.034
100.0%
90.0%
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
90.6%
7.6%
1.9%
93.2%
5.5%
1.3%
88.6%
7.2%
4.2%
Overall
n=899
White/Other
n=620
Black/African American
n=167
Yes
No
Didn't Receive Equipment

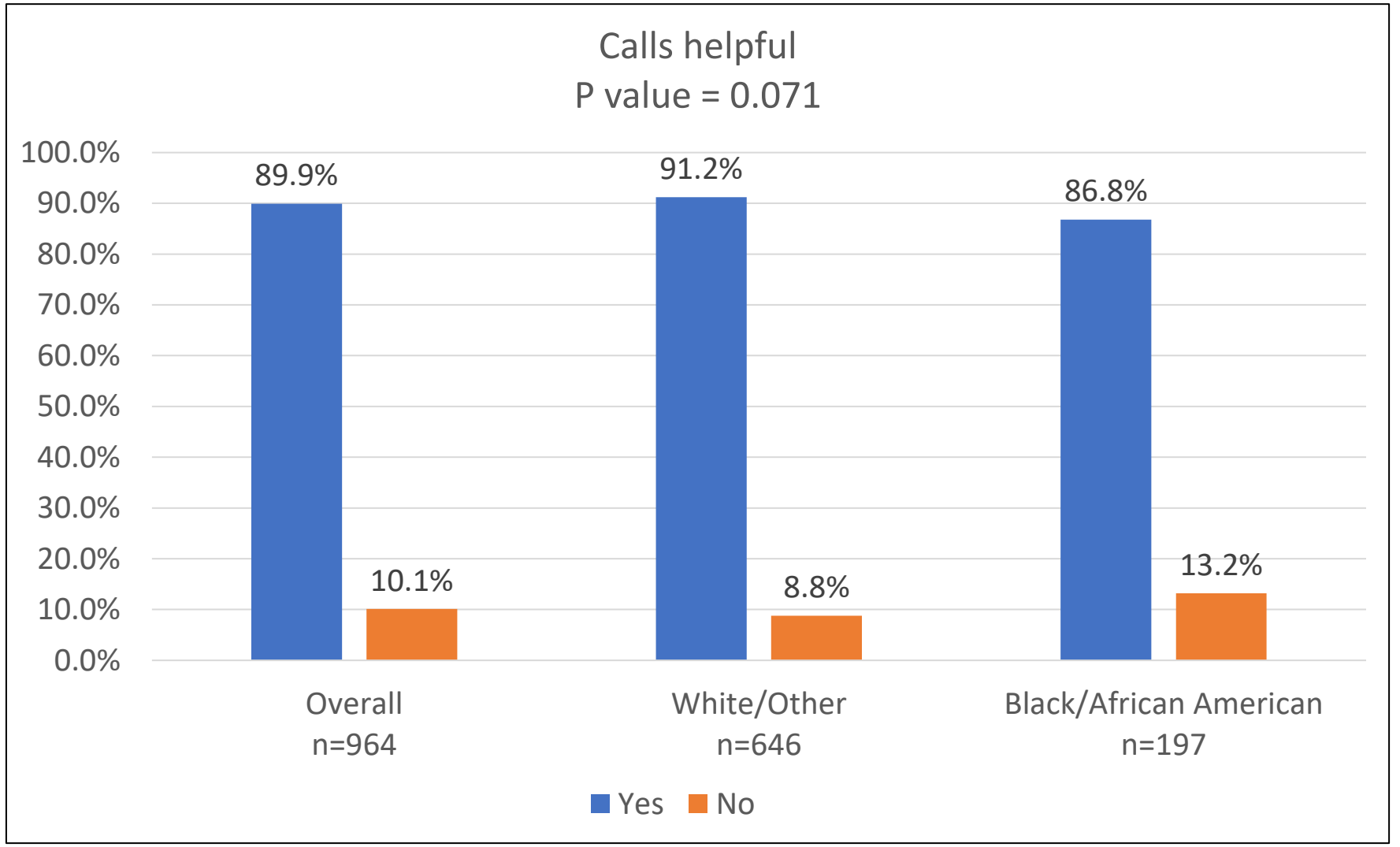
PROs Data


Felt prepared to go home
P value = 0.311
100.0%
90.0%
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
85.9%
9.8%
4.4%
86.0%
8.9%
5.1%
87.5%
9.7%
2.8%
Overall
n=1238
White/Other
n=865
Black/African American
n=248
Yes
No, but it didn't affect health
No, but it did affect health

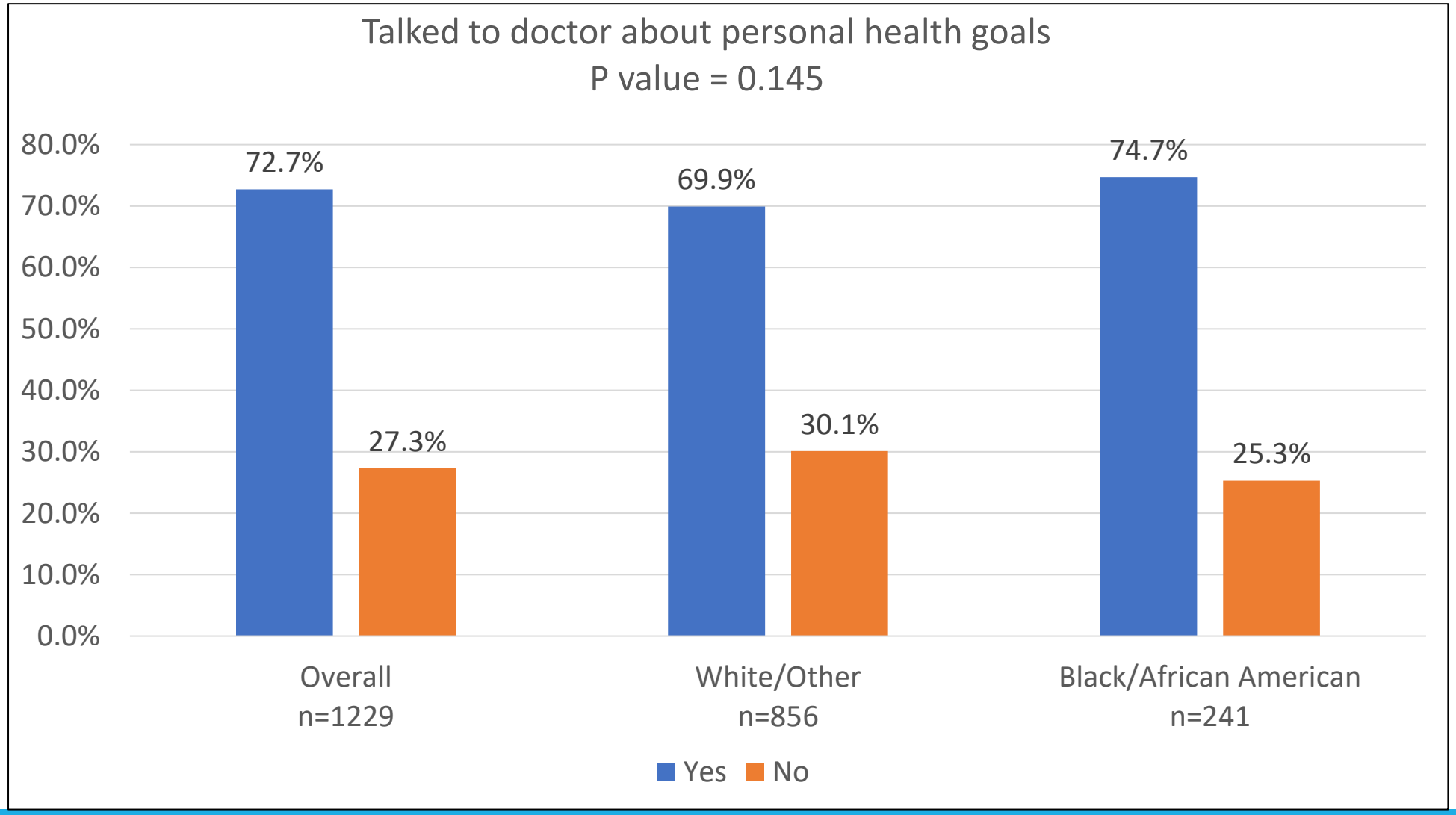
PROs Data


Calls received post-discharge
P value = 0.832
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
21.4%
23.5%
20.8%
47.4%
48.4%
50.0%
22.3%
20.4%
21.6%
8.9%
7.8%
7.6%
None
1-2
3-4
5 or more
Overall n=1243
White/Other n=860
Black/African American n=250

