Thank you for joining!
We will get started promptly at 9:30 am

MICMT

Michigan Institute for Care Management & Transformation

2022 Annual Meeting

October 28, 2028

Welcome

Alicia Majcher, MHSA
Director of Operations

Agenda

Continental Breakfast Available

9:30 – 9:40 AM	Welcome *Alicia Majcher, MHSA* *MICMT Director of Operations*	In Person and Virtual
9:40 – 10:10 AM	Introduction *Martha Walsh, MD, MHSA, FACOG* *Medical Director* *Clinical Partnerships and Provider Engagement* *Blue Cross Blue Shield of Michigan*	In Person and Virtual
10:10 – 10:20 AM	INHALE CQI	
10:20 – 11:00 AM	MICMT Updates *Alicia Majcher, MHSA* *MICMT Director of Operations*	In Person and Virtual
11:00 – 11:10 AM	Break	
11:10 AM – 12:00 PM	Data Updates *MICMT Data Evaluation Team*	In Person and Virtual
12:00 – 1:00 PM	Lunch	In Person Only
1:00 – 2:00 PM	Peer-to-Peer Learning Sessions	In Person Only

MICMT

Introduction

Martha Walsh, MD, MHSA, FACOG

BCBSM, Senior Medical Director &
Associate CMO for Provider Engagement

Care Management Past and Future

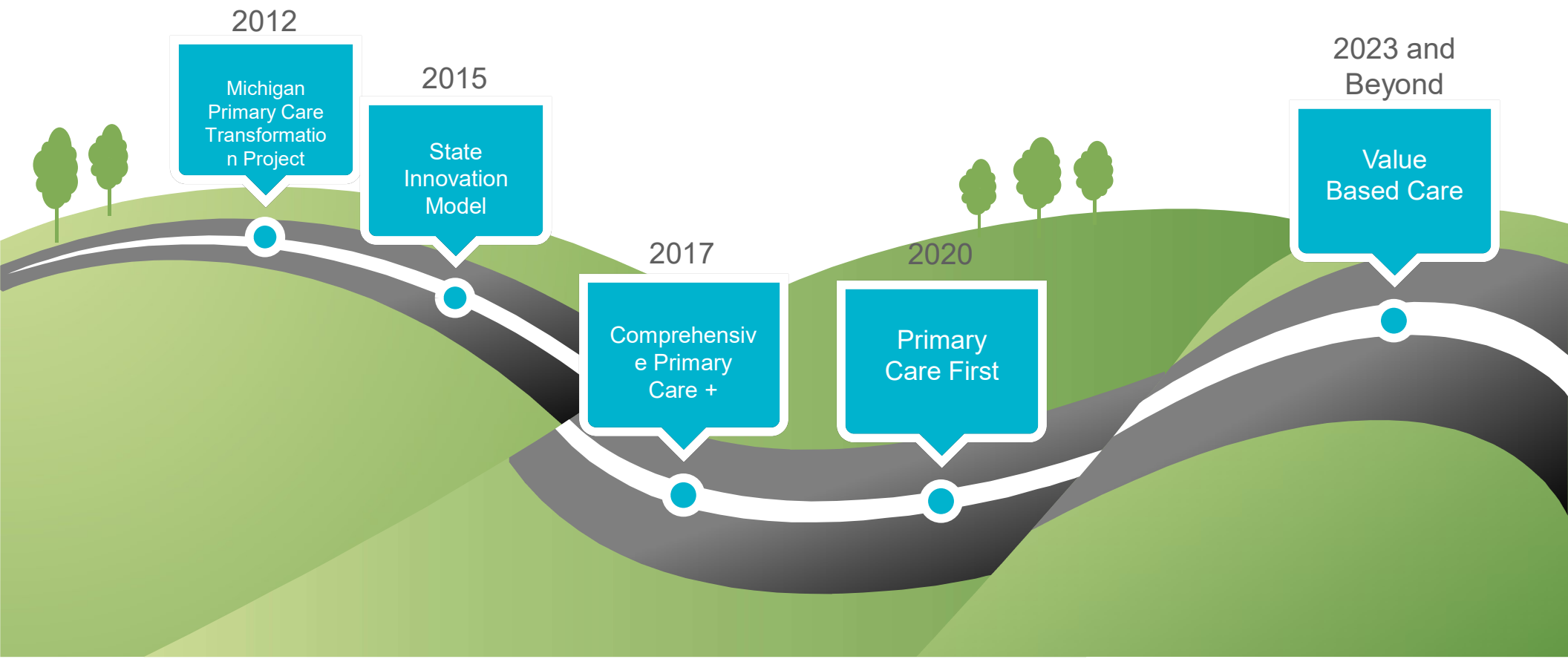
October 28, 2022

Martha Walsh, MD, MHSA, FACOG
Senior Medical Director and Associate CMO for Provider Engagement

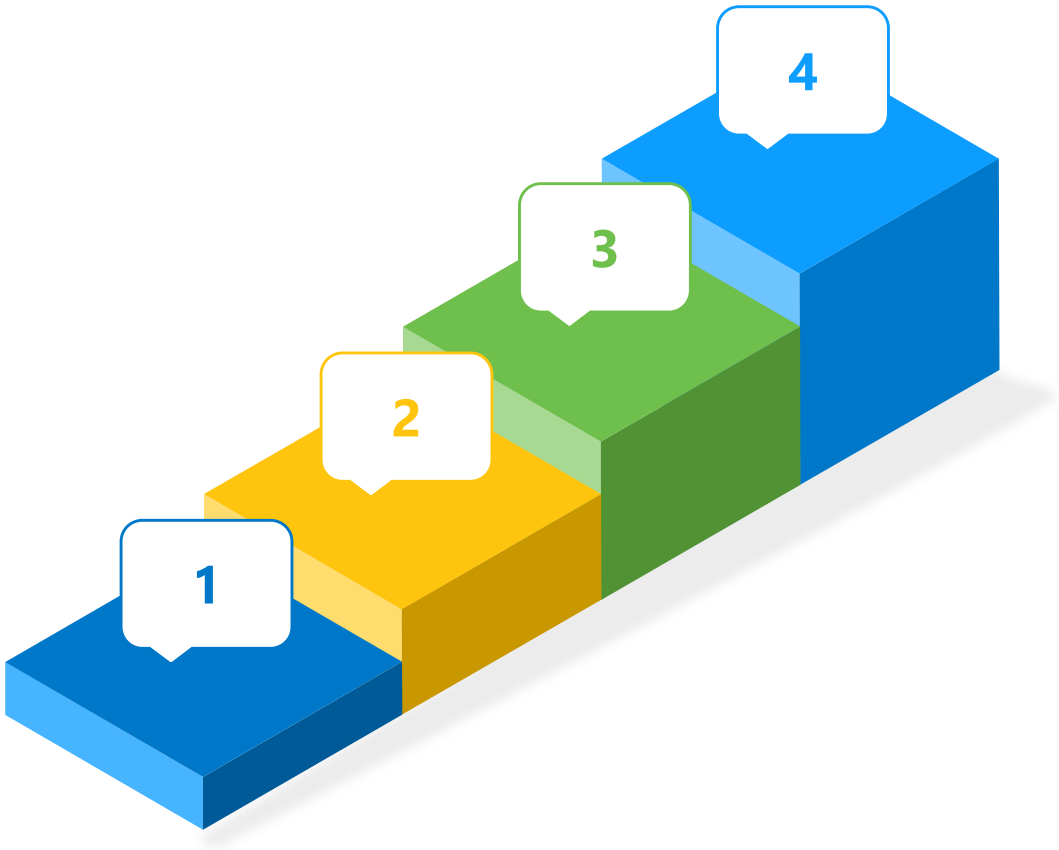
My Care Management Journey

The Care Team Path

Blue Cross Blue Shield Blue Care Network of Michigan



The Care Team Challenges through out the years



Proving the Value of the Care Team

The requirement to prove the value and the return on investment of the care team.

Stable Funding Source

Funding was initially for defined periods of time for specific programs. Not all health plans covered care management.

Staffing

Finding staff that have the experience necessary and skill set to do this work. Challenges in retaining talented staff.

Physician Engagement

Getting Physician's to buy into the care team model and understand the value of care managers.

01

Primary Care Workforce

Over the next several years, the supply of primary care physicians will not keep up with the demand.

02

Rising Rates of Chronic Conditions

60% of U.S. adults have one chronic disease, 40% have 2 or more chronic diseases.(1)

03

Aging Population

10,000 Americans will turn 65 every day from now through the end of 2029.(2)

(1) Chronic Disease Fact Sheets | CDC
(2) By 2030, All Baby Boomers Will Be Age 65 or Older (census.gov)

The only way to meet these challenges is with a Team Based Approach

Blue Cross Blue Shield Blue Care Network of Michigan

Success of Population Health

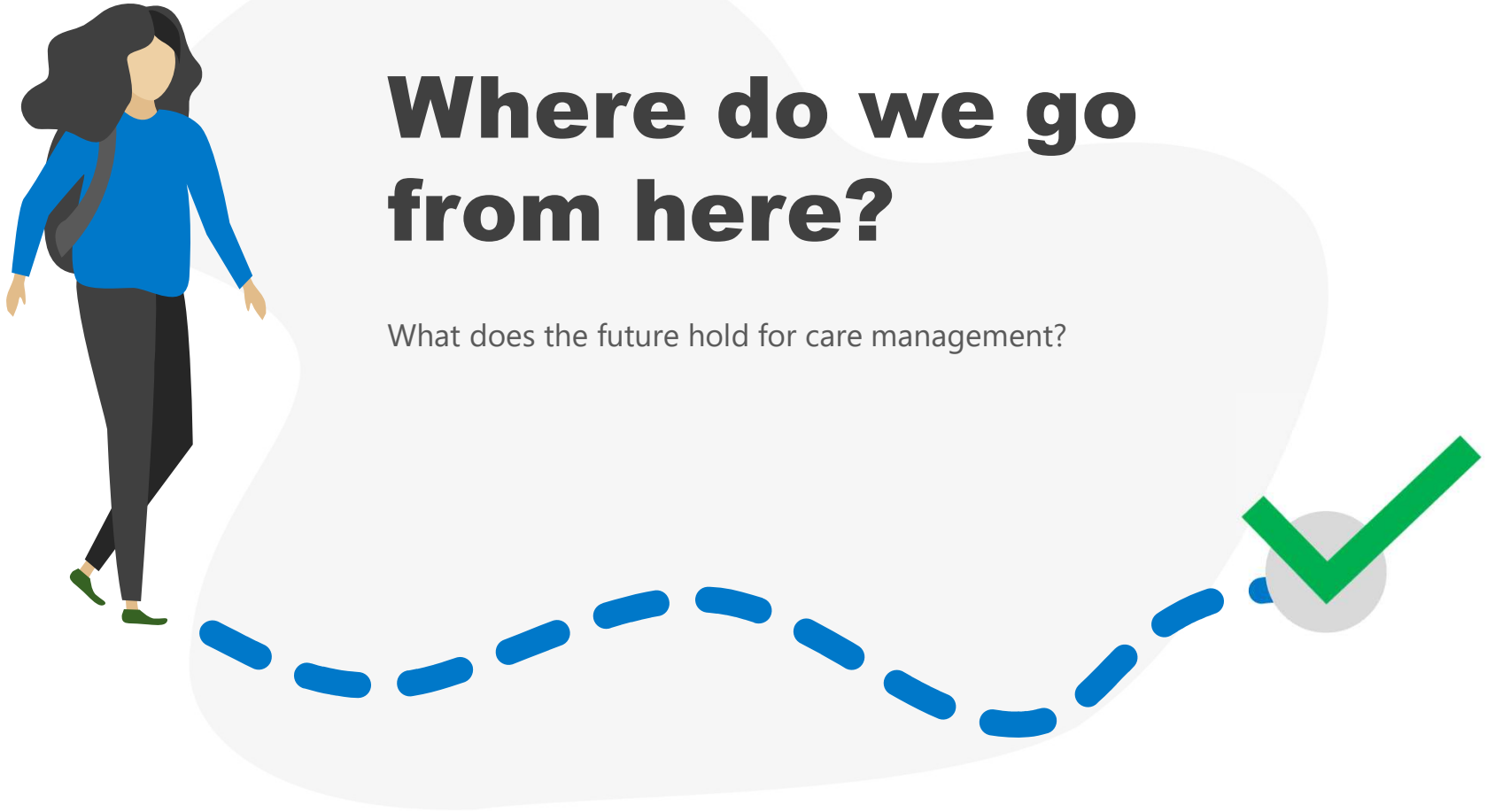
As the primary care workforce declines and chronic conditions increase, we need to leverage the entire care team.

One study showed that with mild improvements in healthy behaviors, we could prevent or delay the development of 40 million cases of chronic conditions a year.(1)

We need the whole team to care for our population.

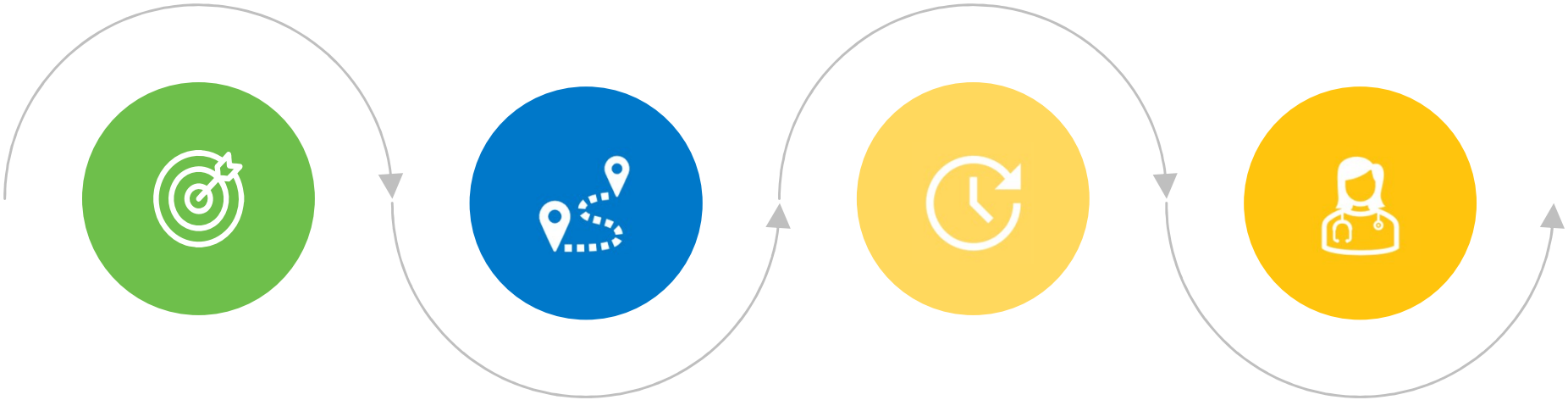
(1)Raghupathi W, Raghupathi V. An Empirical Study of Chronic Diseases in the United States: A Visual Analytics Approach. Int J Environ Res Public Health. 2018 Mar 1;15(3):431. doi: 10.3390/ijerph15030431. PMID: 29494555; PMCID: PMC5876976.