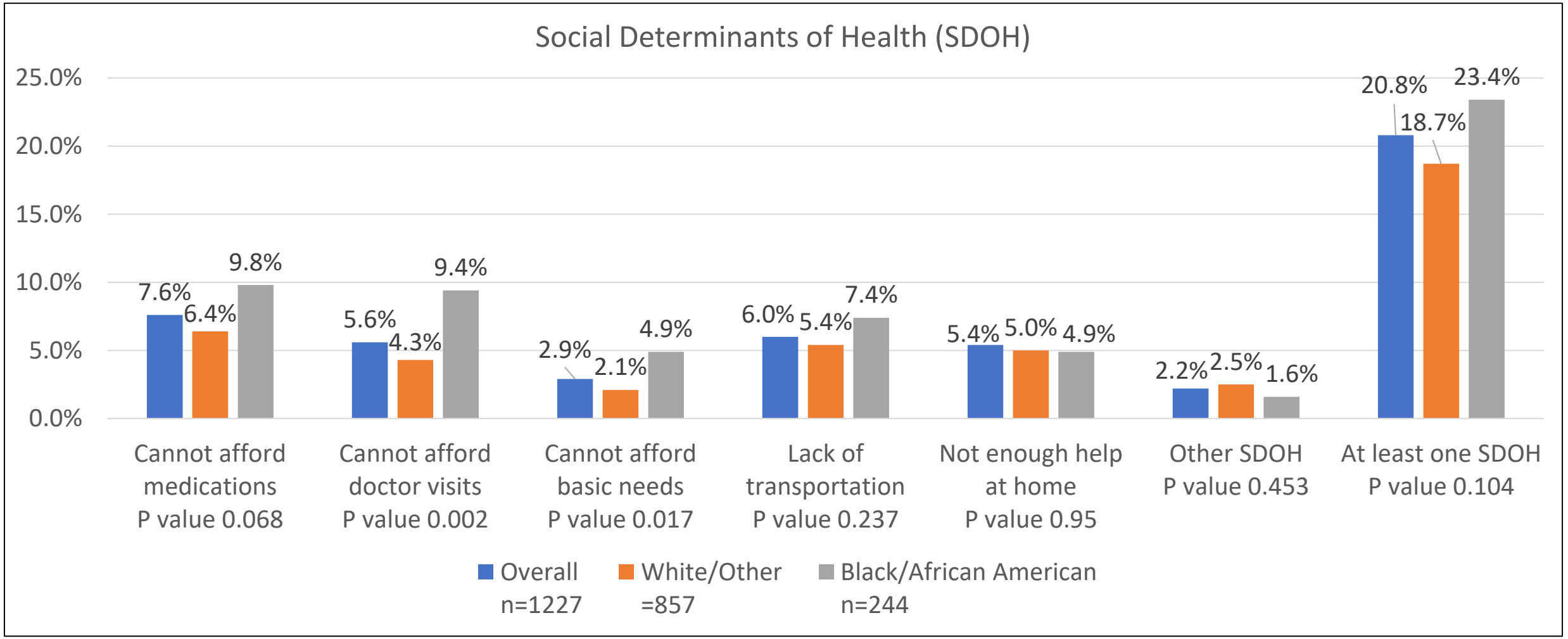
PROs Data


Calls helpful
P value = 0.071
100.0%
90.0%
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
89.9%
10.1%
91.2%
8.8%
86.8%
13.2%
Overall
n=964
White/Other
n=646
Black/African American
n=197
Yes
No

PROs Data


Talked to doctor about personal health goals
P value = 0.145
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
72.7%
27.3%
69.9%
30.1%
74.7%
25.3%
Overall
n=1229
White/Other
n=856
Black/African American
n=241
Yes
No

PROs Data


Social Determinants of Health (SDOH)
25.0%
20.0%
15.0%
10.0%
5.0%
0.0%
7.6%
6.4%
9.8%
5.6%
4.3%
9.4%
2.9%
2.1%
4.9%
6.0%
5.4%
7.4%
5.4%
5.0%
4.9%
2.2%
2.5%
1.6%
20.8%
18.7%
23.4%
Cannot afford medications P value 0.068
Cannot afford doctor visits P value 0.002
Cannot afford basic needs P value 0.017
Lack of transportation P value 0.237
Not enough help at home P value 0.95
Other SDOH P value 0.453
At least one SDOH P value 0.104
Overall n=1227
White/Other =857
Black/African American n=244

Key Take-a-ways

Consider scheduling Cardiology appointment post-discharge from hospital within 14 days to help reduce readmissions

Be on lookout for medication discrepancies between patient instructions and discharge summaries

Consider care management as key intervention to help reduce readmissions for CHF patients and post-SNF patients

Follow-up phone calls are frequent and valued by patients - needs to be patient tailored and address social determinants of health

Exchange of information amongst TEAM is essential!

Questions or Comments

Email Grace Jenq, MD

Gjenq@med.umich.edu

The Michigan Collaborative for Type 2 Diabetes:
Team Based Care

Caroline Richardson, MD

MCT2D Program Director

MiCMT Meeting: October 8th, 2021

MCT2D
MICHIGAN COLLABORATIVE FOR TYPE 2 DIABETES

Agenda

- Introduction to MCT2D
- Team based care in MCT2D

MCT2D
MICHIGAN COLLABORATIVE
FOR TYPE 2 DIABETES

Agenda

- **Introduction to MCT2D**
- Team based care in MCT2D

MCT2D
MICHIGAN COLLABORATIVE
FOR TYPE 2 DIABETES

OLD PARADIGM OF T2 DIABETES

Current Standard of Care

RISK IS GENETIC

Patient says: *"Diabetes runs in my family"*

+

IT'S HARD TO CHANGE BEHAVIORS

=

Diabetes cannot be PREVENTED.

PROGRESSIVE LIFELONG DISEASE

"I saw what it did to my family member. It just gets worse and worse until they start cutting tiny pieces off you."

+

At best, we can aim to

REDUCE RISKS OF COMPLICATIONS, SLOW PROGRESSION

Insulin is the best treatment.

=

Diabetes cannot be REVERSED.

MCT2D
MICHIGAN COLLABORATIVE FOR TYPE 2 DIABETES

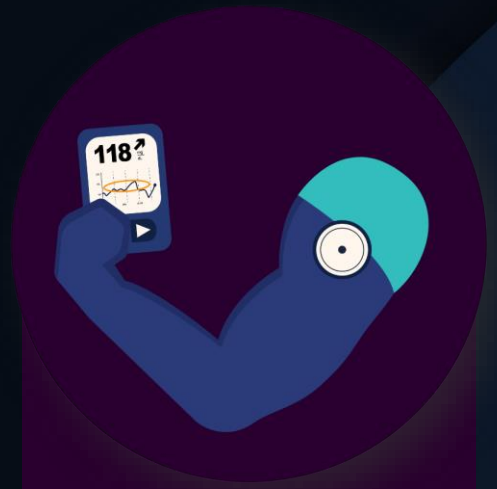
NEW PARADIGM of T2D

Diabetes is preventable and reversible. Shifting towards a culture of healing and repair.

- T2D ≠ insulin deficiency
- Insulin, in fact, accelerates T2D

MCT2D QUALITY IMPROVEMENT GOALS

PRESCRIBING GLP1 AGONISTS & SGLT2 INHIBITORS



EXPANDING USE OF CONTINUOUS GLUCOSE MONITORING (CGM)

SUPPORTING LOWER CARB DIETS

MCT2D
MICHIGAN COLLABORATIVE FOR TYPE 2 DIABETES

MCT2D Year 1 Participation

25 Physician Organizations with **217** primary care practices across Michigan, with over **760** physicians and their healthcare teams participating.

Recruitment

- Year 1 recruitment for physician organizations has closed
  - Will likely begin recruiting in Summer 2022 for a January 2023 start date
- For POs who are participating in Y1:
  - Final deadline for PCP, endocrinology, and nephrology practices is November 15th
  - Practices are currently completing training on the quality initiatives and will begin implementing the QI into their practices in January 2022

MCT2D
MICHIGAN COLLABORATIVE FOR TYPE 2 DIABETES

Agenda

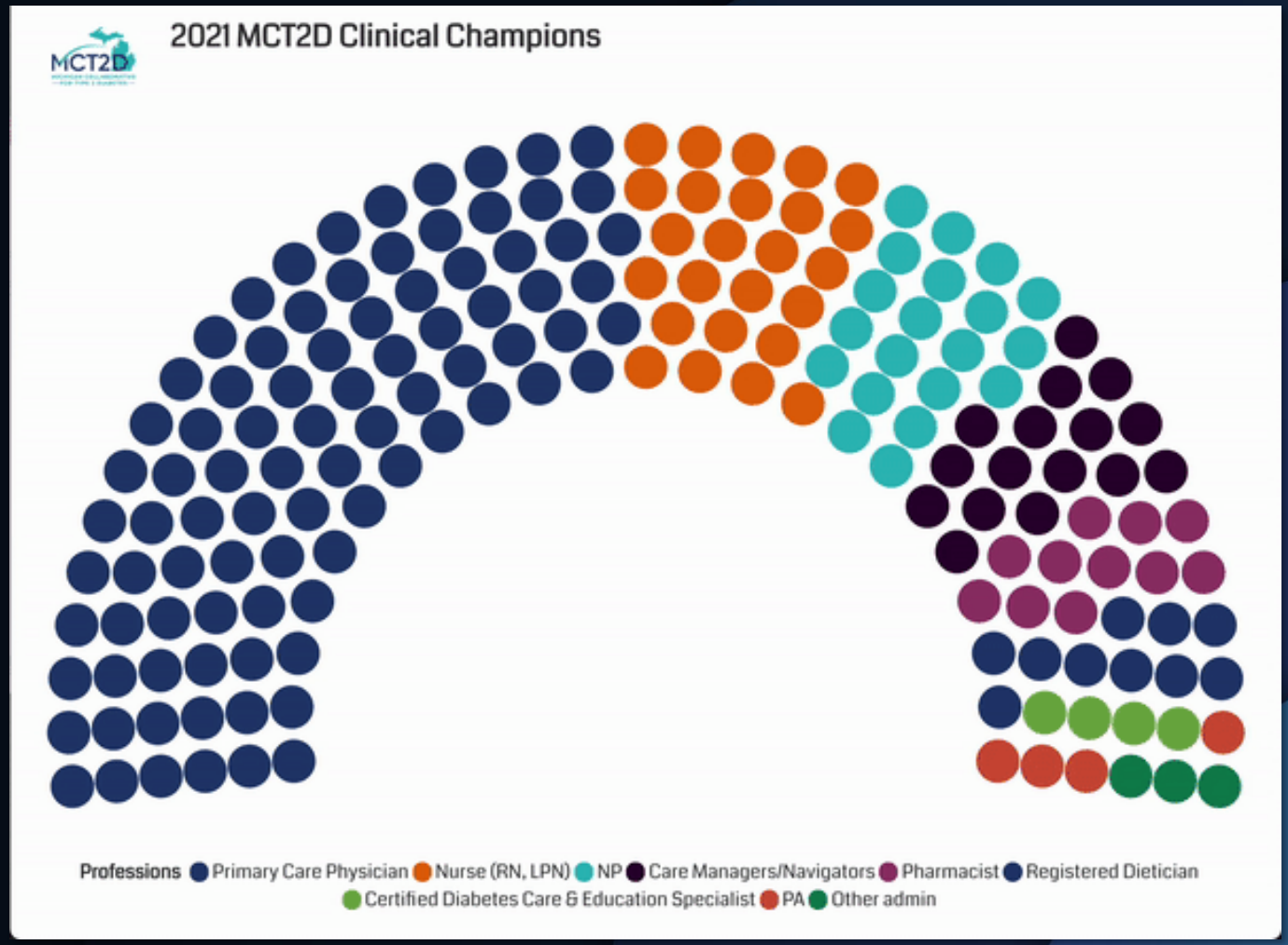
- Introduction to MCT2D
- **Team based care in MCT2D**

MCT2D
MICHIGAN COLLABORATIVE
FOR TYPE 2 DIABETES

MCT2D Clinical Champions

- Traditionally, past CQI programs have primarily only allowed for MD and DO clinical champions

- Understanding the team-based nature of T2D care, MCT2D substantially increased the number of roles that can serve as clinical champions

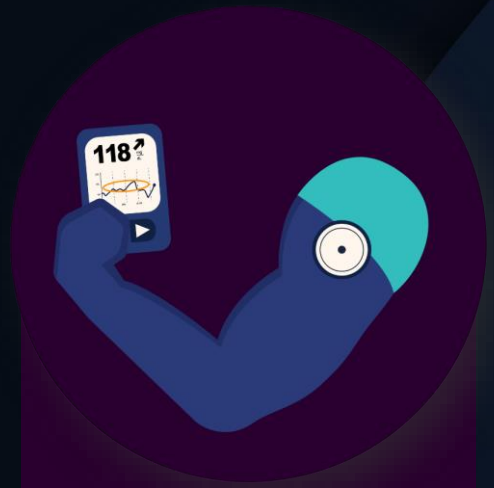


MCT2D
MICHIGAN COLLABORATIVE
FOR TYPE 2 DIABETES

Team Based Approach

- In addition to an expanded roles for the clinical champion, MCT2D hopes to foster team-based care in our quality initiatives.

PRESCRIBING GLP1 AGONISTS & SGLT2 INHIBITORS



EXPANDING USE OF CONTINUOUS GLUCOSE MONITORING (CGM)

SUPPORTING LOWER CARB DIETS

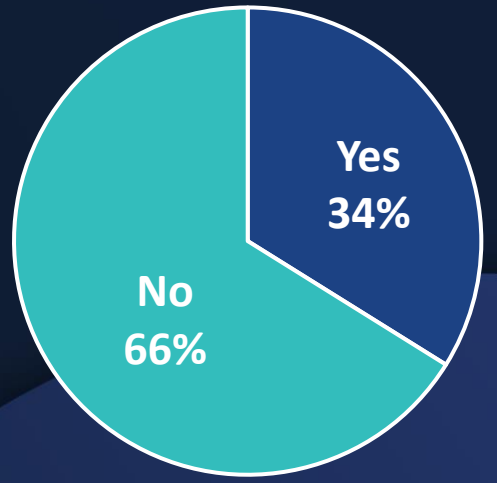
MCT2D
MICHIGAN COLLABORATIVE FOR TYPE 2 DIABETES

Medications

PRESCRIBING GLP1 AGONISTS & SGLT2 INHIBITORS

- Clinical pharmacists help with diabetes medications in complex patients
- Triage Staff (call center, MAs, Nurses) aware of potential side effects and precautions for these newer drugs.
- For some payers, clerical support for prior authorization may be required.

Does your practice routinely refer to a clinical pharmacist?



Those without access to a clinical pharmacists:

- *Medication adjustment*: Work with an endocrinologist who is familiar with these medications
- *Patient education*: Work with diabetes educators or a nurse

MCT2D
MICHIGAN COLLABORATIVE FOR TYPE 2 DIABETES

Continuous Glucose Monitors

EXPANDING USE OF CONTINUOUS GLUCOSE MONITORING (CGM)

- The burden of integrating CGM into practice does not fall completely on the provider and instead represents an opportunity for collaborative work
- While most of our participating practices have prescribed a continuous glucose monitor (65%), less than a third of practices who prescribed one had a process of getting that data from the patients
- MCT2D plans to work with practices to develop a team-based approach to integrating CGMs into a practice workflow.

MCT2D
MICHIGAN COLLABORATIVE FOR TYPE 2 DIABETES

Potential CGM Workflow

Physician or physician's assistant prescribes a CGM

MA helps patient establish sharing link for data

Potential referral to diabetes education for individualized training on CGM use and insertion

Patients without a sharing link can bring in a manual receiver and an MA would upload

MA downloads the medical report and uploads it to the medical record

Physician meets with patient to review CGM data

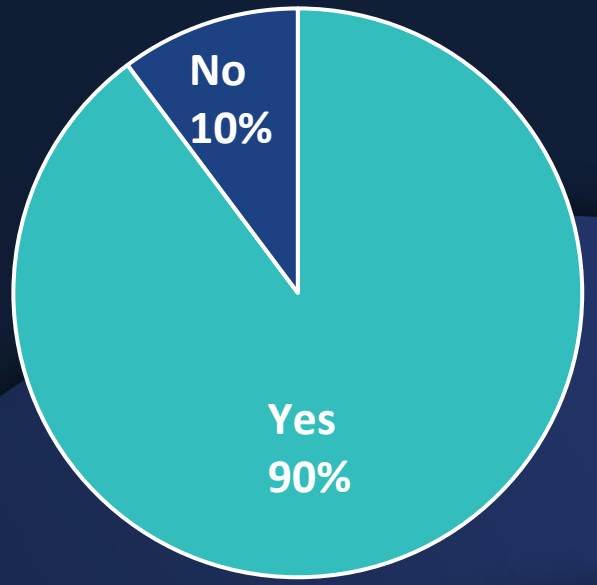
MCT2D
MICHIGAN COLLABORATIVE FOR TYPE 2 DIABETES

Low Carbohydrate Diets

SUPPORTING LOWER CARB DIETS

- Most practices (90%) currently refer to someone for nutrition counseling
- MCT2D plans to work with the 10% of practices who do not to help them identify the best person in their office to fill this role and offer further training
- Work with hospitals to ensure low carb coaching is available to patients
- Provide low carb diet coaching training for the dieticians and diabetes educators.

Does your practice currently refer patients to anyone for nutrition counseling?