Blue Cross Blue Shield Blue Care Network of Michigan



Where do we go from here?

What does the future hold for care management?



Value Based Care

Expansion of the Care Team

Proactive Management and Predictive Modeling

Specialty Care Management

The Challenge of Moving from Fee For Service To Value Based Care

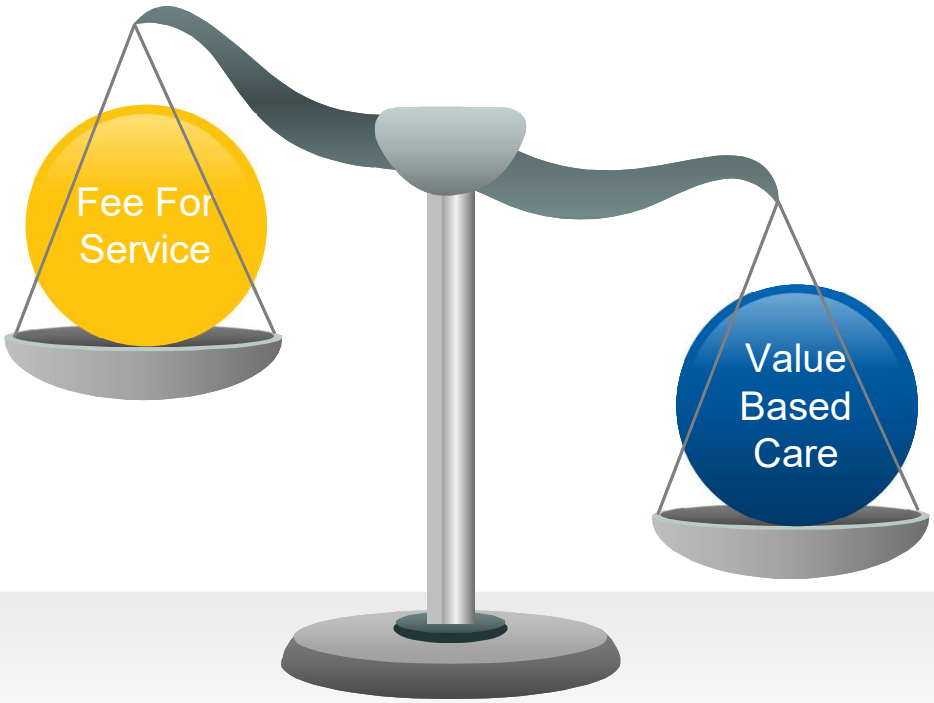
"Those who have one foot in the canoe, and one foot in the boat, are going to fall into the river". Native American Proverb

What is Value Based Care?

Blue Cross Blue Shield Blue Care Network of Michigan

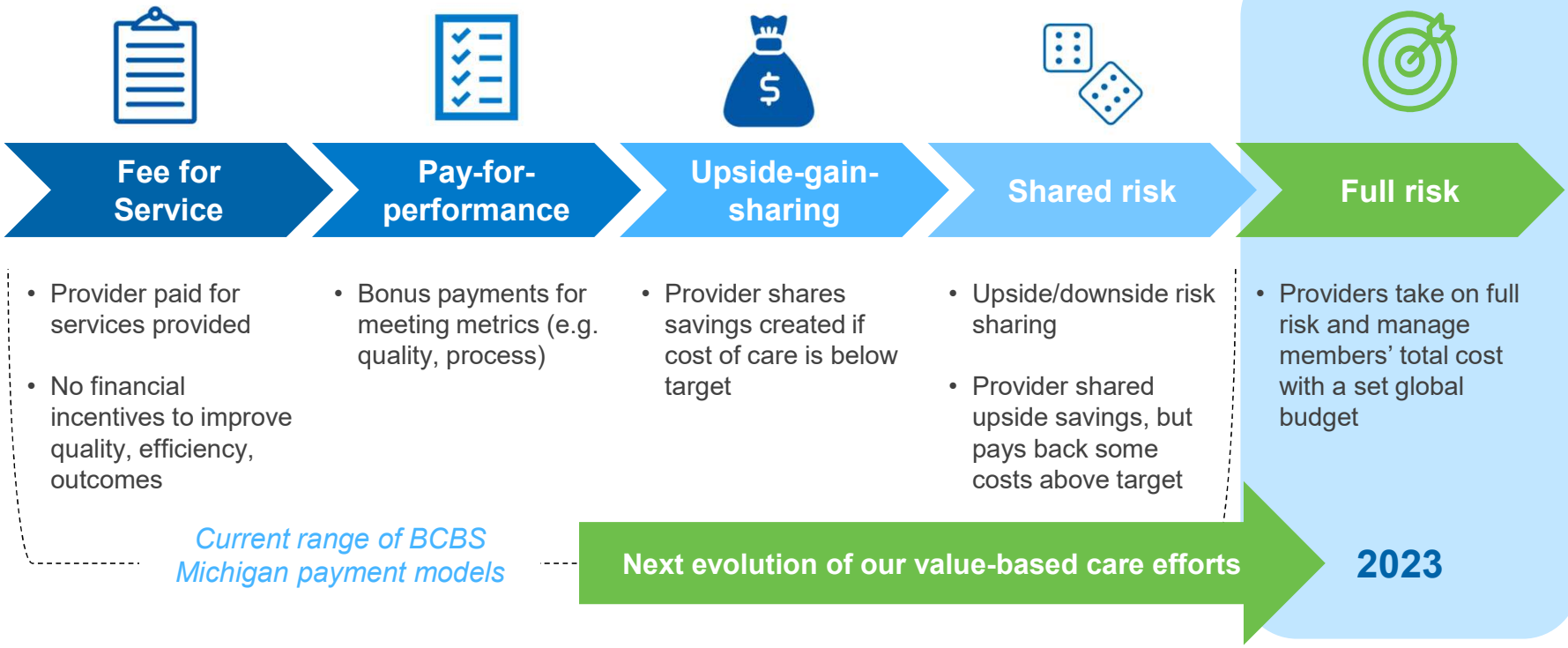
Fee for Service

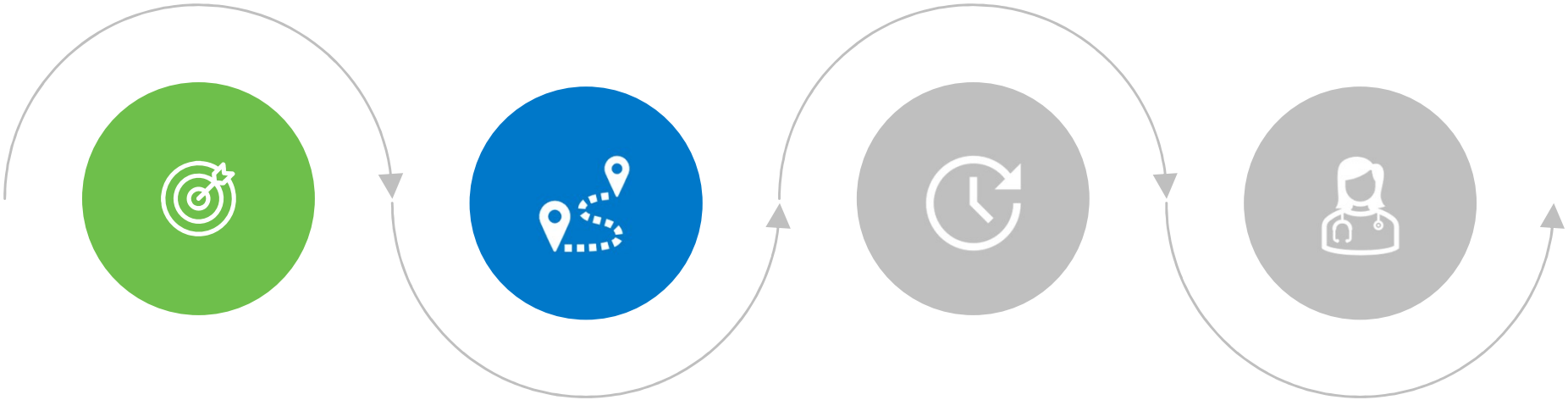
- Payment is based on the number of services provided.
- Based on volume of care and can result in increased cost based on volume.
- No rewards for improved outcomes, quality of care, or patient experience.



Value Based Care

- Payment is based on the outcomes and quality of care for a population.
- Allows for innovations in care not associated with fee for service payment.
- Incentivizes keeping patients healthier and improving the patient experience.



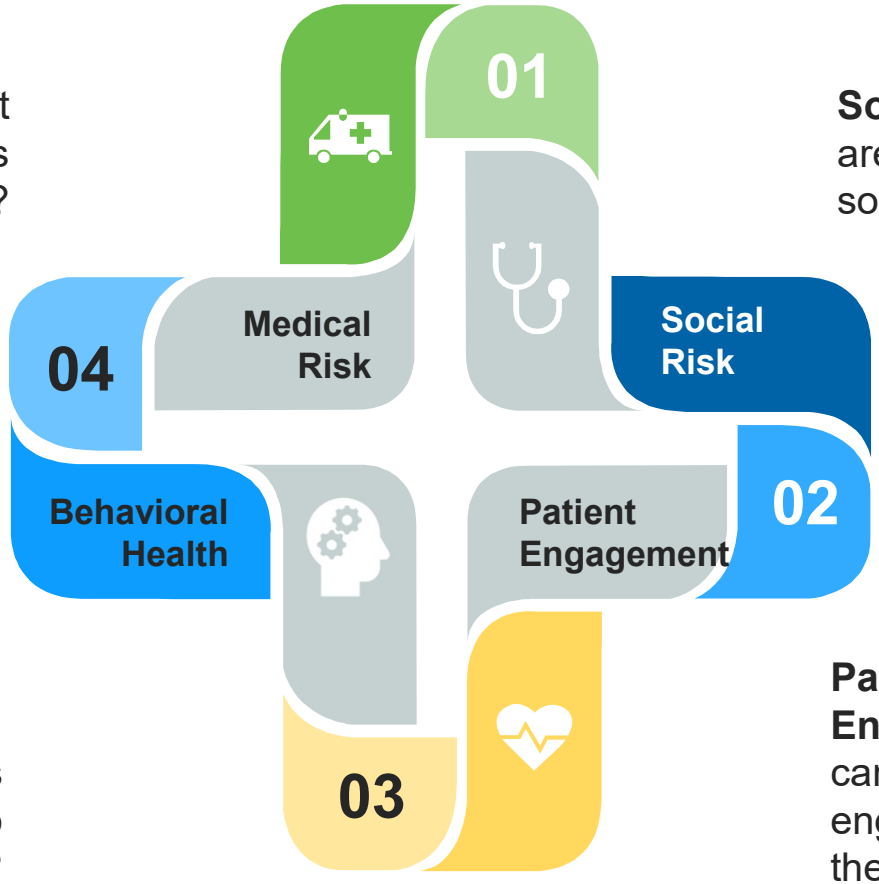


Value Based Care

Expansion of the Care Team

What do we need to know about our patients?

Medical Risk: What are the patient's chronic conditions?

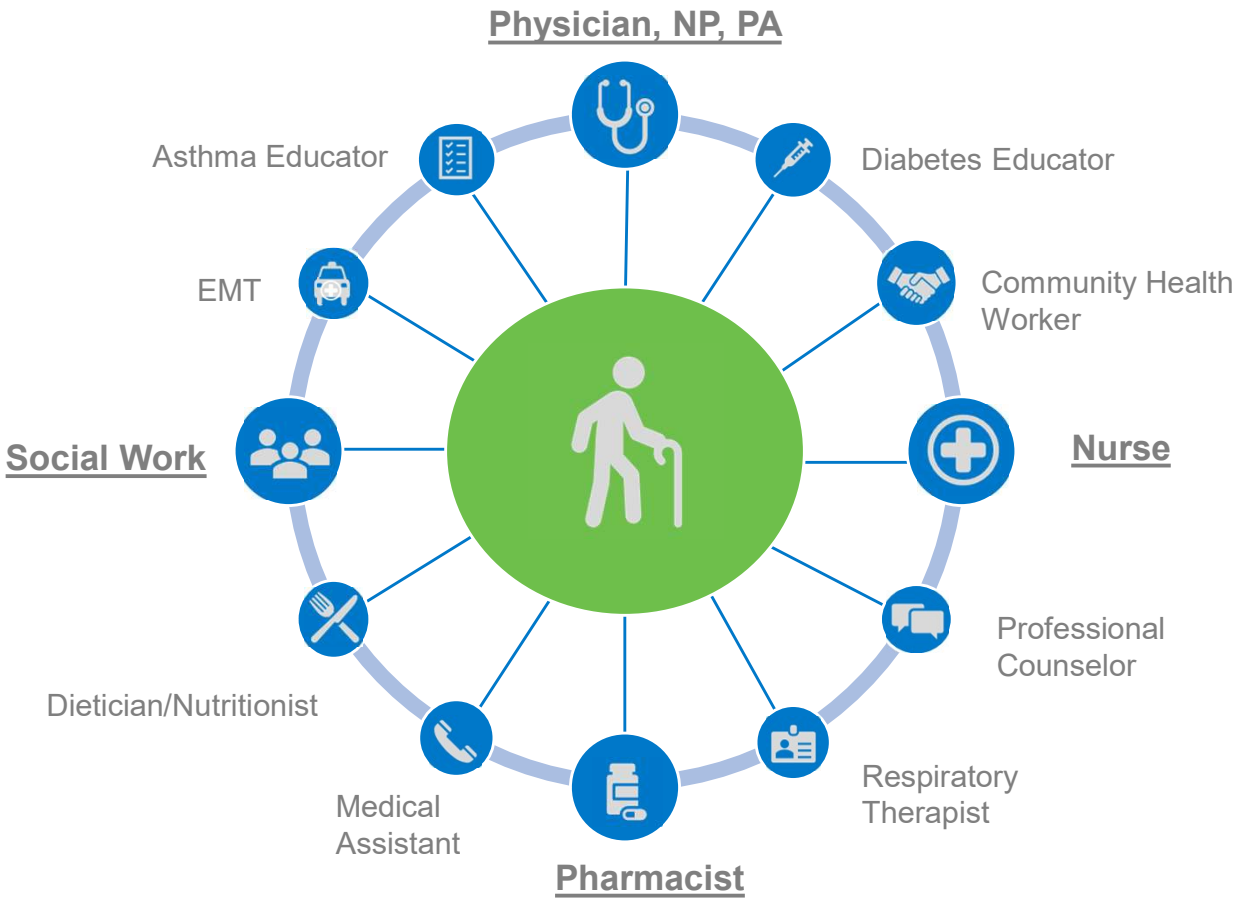


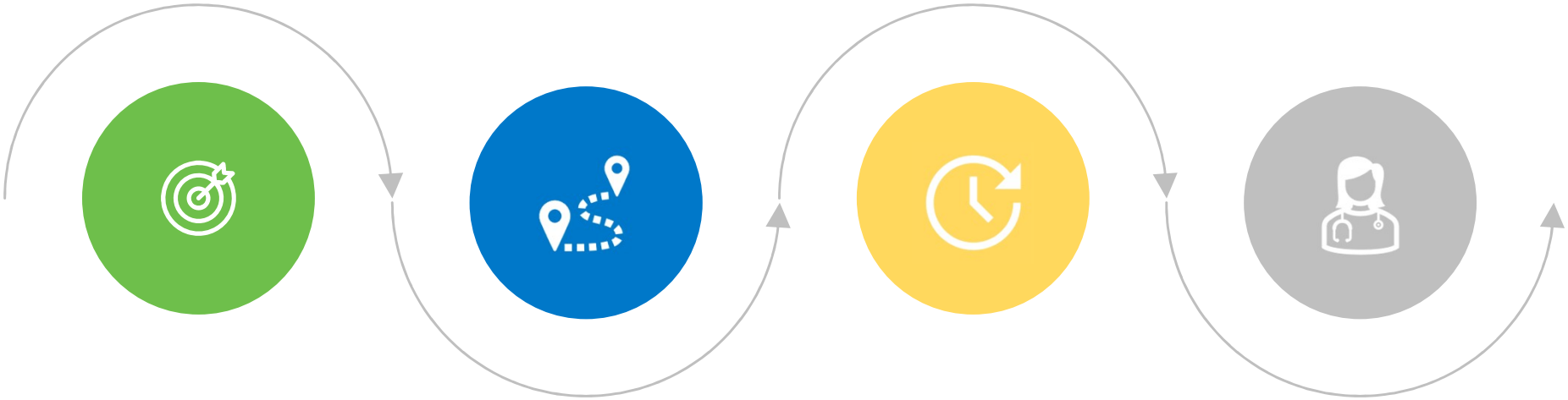
Social Risk: What are the patient's social risk factors?

Behavioral Health: What Behavioral Health issues does the patient need to have addressed?

Patient Engagement: How can we more actively engage patients in their care?

Provider Delivered Care Management Care Team





Value Based Care

Expansion of the Care Team

Proactive Management and Predictive Modeling

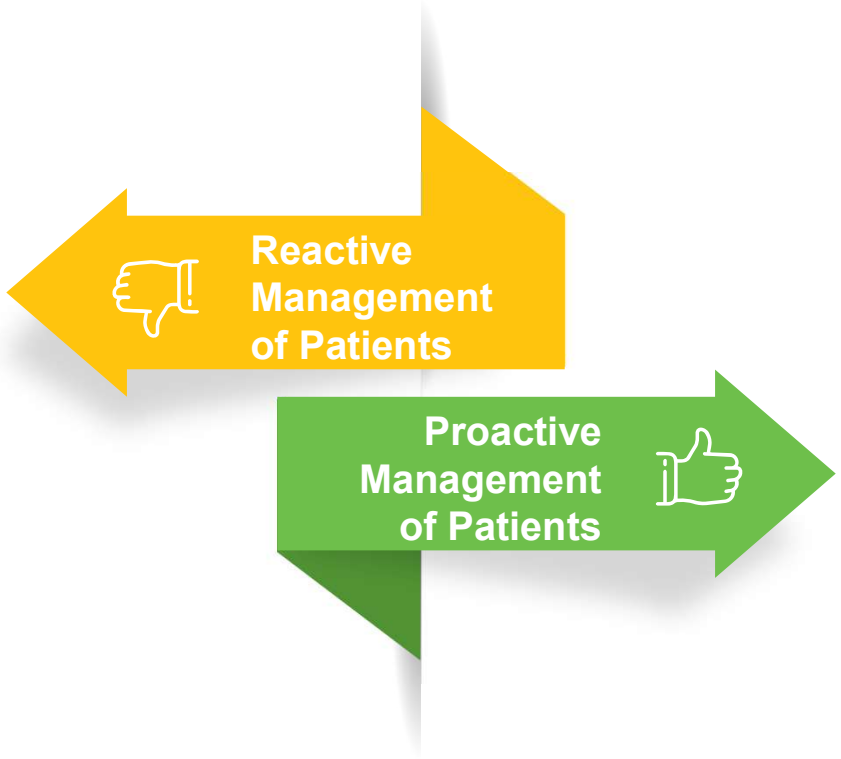
MAL0

Blue Cross Blue Shield Blue Care Network of Michigan

Reactive

Traditionally, we have focused on following up with patients AFTER an event.

Follow up Care is often dependent upon knowing that the patient had an event or received care from another provider.



Proactive

Future path is focusing on patients before an event ever happens.

Who is rising risk?

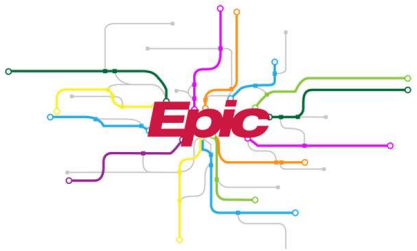
How do you keep patients' chronic conditions under control to avoid the ED and inpatient admit?

Slide 21

MAL0 small thing here but I would flip the slide if possible. Reading left to right ....generally what you are moving away from is on left and what you are moving toward is on the right. Also would make proactive be green and reactive be yellow (ie: red, yellow green) - small signals on the slide that wil better align with you messaging.

McKenzie, Amy L., 2022-10-25T00:35:34.532

How do you identify the patients proactively?



LACE risk score

PAM®
Patient Activation Measure®

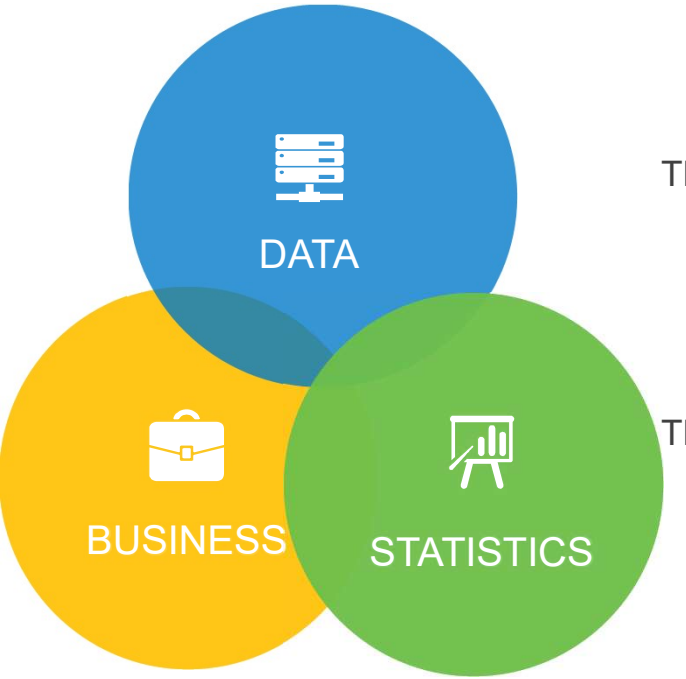
There are many tools to help identify patients who are high risk with different definitions of “high risk.”

How do we operationalize these models, what risks are included in the models (just medical risk vs. other risks) and what is the most appropriate intervention?

Cerner®

Population Health Tools

Future of Predictive Models for Specific Risks



DATA

This is a sample text. Insert your desired text here.

STATISTICS

This is a sample text. Insert your desired text here.

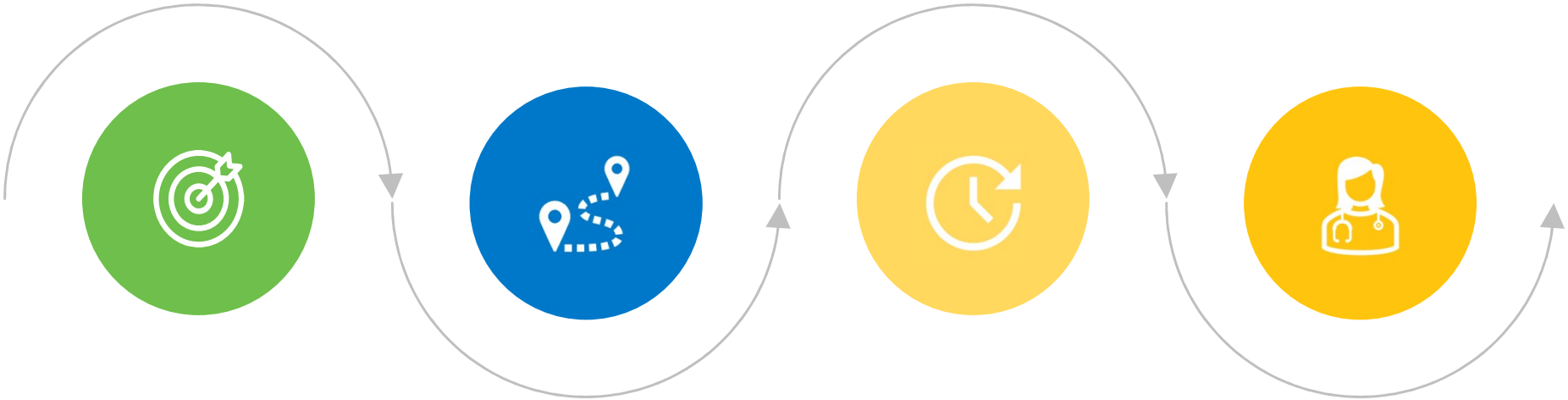
BUSINESS

This is a sample text. Insert your desired text here.

Data Science is the intersection of data, statistics, and business need.

What types of data science models could we use to predict specific risks for patients?

In predicting specific risks, we can consider specific interventions that would be most valuable to patients.



Value Based Care

Expansion of the Care Team

Proactive Management and Predictive Modeling

Specialty Care Management

How do we give patient the same level of support in specialty practices?

- What types of specialties and patients would most benefit from care management availability?
- What types of care management resources would be most valuable in a specialty practice?
- How should the care managers in primary care and specialty care coordinate so that there is not increased fragmentation and duplication of services?
- How do you get specialty physician buy-in to the model of care team support for all patients?

INHALE CQI

Alicia Majcher, MHSA
MICMT, Administrative Director

INHALE & Care Management

- INspiring Health Advances in Lung CarE (INHALE)
- Seek to improve asthma and COPD patient outcomes
- Primary care and specialist practices
- Cohort 1 recently launched
- Opportunity for care management involvement

INHALE & MICMT

- MICMT is partnering with INHALE team
- Looking for opportunities to employ care team members & possible innovative approaches
- If you are participating in INHALE & have ideas regarding how MICMT can support this work, please let us know

MICMT Updates

Alicia Majcher, MHSA
MICMT, Administrative Director

2022 – Year in Review

- **Congrats to all on a successful year!**
- Highlights of the year
  - 419 attendees at Team-Based Care Conference
    - 15 presenters from 13 organizations
    - Analysis presentation highlighted significant impact of PDCM on utilization measures
  - New billing course launched 5/12/22
  - Successful care management attestation process with updates to website
    - Verification process simplified for care managers with unchanged information
    - Process captured dedicated and centralized care managers
  - Pediatric weight management webinar series

MICMT

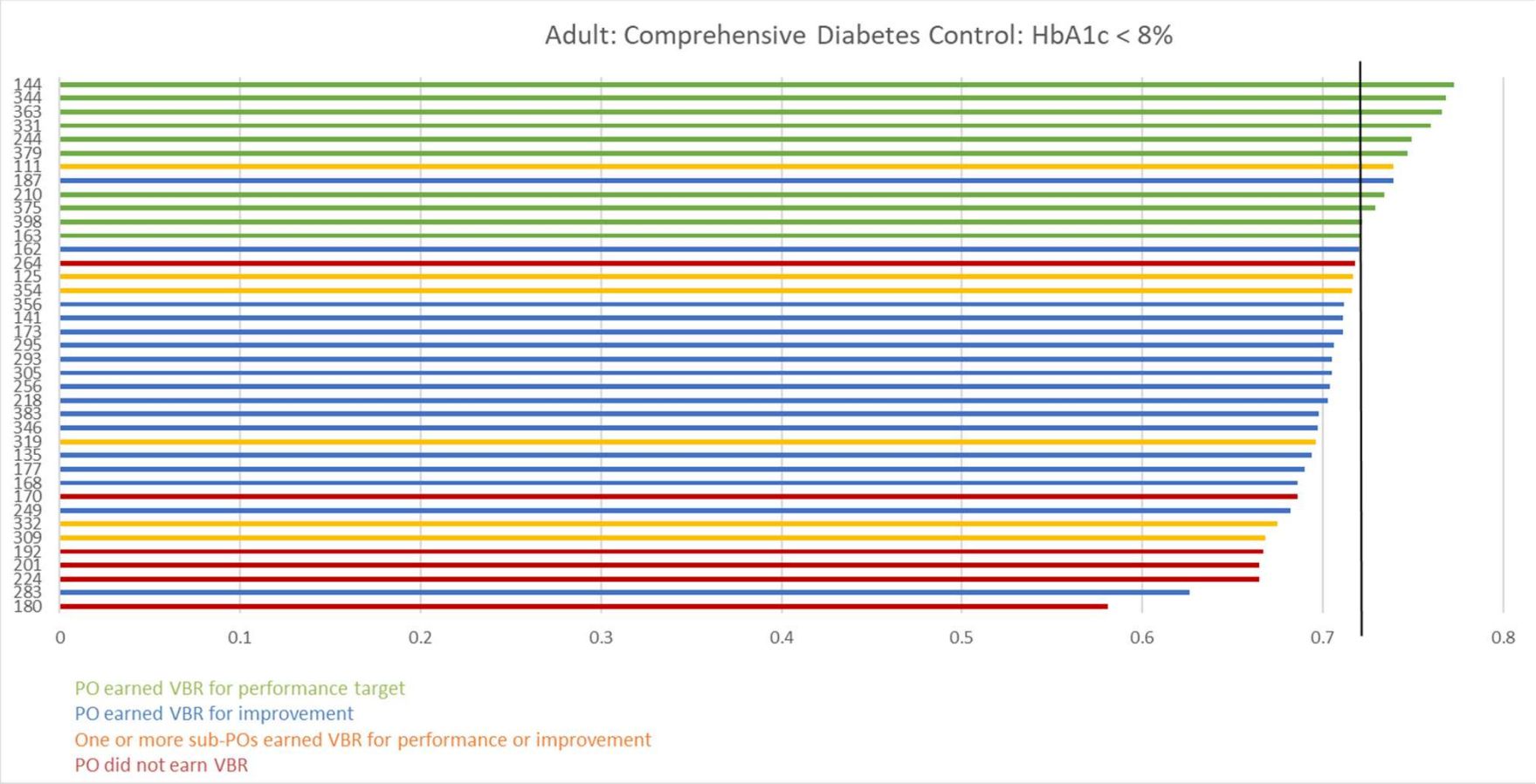
2022 Training Cycle Summary

- Intro to Team-Based Care
  - Totals:
    - **903 Attendees**
    - 35 Approved Trainers
    - 88 Sessions
- Foundational CM Codes & Billing
  - Totals:
    - **233 Attendees**
    - 12 Approved Trainers
    - 16 Sessions
- Patient Engagement
  - Totals:
    - **783 Attendees**
    - 12 Approved Trainers
    - 64 Sessions
- Intro to Palliative Care
  - Totals:
    - **41 Attendees**
    - 4 Approved Trainers
    - 10 Sessions