MCT2D
MICHIGAN COLLABORATIVE FOR TYPE 2 DIABETES

Other Aspects of Team Based Care in MCT2D

- Training is open to anyone from the practice who would find it useful, and is not just limited to clinical champions or physicians
- MCT2D has been trying to work with how care is currently being delivered in practices in order to align with their current team-based care approaches instead of making all practices follow a one-size fits all approach
- MCT2D is also enrolling endocrinology and nephrology practices in order to ensure that specialists and primary care physicians are on the same page on caring for their T2D patients
- Plan to work with hospitals in the future around aligning diabetes education and dietician guidance

MCT2D
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Thank you!!!
Questions?

www.mct2d.org

@MCT2D on Twitter

MCT2D
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FOR TYPE 2 DIABETES

MICMT Program Evaluation & Team-Based Care Data Analysis

Care Management Attestation 2021

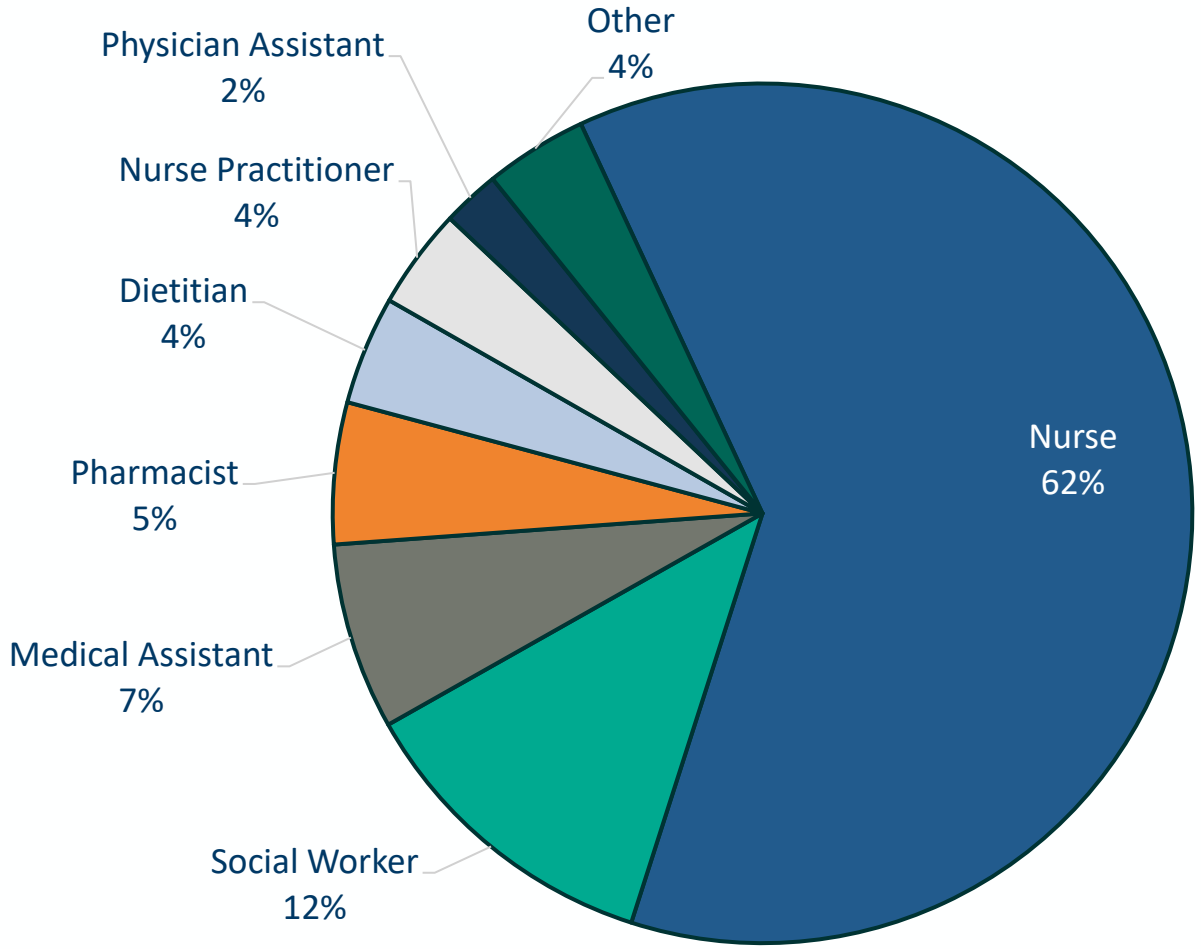
Data Collection:

- Survey responses from
  - 37 / 40 (%) provider organizations completed attestation
  - 999 practices listed Care Team Members
    - 895 PCMH practices
    - 47 Specialty practices
    - 57 Other PCP or Mixed Non-PCMH practices
  - 2,125 Care Team Members Records updated
  - 1,296 **active** Care Team Members (not end-dated)

Data collected summer 2021

Care Management Attestation 2021

by Role



Other:

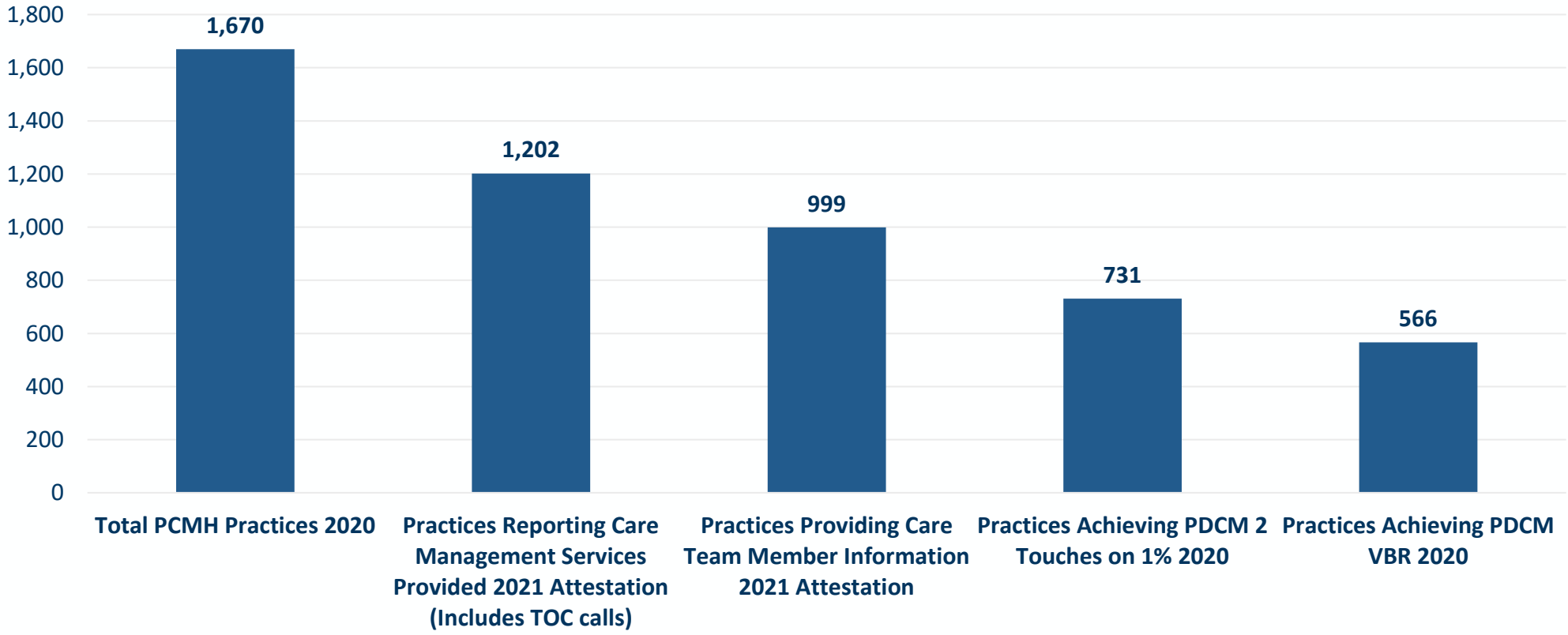
Behavioral Health Care Manager	1.2%
Practice Administration	0.9%
Licensed Professional Counselor	0.5%
Non Clinical Care Navigator	0.4%
Non Clinical Community Health Worker	0.3%
Psychologist	0.2%
Respiratory Therapist	0.1%
Health Educator	0.1%
Practice Staff	0.1%
Audiologist	0.1%
Physician	0.1%

N = 1,296 Care Team Members

Distinct count across all 37 POs and 999 practices

Care Management Attestation 2021

Practices self-reporting care management services compared to PCMH designated and PDCM eligible practices