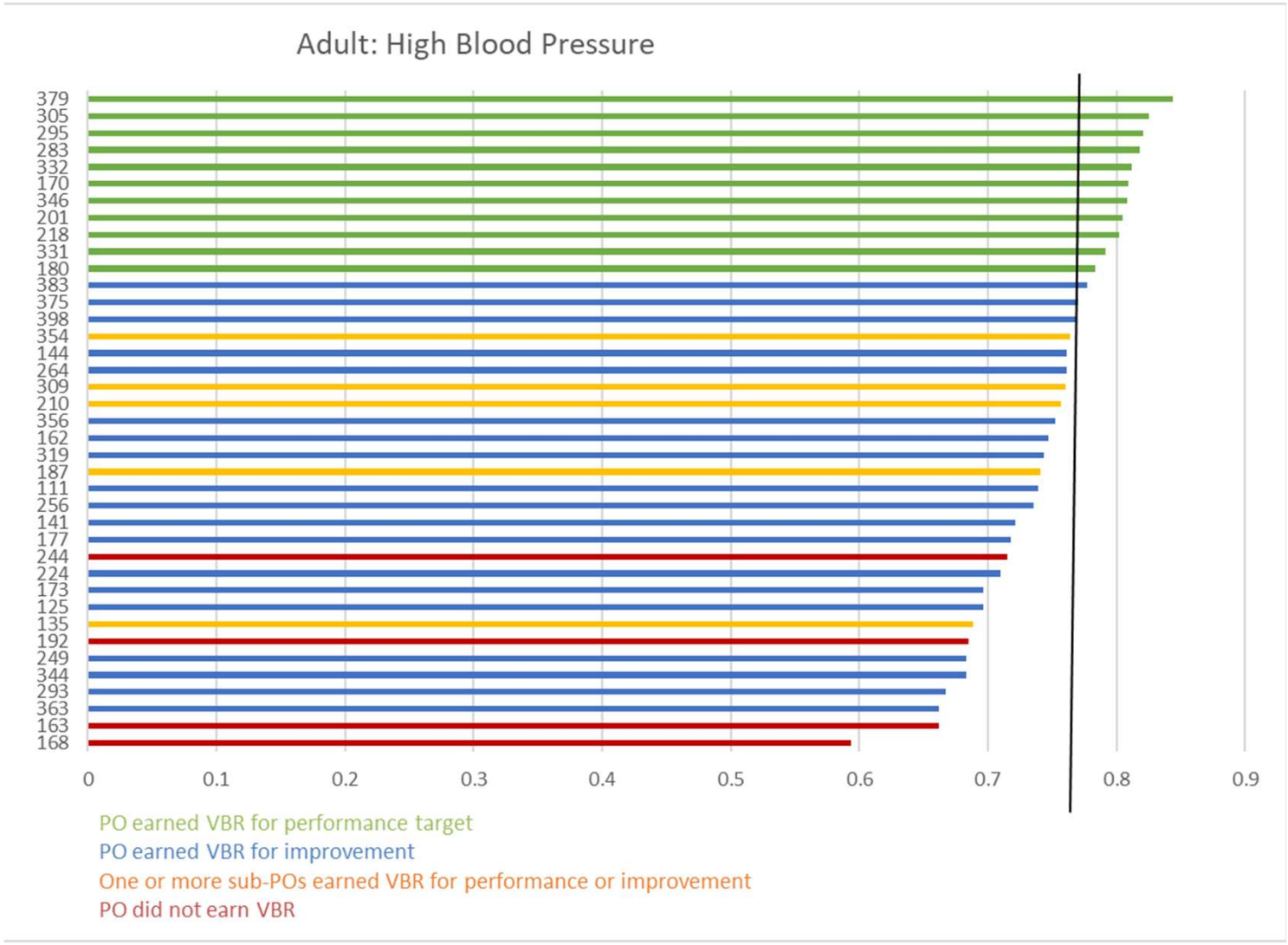
Trainings that occurred between 10/11/21 & 10/10/22.

MICMT

2021 OVBR PO Rankings – A1c



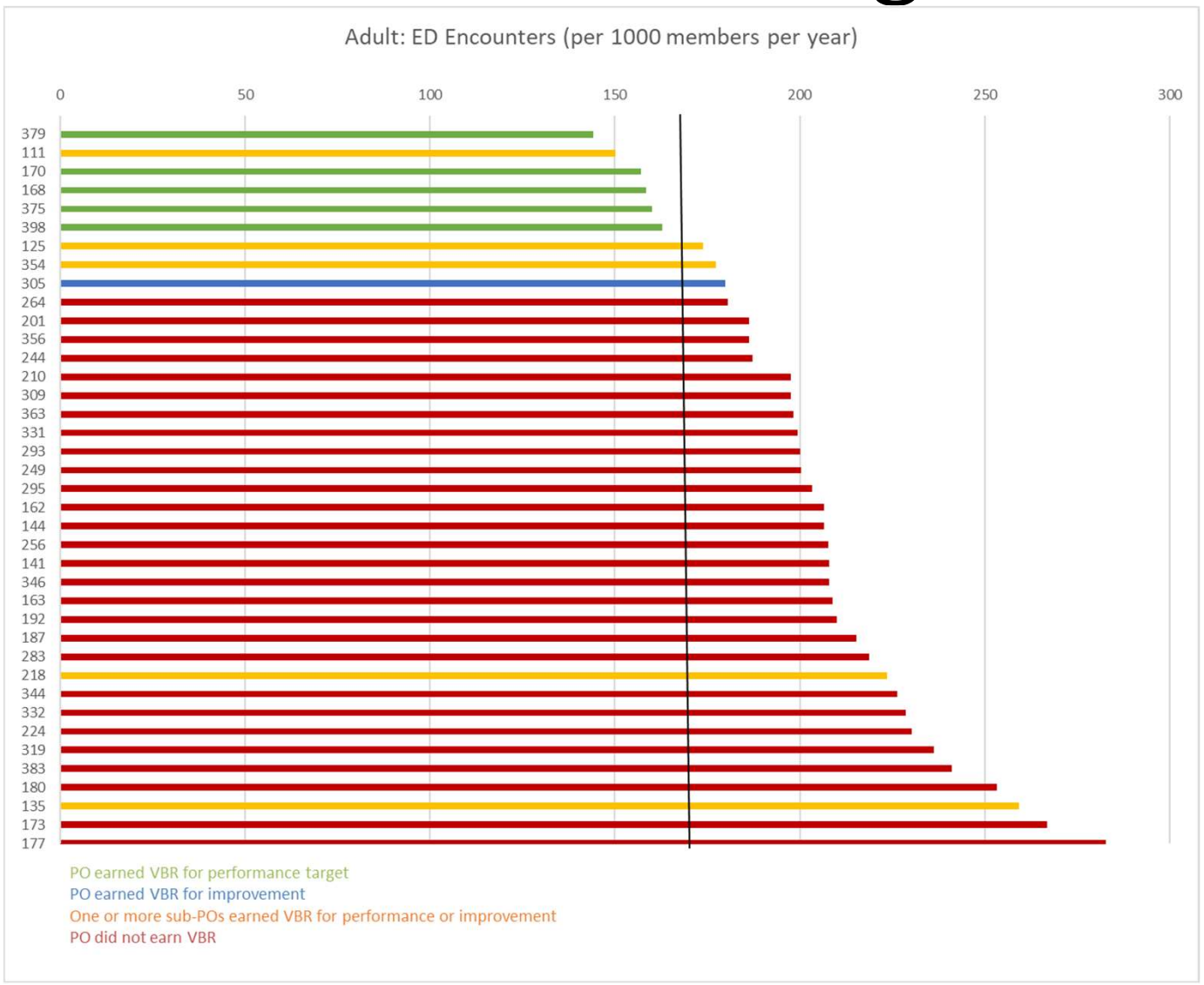
2021 OVBR PO Rankings – BP



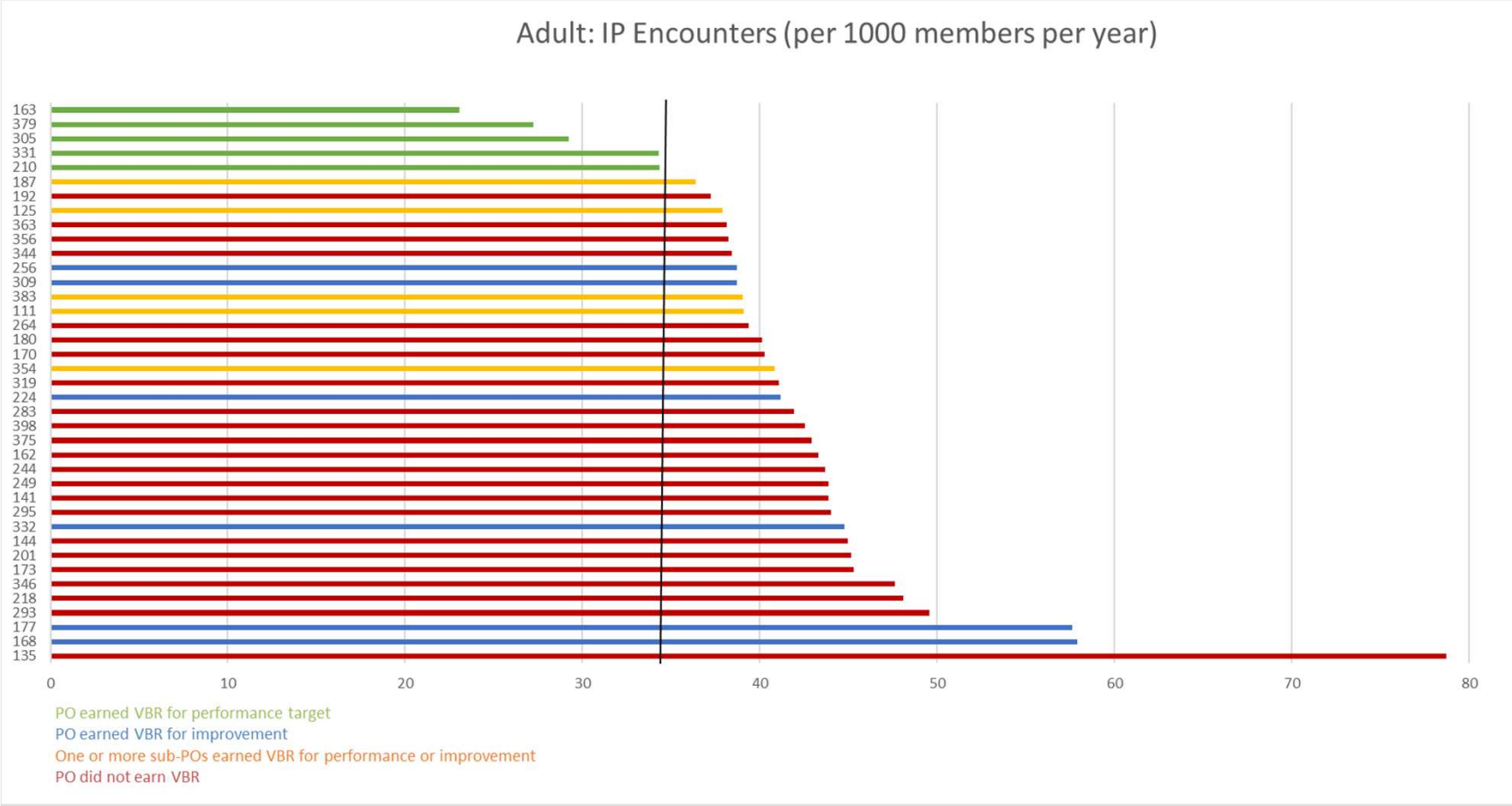
MICMT

Graphs will be shared during MICMT/PO calls in November

2021 OVBR PO Rankings – ED



2021 OVBR PO Rankings – IP



MICMT

Graphs will be shared during MICMT/PO calls in November

2022 MICMT Scorecard - Updates

- Consistent with changes to 2021 Scorecard
- Payment will be in January 2024
- Care management operations:
  - 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.~~

2023 MICMT Scorecard

- Training reimbursement paid in January 2024 check. Will include those trainings that occur between October 11, 2022, and October 10, 2023.
- Scorecard payment paid in January 2025 check.

2023 Scorecard				
Measure #	Weight	Measure Description	Points	Data Source
1	48	**Outcomes**		
		Points for the below outcome measures are earned based on the PO performance with the PDCM Outcomes VBR. *(See Appendix A for more information)*		Outcomes measures align with BCBSM outcomes reporting for POs/sub-POs.
		Peds: IP Utilization	**6**	
		Peds: ED Utilization	**6**	
		Peds: Weight Metric	**6**	
		Peds: Composite Metric	**6**	
		Adult: A1c performance	**6**	
		Adult: BP Performance	**6**	
		Adult: ED Utilization	**6**	
		Adult: IP Utilization	**6**	

2023 MICMT Scorecard (cont.)

Michigan Institute for Care Management & Transformation

2023 Scorecard

Measure #	Weight	Measure Description	Points	Data Source
2	20	**Care Management Operations (Note: This will not impact PDCM Outcomes or Population Outreach VBR)**		
		Percent of PCMH Designated practices that achieve the PDCM Participation threshold (2 encounters on 1% of the PDCM attributed population). **Note that this uses a different list:** The % of PDCM Participating practices will be assessed using the 2024 1% PDCM List (2 encounters on 1% of patients) from 2023 Claims. These practices are identified in the reports provided with the Value-Based Reimbursement and PDCM Participation reports that BCBSM will distribute in Fall, 2024.	% of PCMH practices: # of points 90%: 5 75%: 4 50%: 2 25%: 1	BCBSM 2024 PDCM reports (2023 claims) titled "....2023_PDCM_PU_Rpt ...".
		Percentage of PDCM Participating (2 encounters on 1% of the PDCM population) practices that achieve the Population Management VBR (2 encounters on 4% of the PDCM attributed population). **Note that this uses a different list:** The % of PDCM Participating practices will be assessed using the 2024 1% PDCM List (2 encounters on 1% of patients) from 2023 Claims. These practices are identified in the reports provided with the Value-Based Reimbursement and PDCM Participation reports that BCBSM will distribute in Fall, 2024.	% of PDCM practices: # of points 90%: 5 75%: 4 50%: 2 25%: 1	BCBSM 2024 PDCM reports (2023 claims) titled "....2023_PDCM_PU_Rpt ...".
		Patient Satisfaction Survey: PCMH Capability 4.4 in place. "PCMH/PCMH-N patient satisfaction/office efficiency measures are systematically administered."	% of PDCM practices: # of points 90%: 4 75%: 3 50%: 2 25%: 1	First snapshot of 2024, looking at CY 2023.
		Patient Satisfaction Evaluation & Improvement: PCMH Capability 4.23 in place. "Practice has engaged in root cause analysis of any areas where there are significant opportunities for improvement in patient experience of care using tested methods such as Journey Mapping or LEAN techniques."	% of PDCM practices: # of points 90%: 6 75%: 4 50%: 3 25%: 2	First snapshot of 2024, looking at CY 2023.

2023 MICMT Scorecard (cont.)

3	32	**Engagement:**		
		Patient Engagement SME Identified by 3/1/23 & participate in PE SME activities (meetings & surveys)	**4**	MICMT Reporting For capability: First snapshot of 2024, looking at CY 2023.
		Advanced Patient Engagement Training Completed by SME (During calendar year 2022 or 2023)	**5**	
		Patient Engagement Capability 11.8 in place. "At least one member of PO or practice unit is formally trained through completion of a nationally or internationally-accredited program in self-management support concepts and techniques, and regularly works with appropriate staff members at the practice unit to educate them so they are able to actively use self-management support concepts and techniques."	**5** **% of PDCM practices** / **# of points** **75%** / **5** **50%** / **4** **30%** / **3** **20%** / **2**	
		Practice & Care Team Member Attestation/Verification	**5**	
		At least 3 scheduled phone conferences (30 minutes) with MICMT	**5**	
		Participation in the entire Annual Team-Based Care Conference by at least 1 PO representative	**4**	
		Participation in the entire Annual MICMT meeting by at least 1 PO Representative with a leadership role in Care Management activity at the PO level	**4**	

New to MICMT - Clinical Leads

Nada Farhat, PharmD

- PharmD since 2015
- Clinical pharmacist in primary care
- Practice interests in ambulatory care practice advancement, transitions of care, & chronic disease state management
- Working with INHALE team

Amy Schneider, MS, RD, CDCES

- RD since 2007
- Certification in Diabetes Care and Education
- Master of Science in Nutrition Education
- Health and Wellbeing Coach
- Patient Engagement Focus

MICMT

Patient Engagement Opportunities

Training Simulation

- For individuals who recently took Patient Engagement course*
- Topics covered in course
- Structured practice
- One-time session
- Immediate feedback

Coaching

- For anyone interested in discussion with another clinical team member
- Open-ended conversation or unstructured practice
- Can be multiple sessions or ongoing feedback
- Contact MICMT for more details

MICMT

* Course Trainer may conduct simulation, will direct learners on process

Patient Activation Measure (PAM)

- Brief PAM survey can accurately measure a patient's level of "activation"—their knowledge, skills and confidence for self-management
- Pilot launching with 1 PO – Huron Valley Practice Affiliates (HVPA)
- Plan to implement PAM survey in practices with Phreesia patient intake software in place

Physician Education

- Slide deck will be available soon on website
- Highlights the benefits of provider-delivered care management
- PO leaders can use slides in meetings with physicians/practices not yet participating in PDCM
- Recorded version will also be available, if preferred

Community Health Worker Upcoming Webinar Series

- CHW: Program Perspectives
  - November 15, 2022
- CHW: Type & Scope of Roles
  - January 11, 2023
- CHW: Sustainability
  - March 8, 2023
- CHW: Billing Workflows
  - May 10, 2023

All sessions from 12-1

Collaborative Care Model (CoCM) Upcoming Trainings

- Base Training
  - Day 1: January 24th
  - Day 2: January 26th
  - Day 3: January 31st
- Perinatal Training
  - Day 1: February 22nd
  - Day 2:
    - February 28th – Psychiatric Consultants
    - March 1st - BCHM and Clinical Supervisors
- Adolescent Training
  - Day 1: March 20th
  - Day 2: March 21st

Visit CoCM Page on MICMT website for more details www.MICMT-cares.org

PGIP CoCM Reminders

Training reminder

- As mentioned the Adolescent Training and the upcoming Perinatal Training are based on subject matter from the Base Training. For that reason, BCBSM requires practices to complete the Base Training prior to enrolling for the other two trainings.

AIMS Tracker Reward

- If you signed user license agreement(s) in 2022, you will receive reimbursement in the January 2023 if you submit your invoice(s) by Nov. 11, 2022.
- The reward will reimburse your user license expense at 100%. However, BCBSM will not reward vendor or other amounts not directly related to the licensing.
- If you are currently using the standard version of the Caseload Tracking tool, and would like to use the EHR integrated tool, BCBSM will reimburse your transfer.
- This reward is only available to designated practices, however; once your practice receives designation, BCBSM will reward for the license agreement at that time.

CoCM Nomination Dates

- Waiting on firm dates from the BCBSM operations team, but nominations will be due at the same time as the April snapshot closes. BCBSM will open the nomination cycle and publish the process as soon as it's ready – likely mid-November.

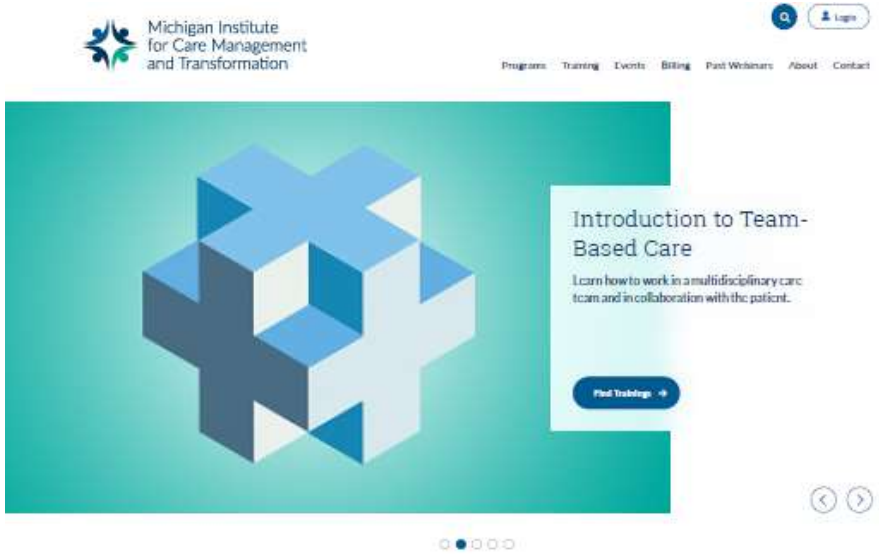
MICMT

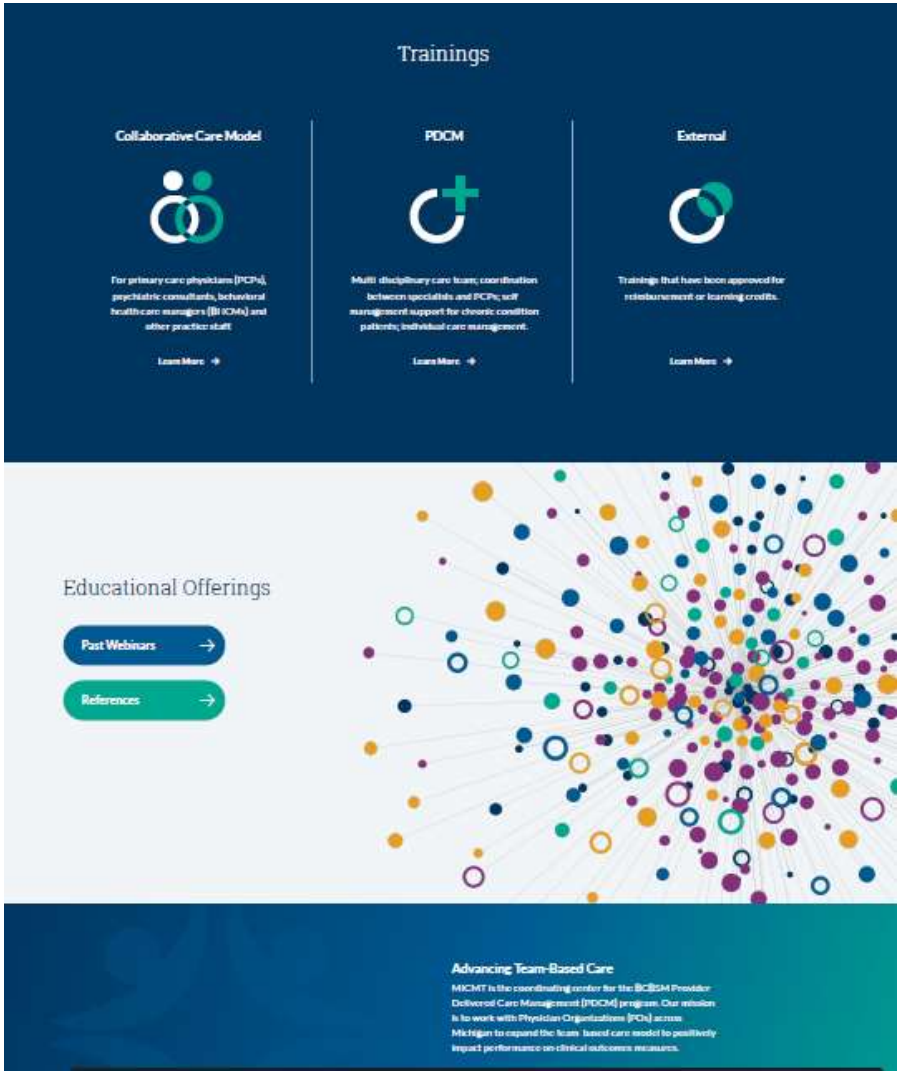
Barbershop Initiative

Planned Website Enhancements

- Job Board for POs to submit postings for care management/team-based care positions
- Improved navigation with focus on types of users
- Updated look and feel
- Updates to Attestation based on feedback
  - More flexibility
  - Live today

Website Enhancements: Updated Look & Feel



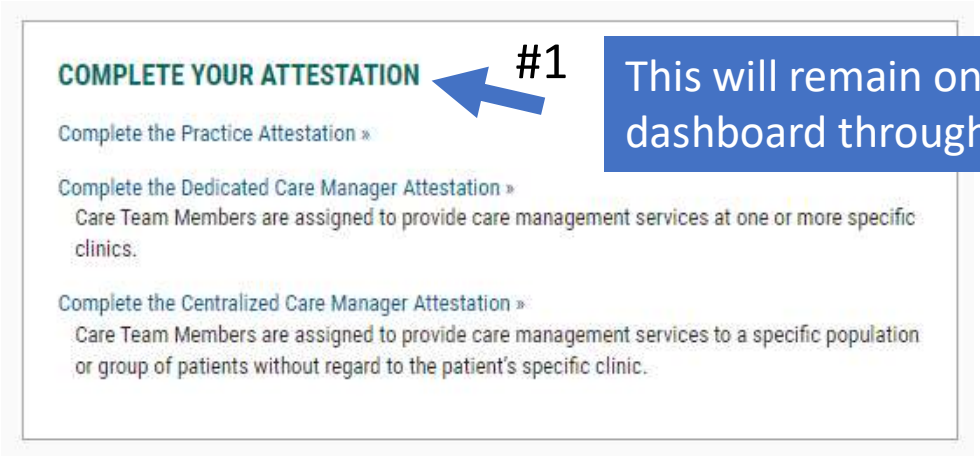


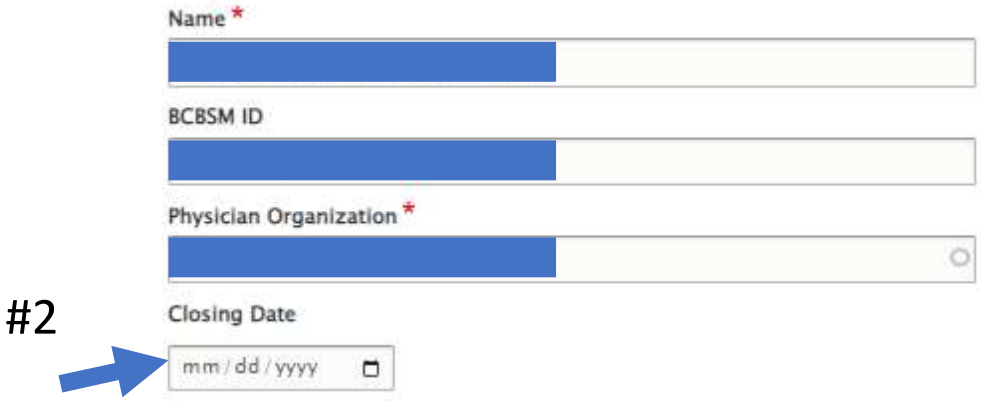
MICMT

Website Enhancements: Attestation

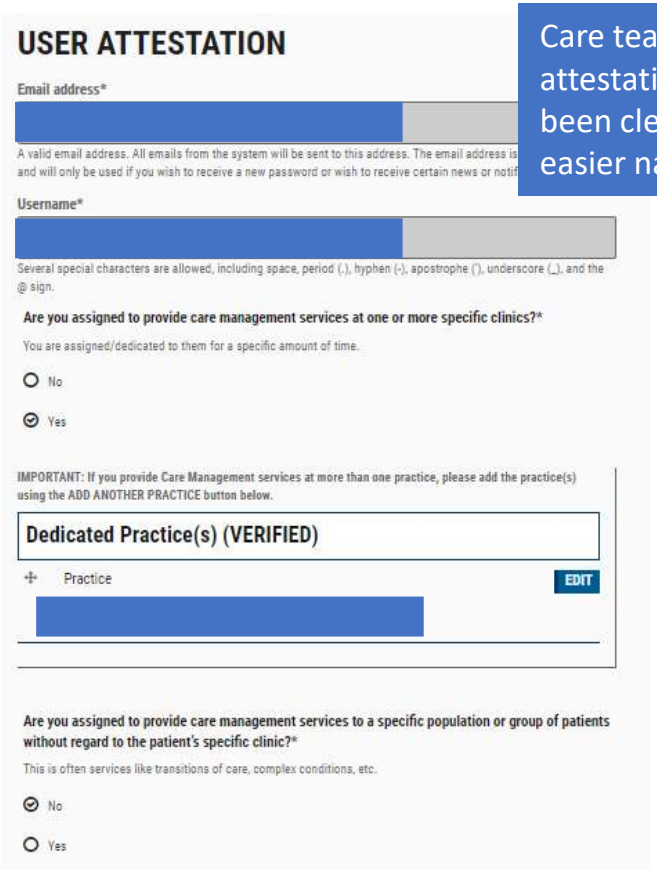
New changes will allow users to:

1) Access attestation anytime throughout the year
2) End date practices
3) Edit care team members/practices after verifying

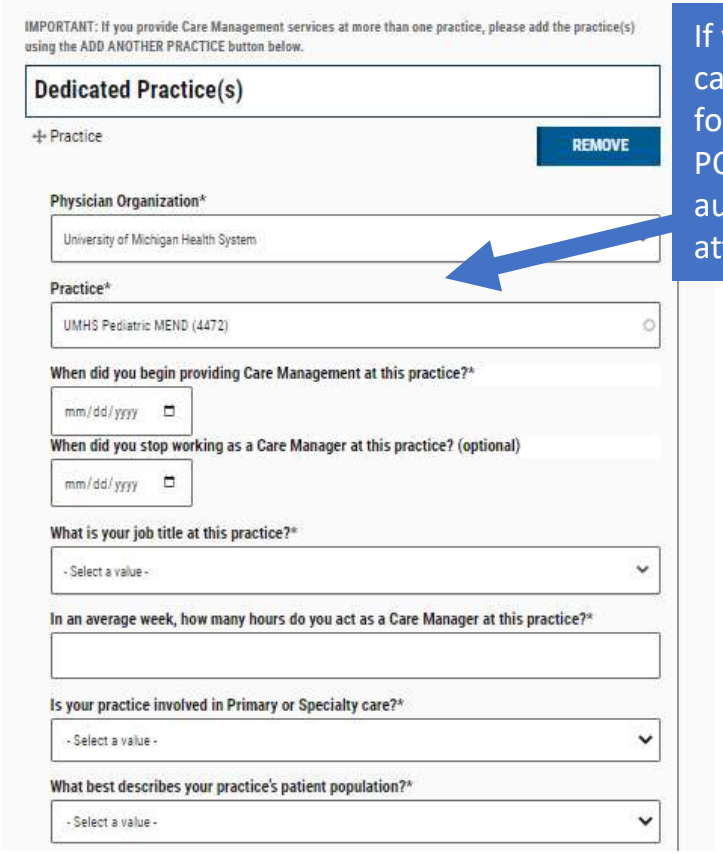




Website Enhancements: Attestation



Care team member attestation form has been cleaned up for easier navigation



If you are adding a care team member for the first time, their PO and practice will auto populate in the attestation fields.

Reminder:

- PO leaders are <u>not</u> required to update throughout the year.
- There will still be an annual verification period during which PO leaders will need to verify and attest for care team members and practices.

52

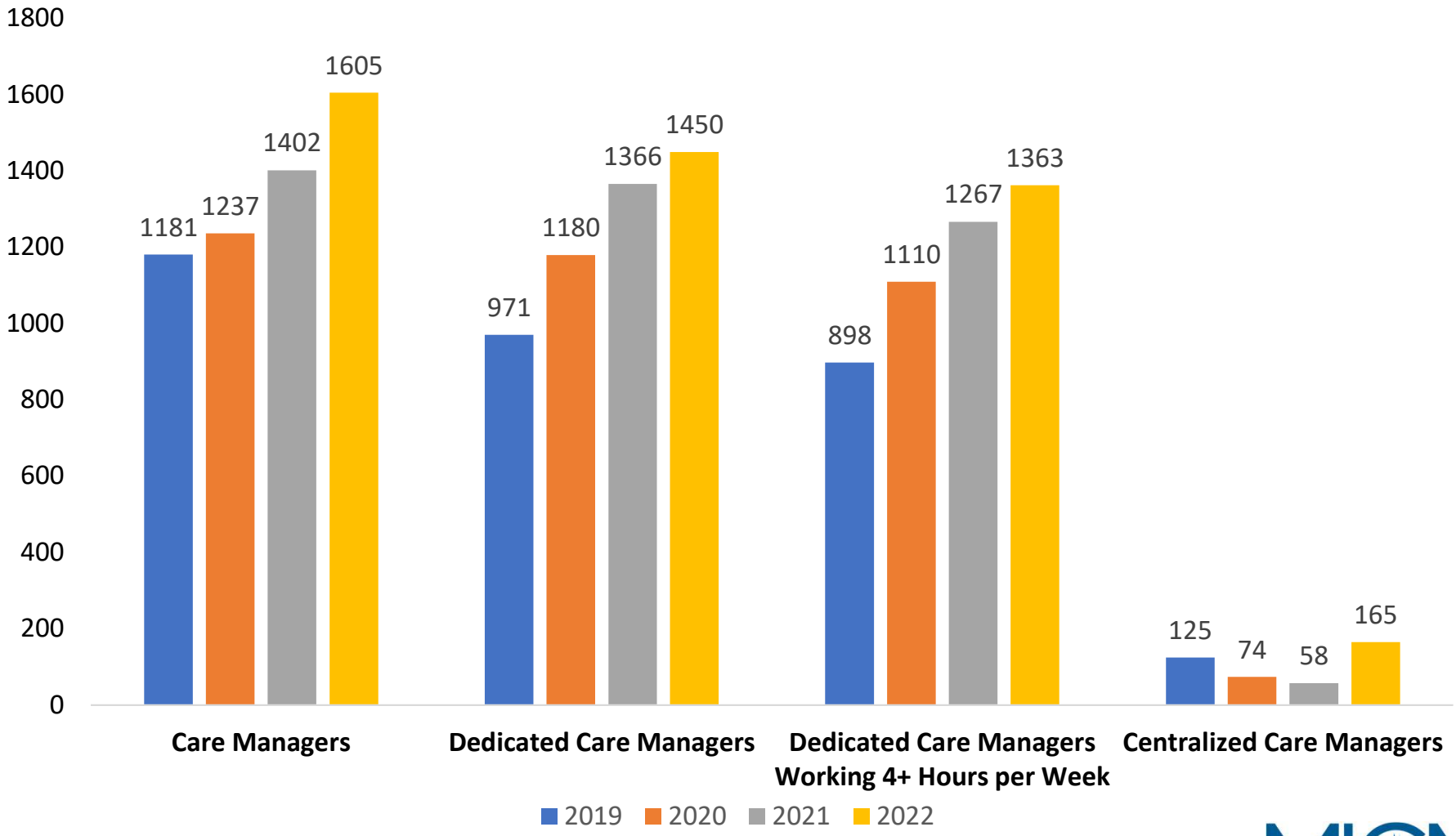
2023 Team-Based Care Conference

- Looking for high performing teams or those using innovative approaches to present
- Possible topics include:
  - Collaborative Care Model
  - Palliative Care
  - Team-Based Care in Specialty Practices
  - Multi-disciplinary Teams in Primary Care or Specialty care
  - ????
- Send us any ideas you have for topics/presenters

MICMT

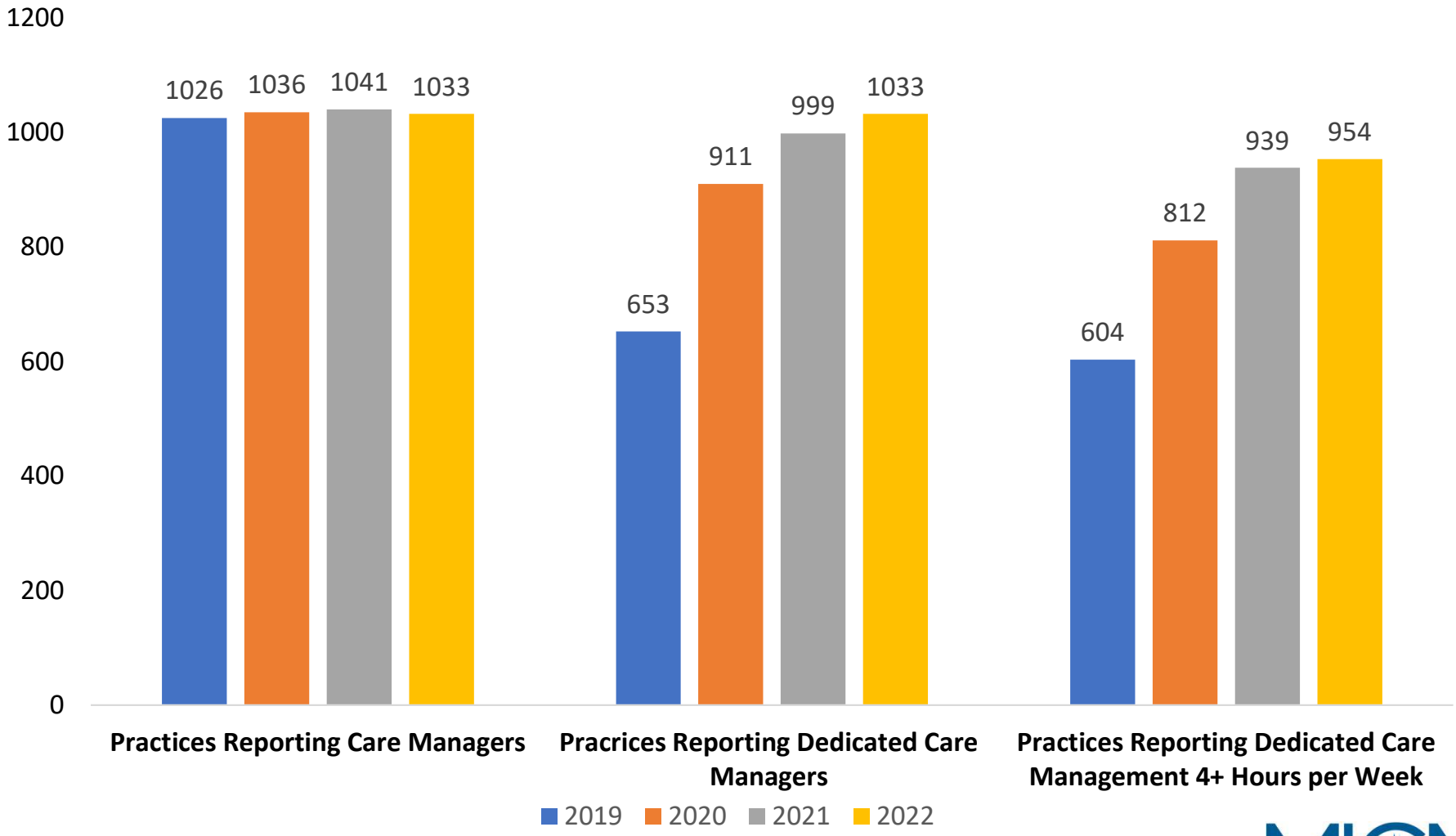
Care Management in Michigan

Self-Reported Care Managers



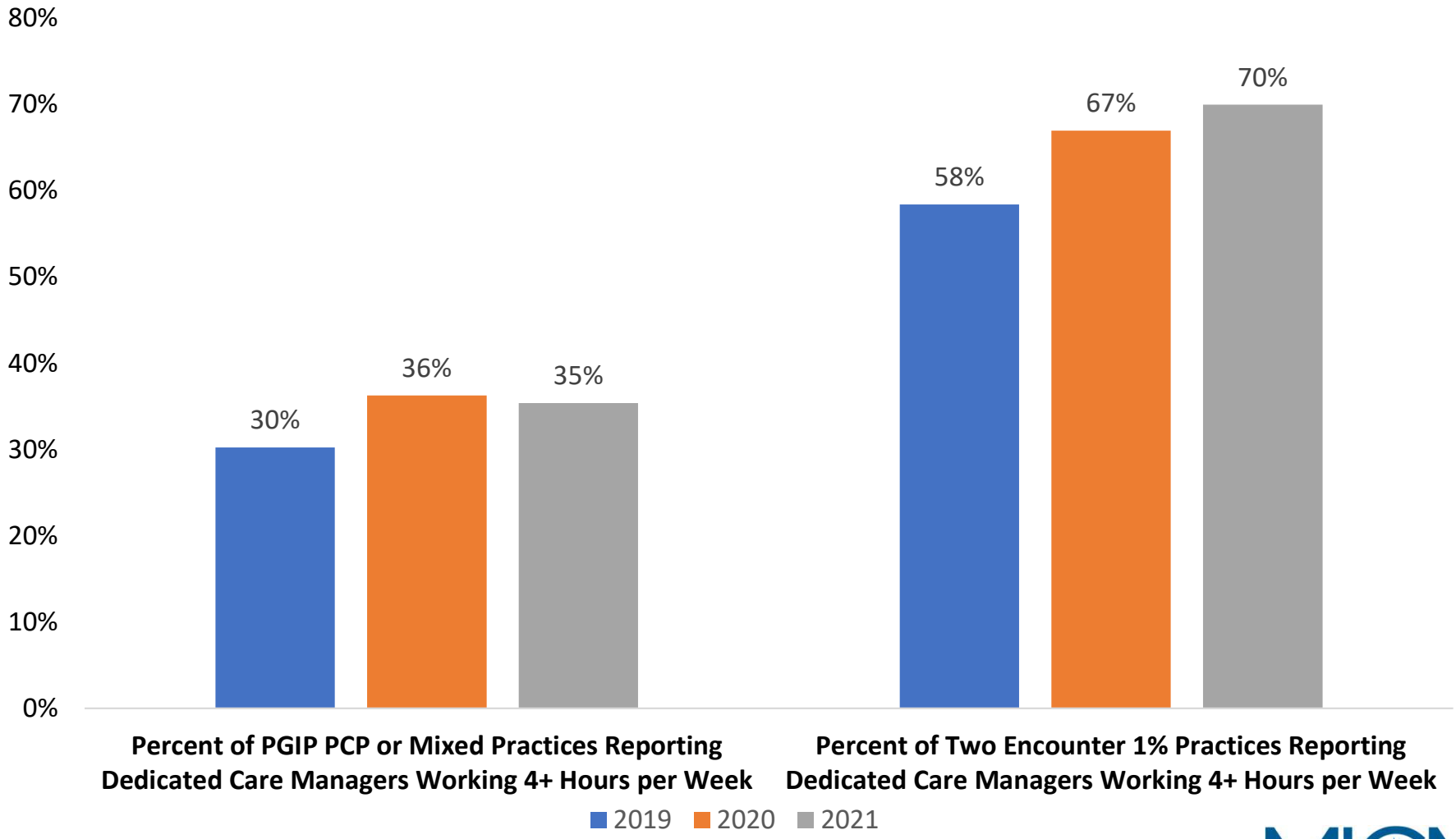
*Care Managers counted who were reported active at least one day in year.