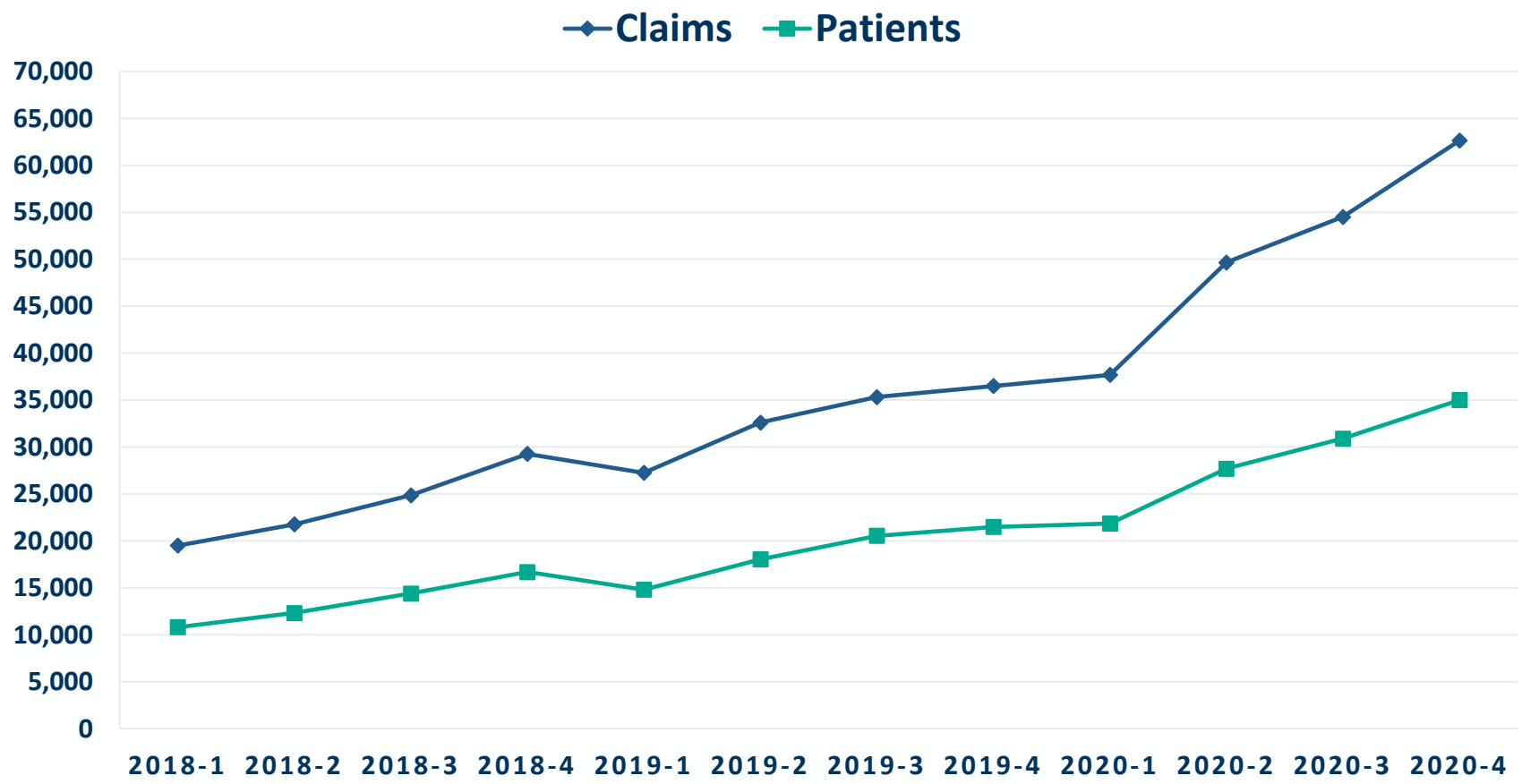
Provider Delivered Care Management (PDCM)

Purpose:

- Engage eligible patients in care management services
- Incentivize physician organizations (POs) to provide care management to at least 4% of their PDCM population with a minimum of 2 encounters per member

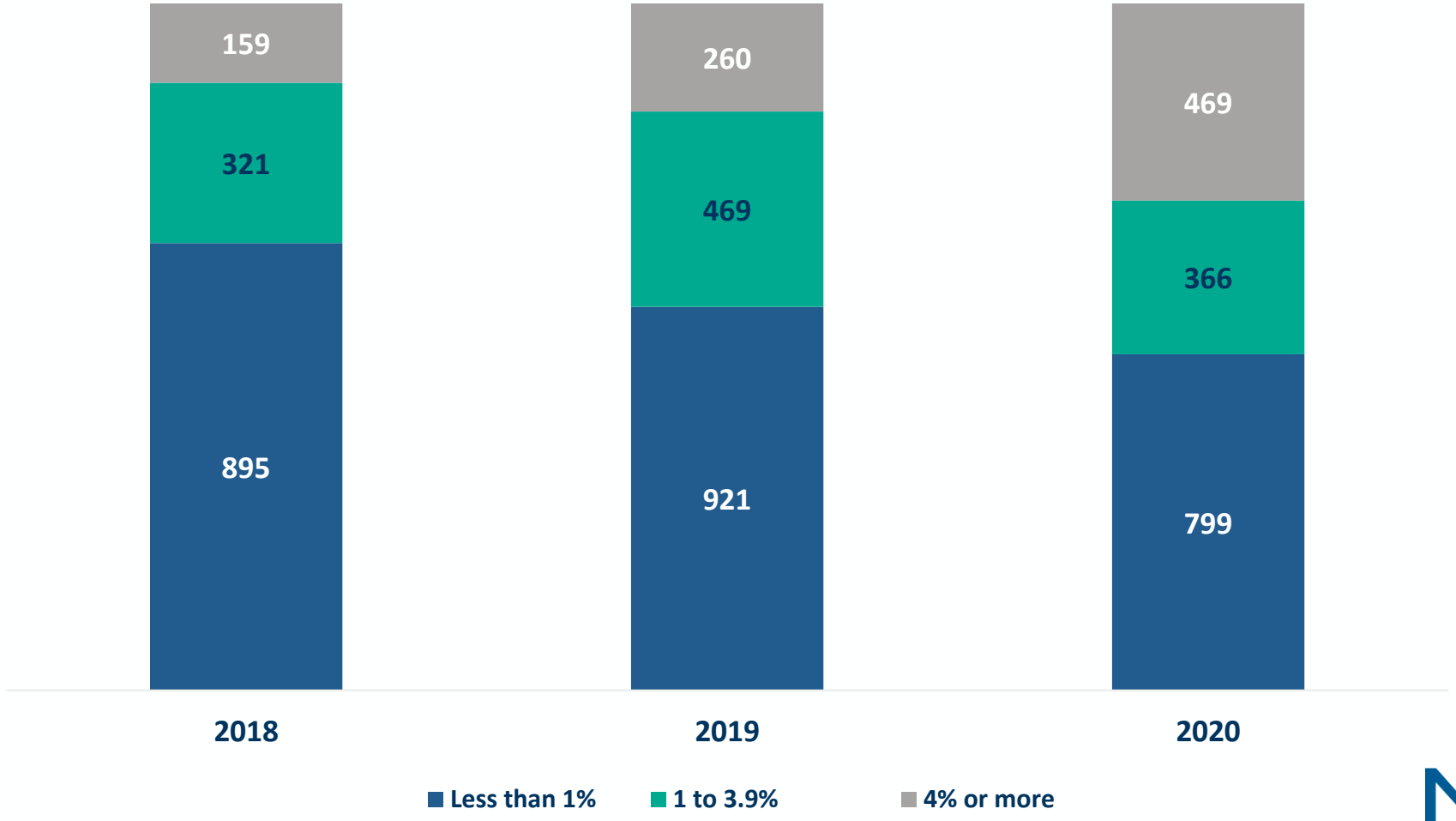
PDCM Billing

Quarterly



Population Management VBR

PCMH practices with PDCM attributed members that achieved 2 touches



POs Achieving at Least 4% Two Touch Engagement Overall

- Affinia Health Network Lakeshore
- Great Lakes OSC, LLC
- Holland PHO
- Huron Valley Physicians Assoc PC
- Integrated Health Partners
- Jackson Health Network, L3C
- LPO, LLC
- Medical Network One
- Oakland Southfield Physicians
- United Physicians, Inc
- Wexford PHO

PDCM Outcomes Data Analysis

Analysis outline

There are several key questions about the effectiveness of care management and of physician/practice profiling

- Do patients who have care management contact have better outcomes?
- Is there a relationship between intensity (“touches”) and outcomes?
- Should care management and quality be evaluated at the PO, practice, or physician level?