Practices Self Reporting Care Managers



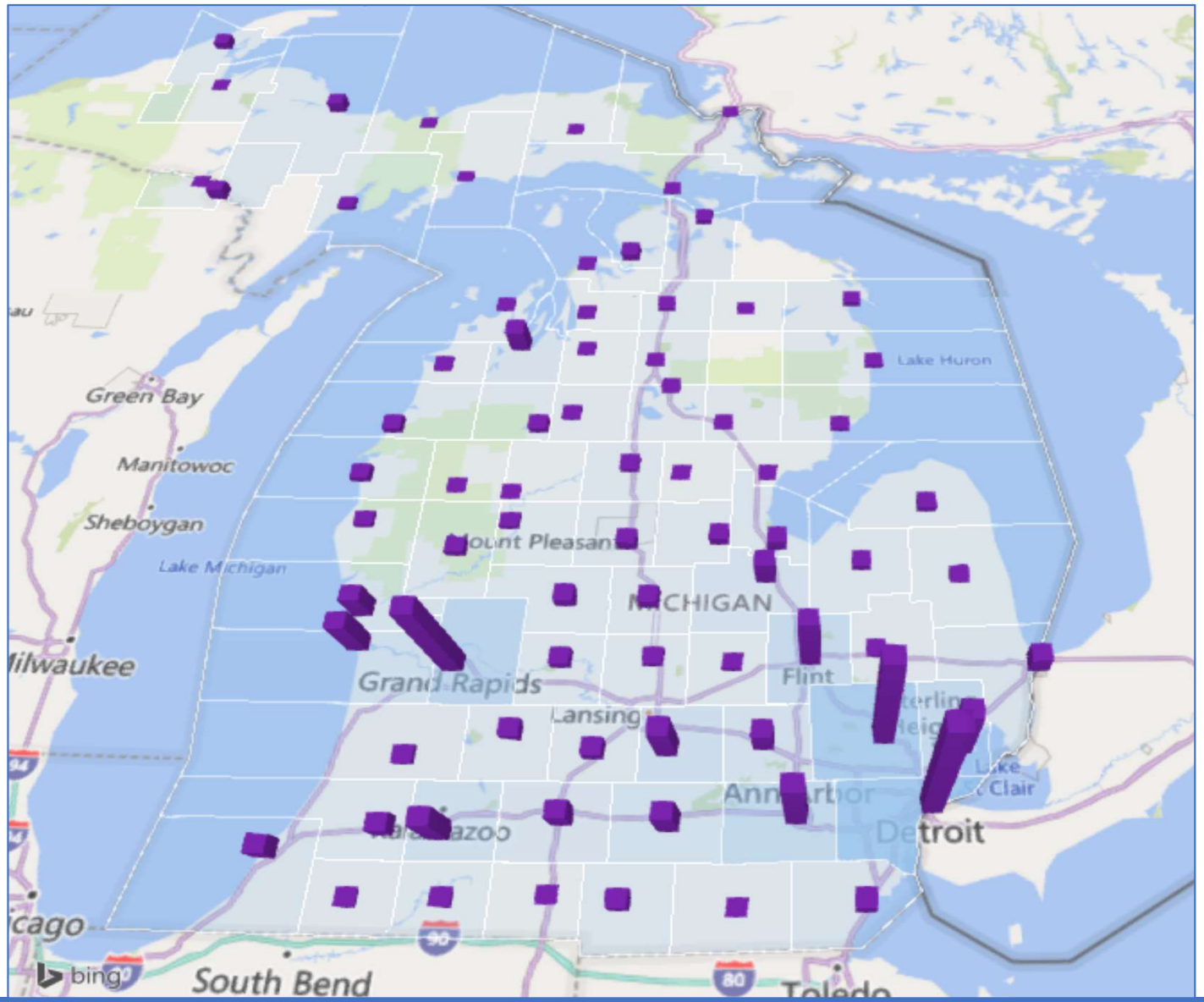
*Care Managers counted who were reported active at least one day in year.

Proportion of Practices with Dedicated Care Managers Working 4+ Hours per Week



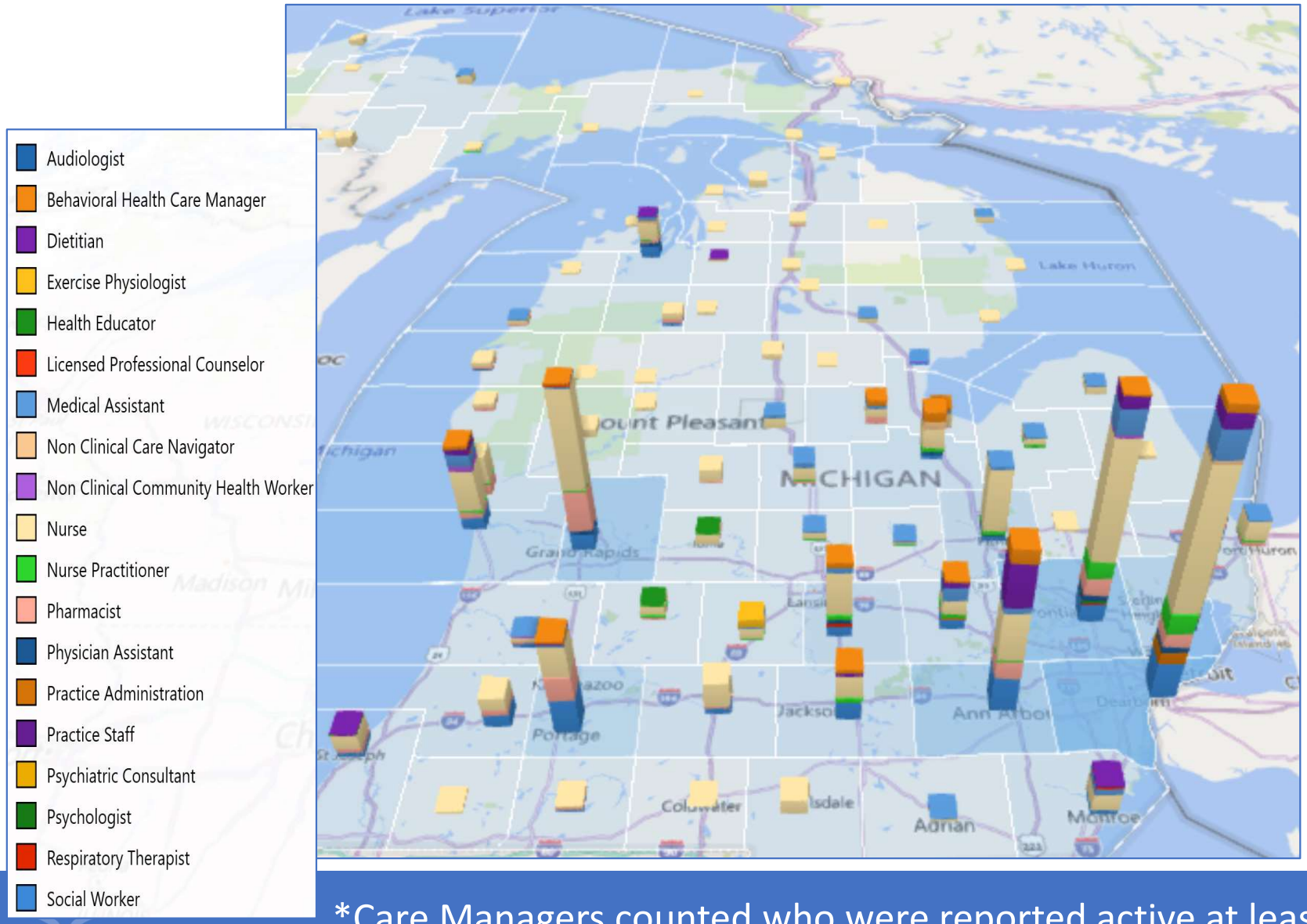
*Care Managers counted who were reported active at least one day in year.

Practices with Dedicated Care Management 2022 Attestation by County



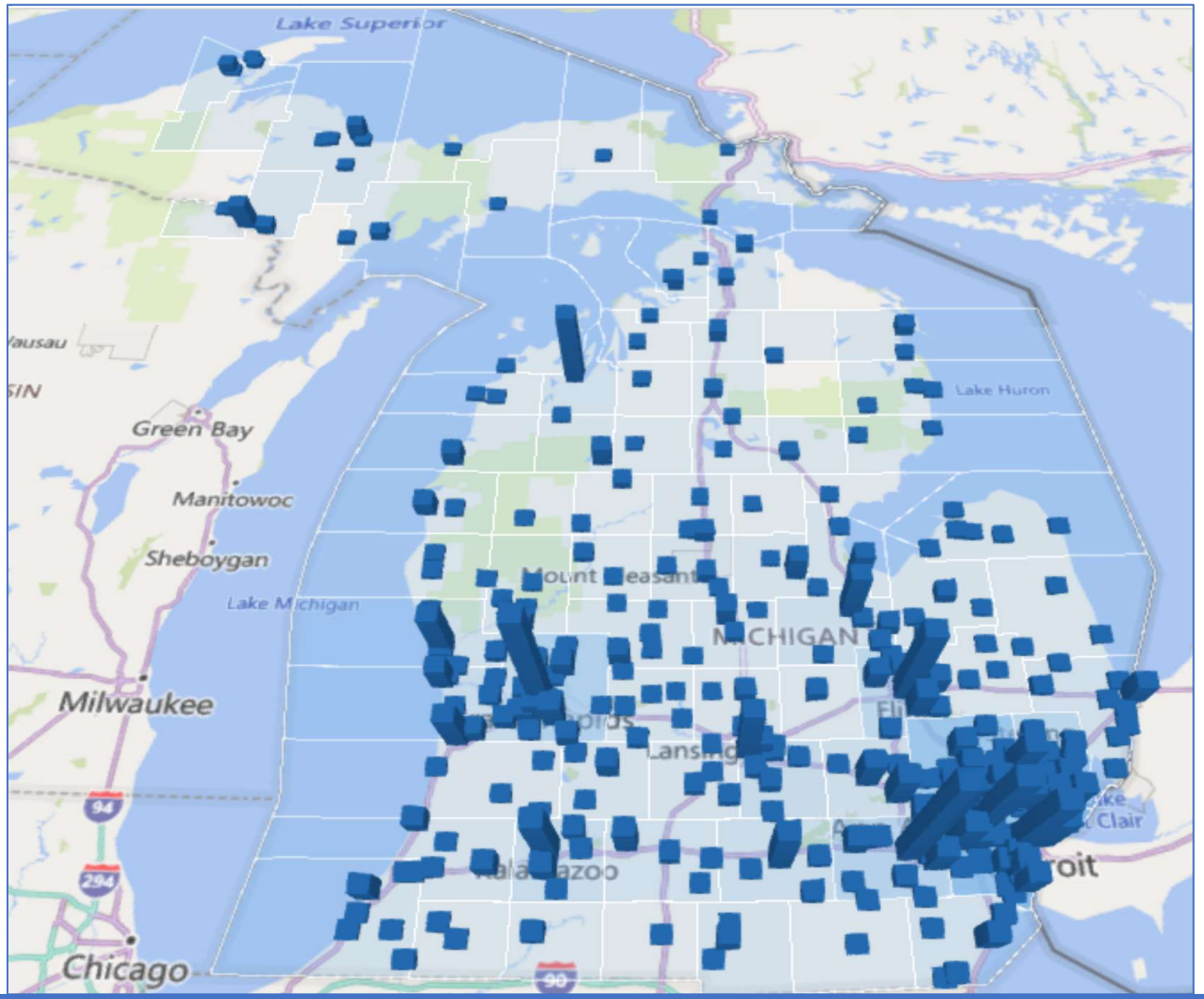
*Care Managers counted who were reported active at least one day in year.