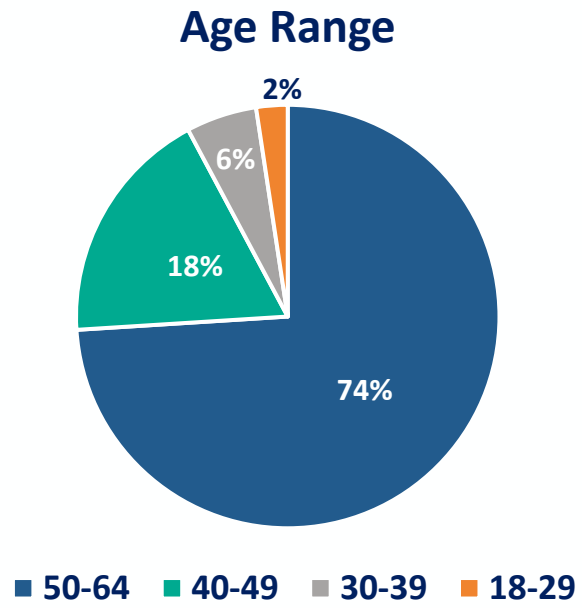
Analysis outline

We used BCBSM data on PDCM outcomes measures(A1c, BP, ED use, inpatient use) to try and examine the relationships between care management and outcomes based on 2018 and 2019 data

2018 & 2019 Data Analysis
A1c Measure (Patients with Diabetes)

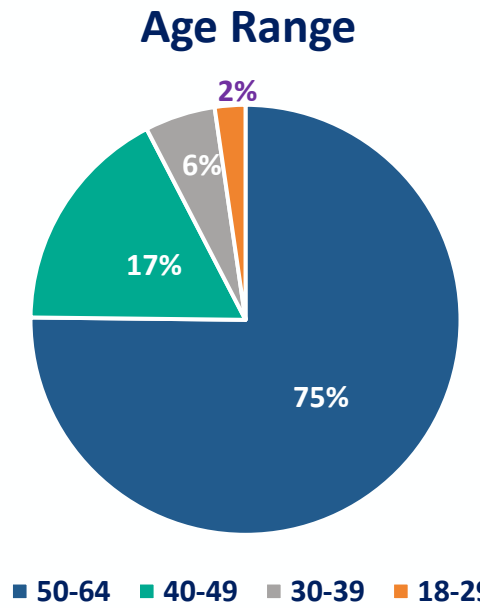
2018

- N=158,032 patients
- 43% female / 57% male



2019

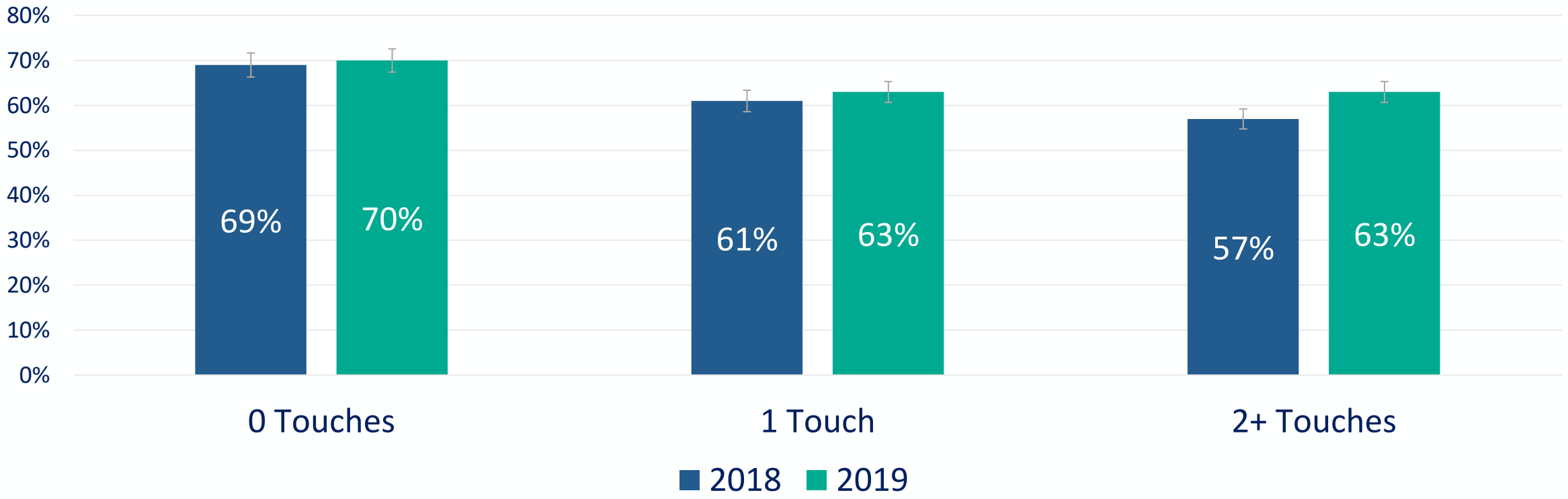
- N=171,527 patients
- 44% female / 56% male



Care Management Touches
Patients with Diabetes - A1c Measure

Touches	0	1	2+
2018	86%	5%	9%
2019	79%	6%	15%

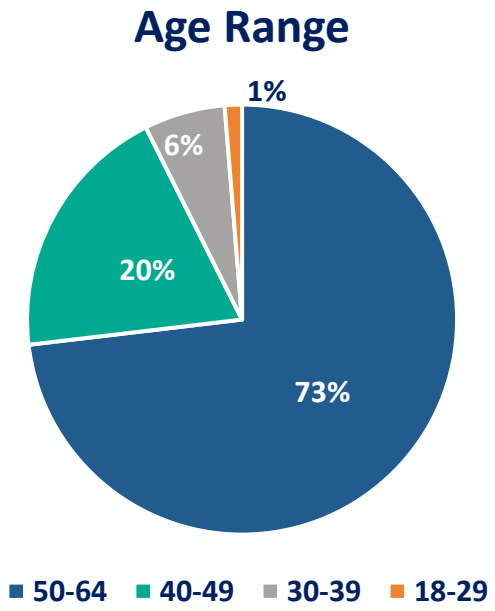
A1c Measure (% of Patients with Diabetes in control) (Preliminary)



2018 & 2019 Data Analysis
Blood Pressure Measure (Patients with Hypertension)

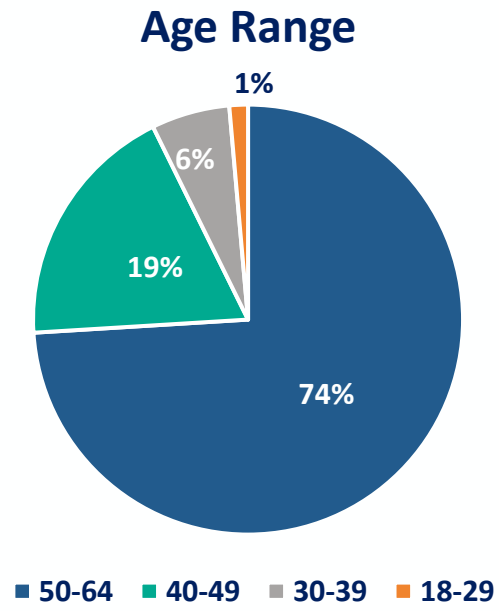
2018

- N=504,192 patients
- 49% female / 51% male



2019

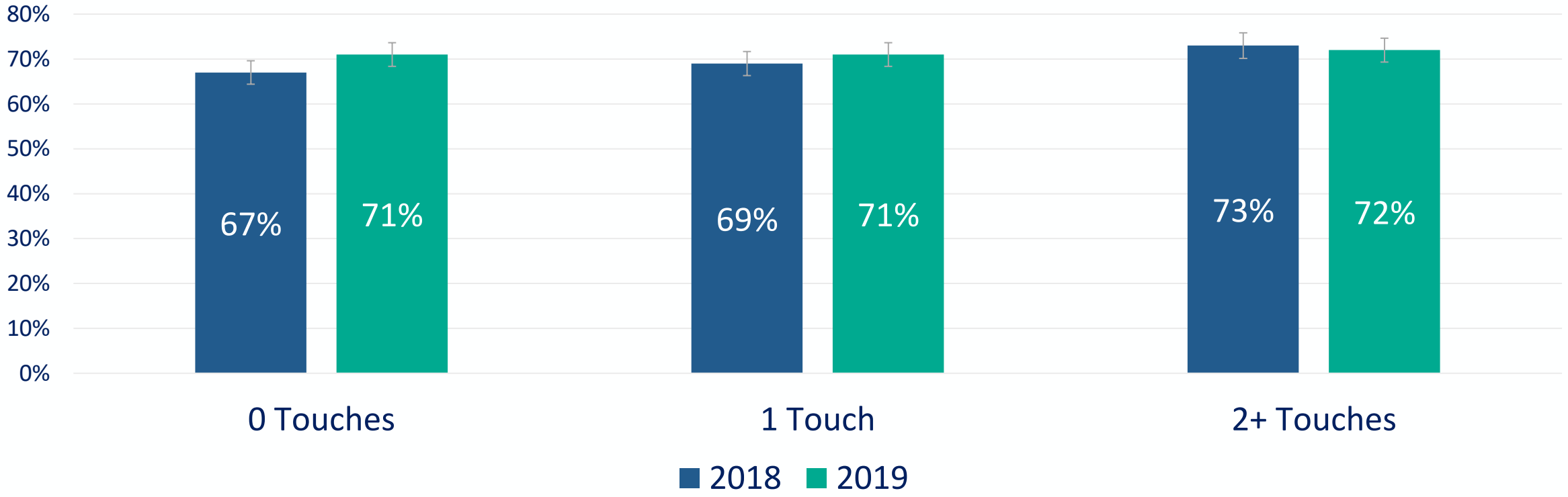
- N=561,936 patients
- 49% female / 51% male



Care Management Touches
Patients with Hypertension

Touches	0	1	2+
2018	87%	5%	8%
2019	84%	6%	10%

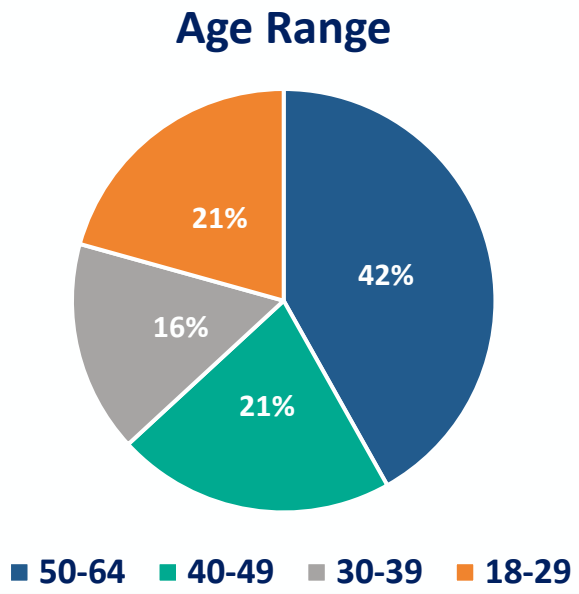
Blood Pressure Measure (% of patients in control) (Preliminary)



2018 & 2019 Data Analysis
ED Utilization Measure

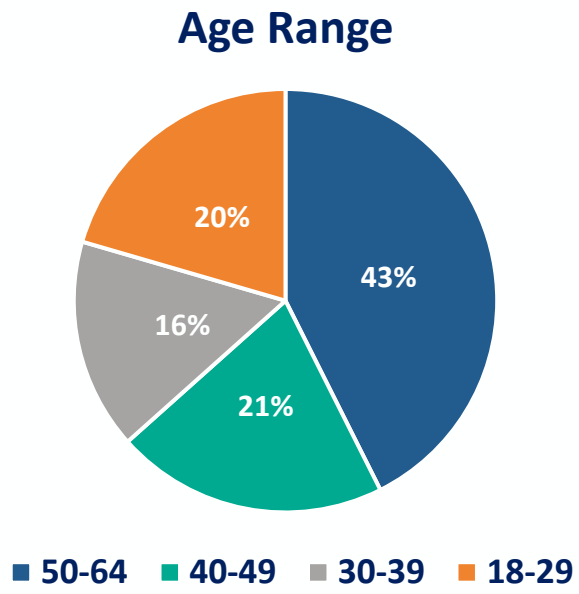
2018

- N=882,753 patients reviewed
- 15% had ED visits
  - 59% female / 41% male



2019

- N=908,990 patients reviewed
- 15% had ED visits
  - 59% female / 41% male



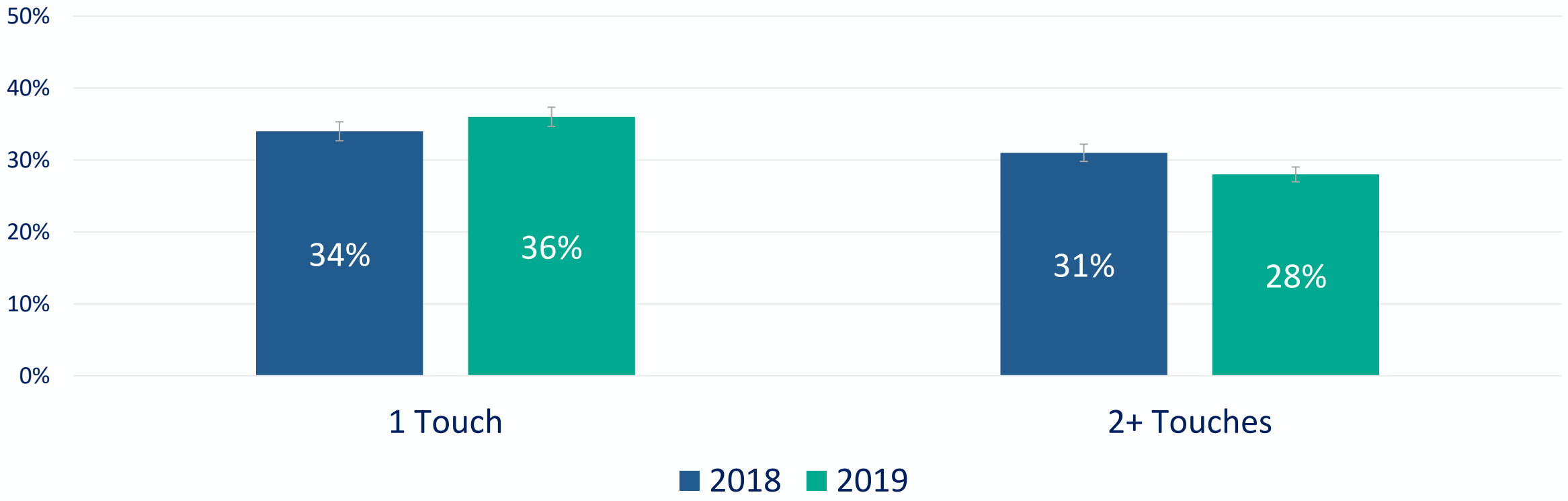
Care Management Touches
Patients with ED visits

2018	No Visit	Visit
0 Touches	97%	90%
1 Touch	1%	5%
2+ Touches	2%	5%

2019	No Visit	Visit
0 Touches	96%	88%
1 Touch	2%	6%
2+ Touches	2%	6%

ED Utilization Model (Preliminary)

Those with one touch had 34% and 36% utilization; those with 2 touches had 31% and 28% ED utilization in 2018 and 2019, respectively.

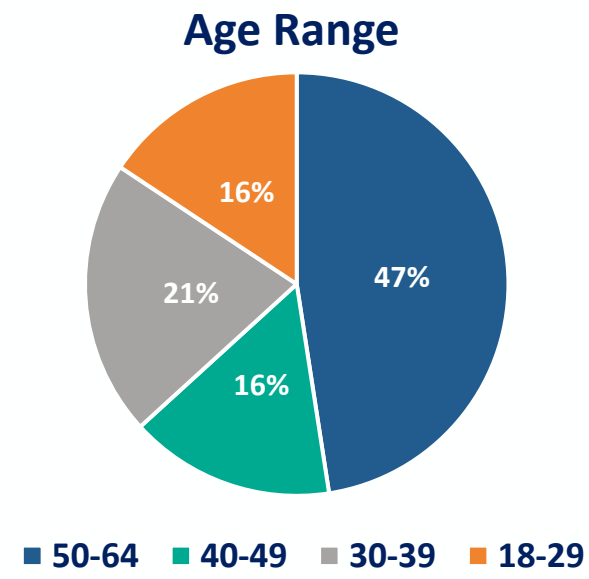


*Adjusted for gender, prospective risk score, year

2018 & 2019 Data Analysis
Inpatient Utilization Measure

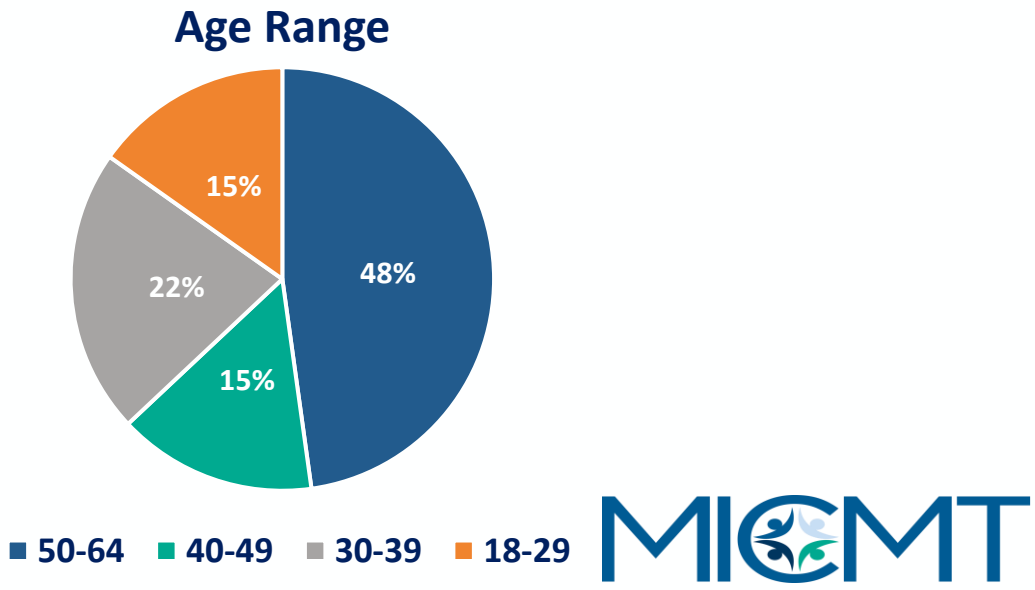
2018

- N=882,753 patients reviewed
- 5% had IP stay
  - 64% female / 36% male



2019

- N=908,990 patients reviewed
- 4% had IP stay
  - 64% female / 36% male



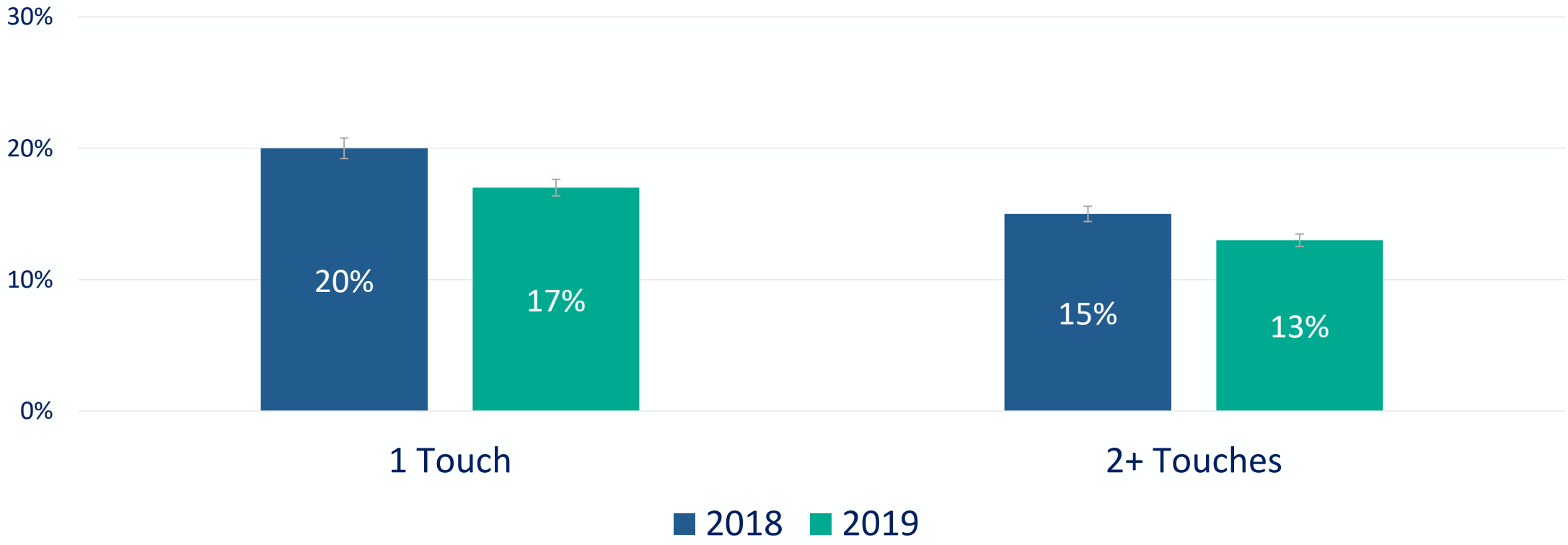
Care Management Touches
Patients with Inpatient Stays

2018	No IP Stay	IP Stay
0 Touches	97%	79%
1 Touch	1%	10%
2+ Touches	2%	11%

2019	No IP Stay	IP Stay
0 Touches	96%	74%
1 Touch	2%	12%
2+ Touches	2%	14%

Inpatient Utilization Model (Preliminary)

Those with one touch had 20% and 17% utilization; those with 2 touches had 15% and 13% IP utilization in 2018 and 2019, respectively.



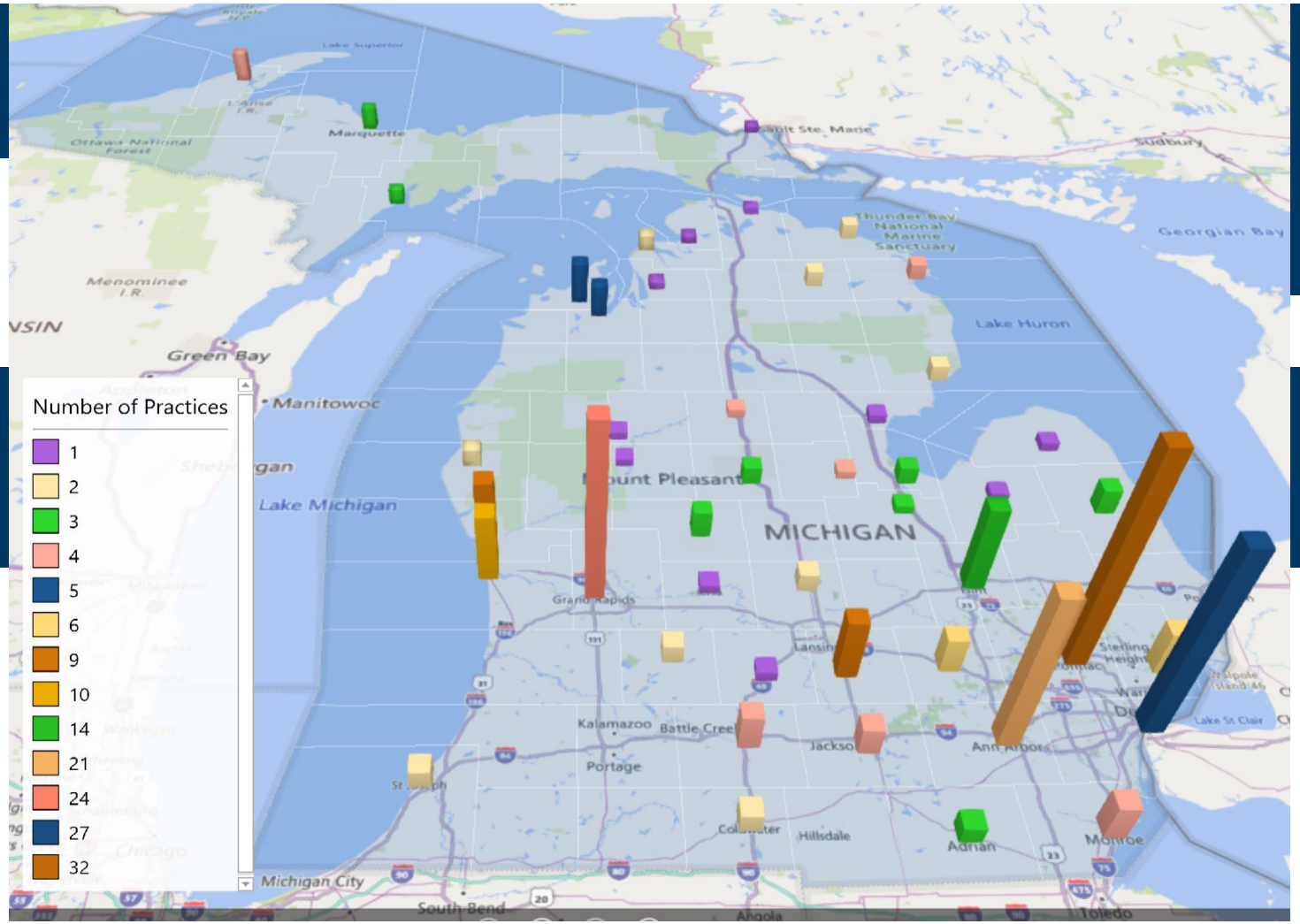
*Adjusted for gender, prospective risk score, year

Medication Assisted Treatment (MAT) Update

Spring 2020 - Spring 2021 Data
Number of MAT Practices by County

MAT providers across the state increased from 317 to 717.

Number of zip codes with MAT services increased from 115 to 167.



Top 5 Counties:

1) Oakland
2) Wayne
3) Kent
4) Washtenaw
5) Genesee

58 counties now have PCPs delivering treatment; 20 of those counties had zero providers before initiative.

Data Collections: Spring 2020, Fall 2020, Spring 2021

Spring 2020 - Spring 2021 Data Collection Summary
% of PGIP Practices Providing MAT

1 - 4.9%	5 - 9.9%	10 - 14.9%	15% or More
Answer Health Physician Organization	Genesys PHO LLC	CIPA	Affinia Health Network Lakeshore
Beaumont ACO	Great Lakes OSC, LLC	IHA	Holland PHO
Lakeland Care Inc	Huron Valley Physicians Assoc PC	Oakland Southfield Physicians	MidMichigan Collaborative Care Organization
McLaren Physician Partners	Integrated Health Partners	Olympia Medical LLC	University of Michigan Health System
Medical Network One	Jackson Health Network, L3C	Physician Healthcare Network PC	
Metro Health Integrated Network	Lake Huron PHO	Upper Peninsula Health Group	
Novello Physicians Organization	LPO, LLC		
Oakland Physician Network Services	Spectrum Health Medical Group		
Primary Care Partners, Inc	WEXFORD PHO		
Professional Medical Corporation PC			
Reliance PO of Michigan, Inc.			
Sparrow Care Network			
United Physicians, Inc			

26 POs reported having at least one new practice beginning to provide treatment

147 new PCMH practices are delivering treatment

Data Collections: Spring 2020, Fall 2020, Spring 2021

Closing Remarks

Thank You for Joining!

Please complete the evaluation e-mailed to you after the meeting.