Practices with Dedicated Care Management 2022 Attestation by County and Role



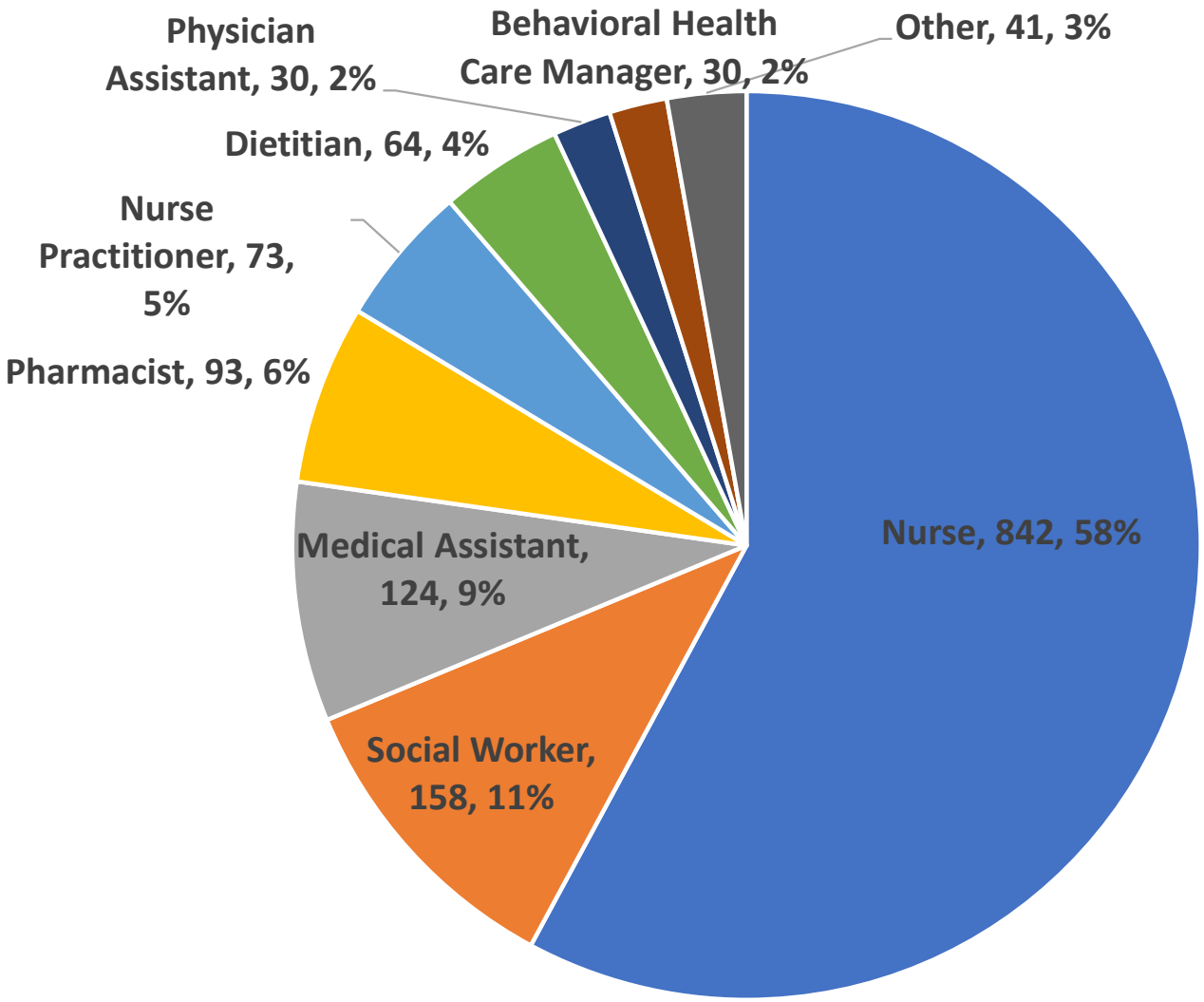
*Care Managers counted who were reported active at least one day in year.

Practices with Dedicated Care Management 2022 Attestation by City



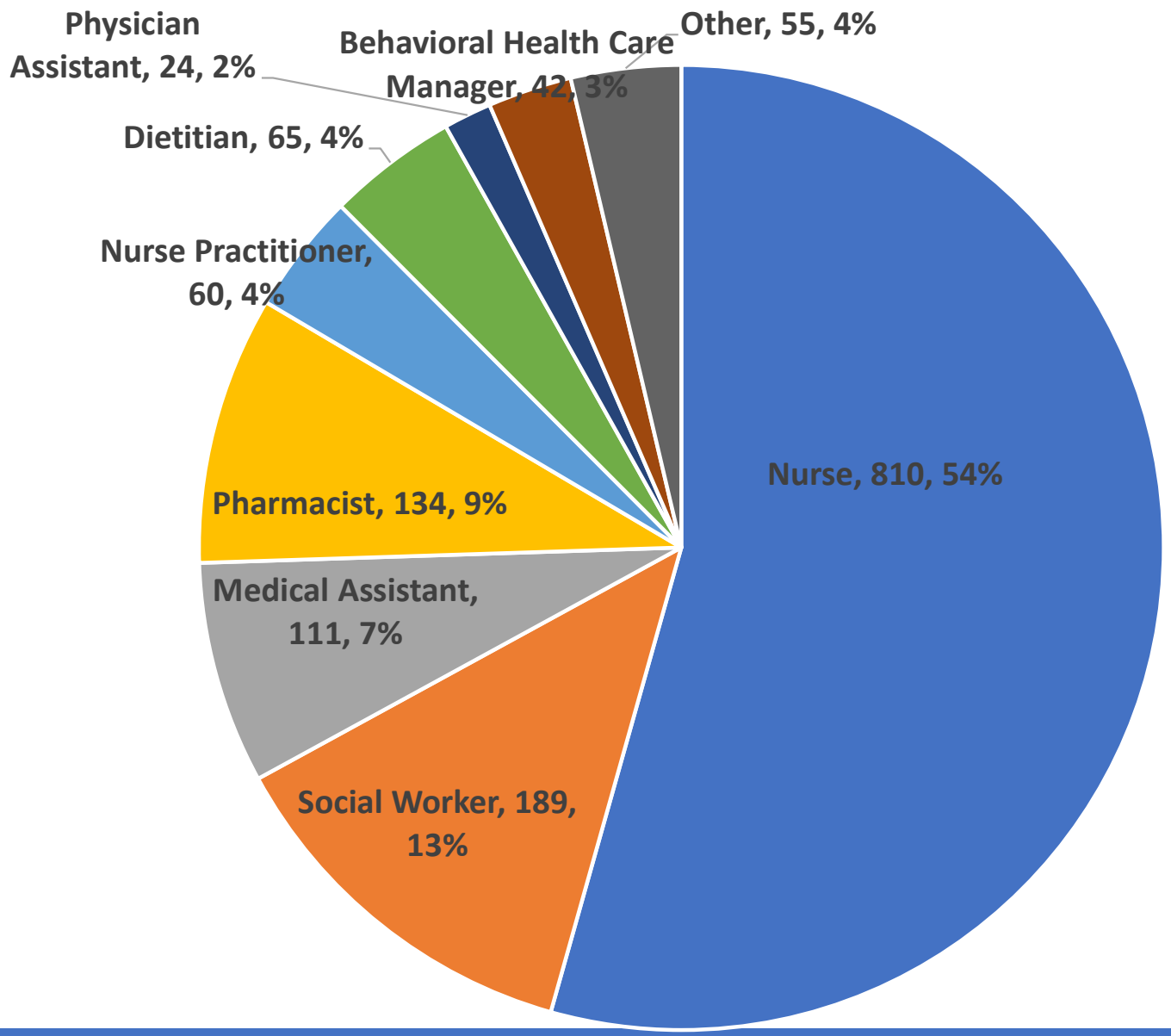
*Care Managers counted who were reported active at least one day in year.

Dedicated Care Managers by Role



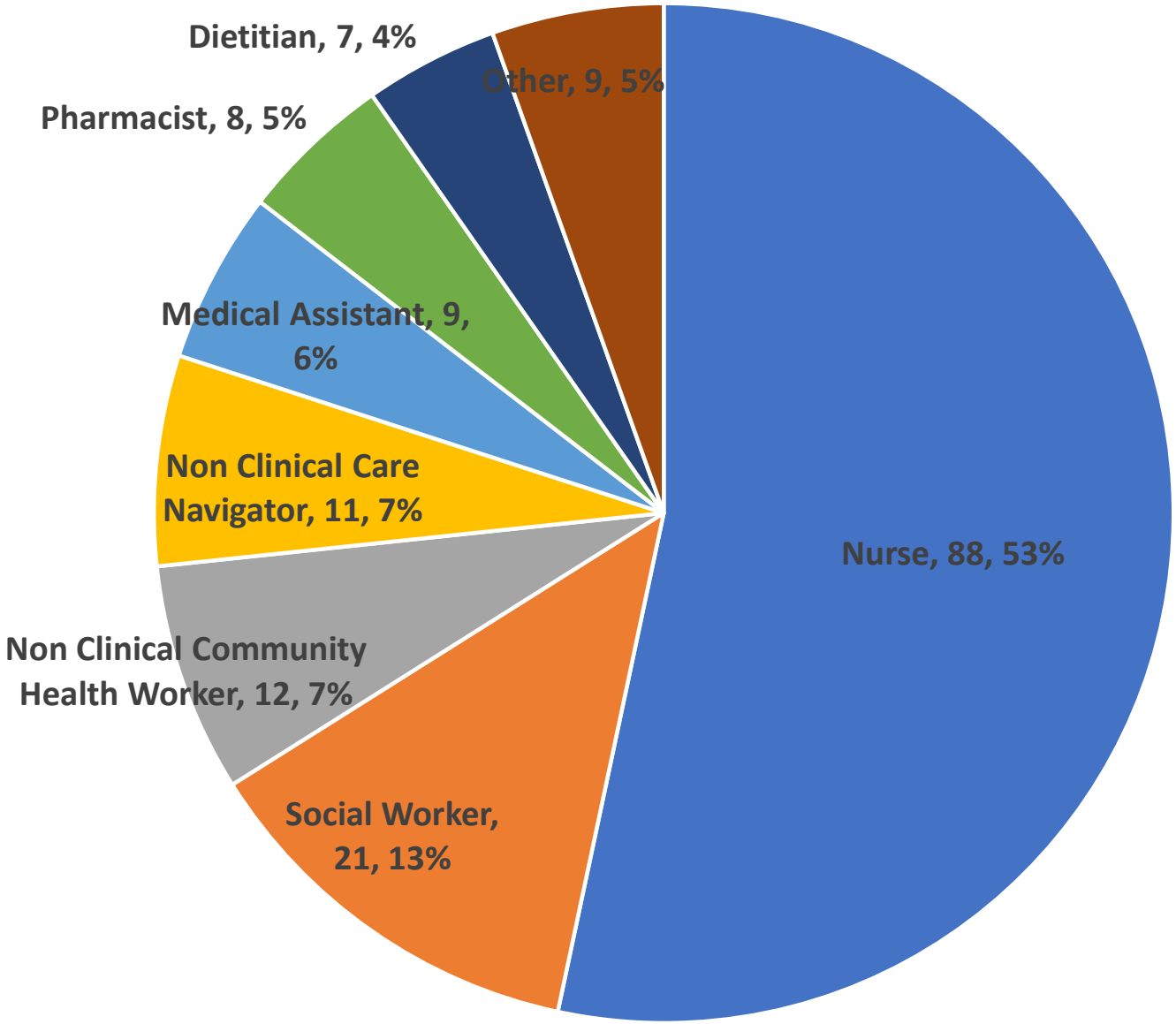
*Care Managers counted who were reported active at least one day in year.

Dedicated Practices by Role



*Care Managers counted who were reported active at least one day in year.

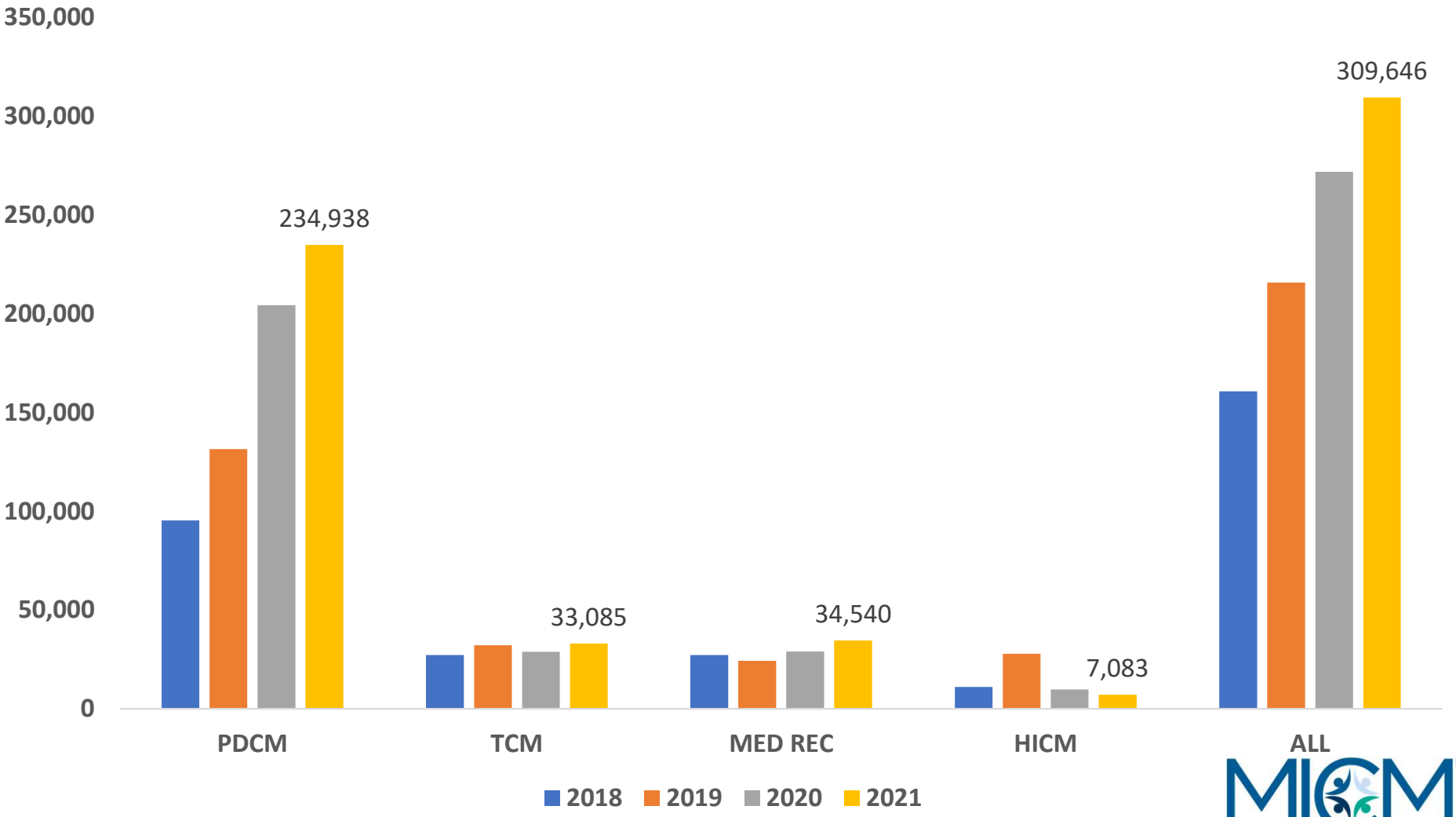
Centralized Care Managers by Role



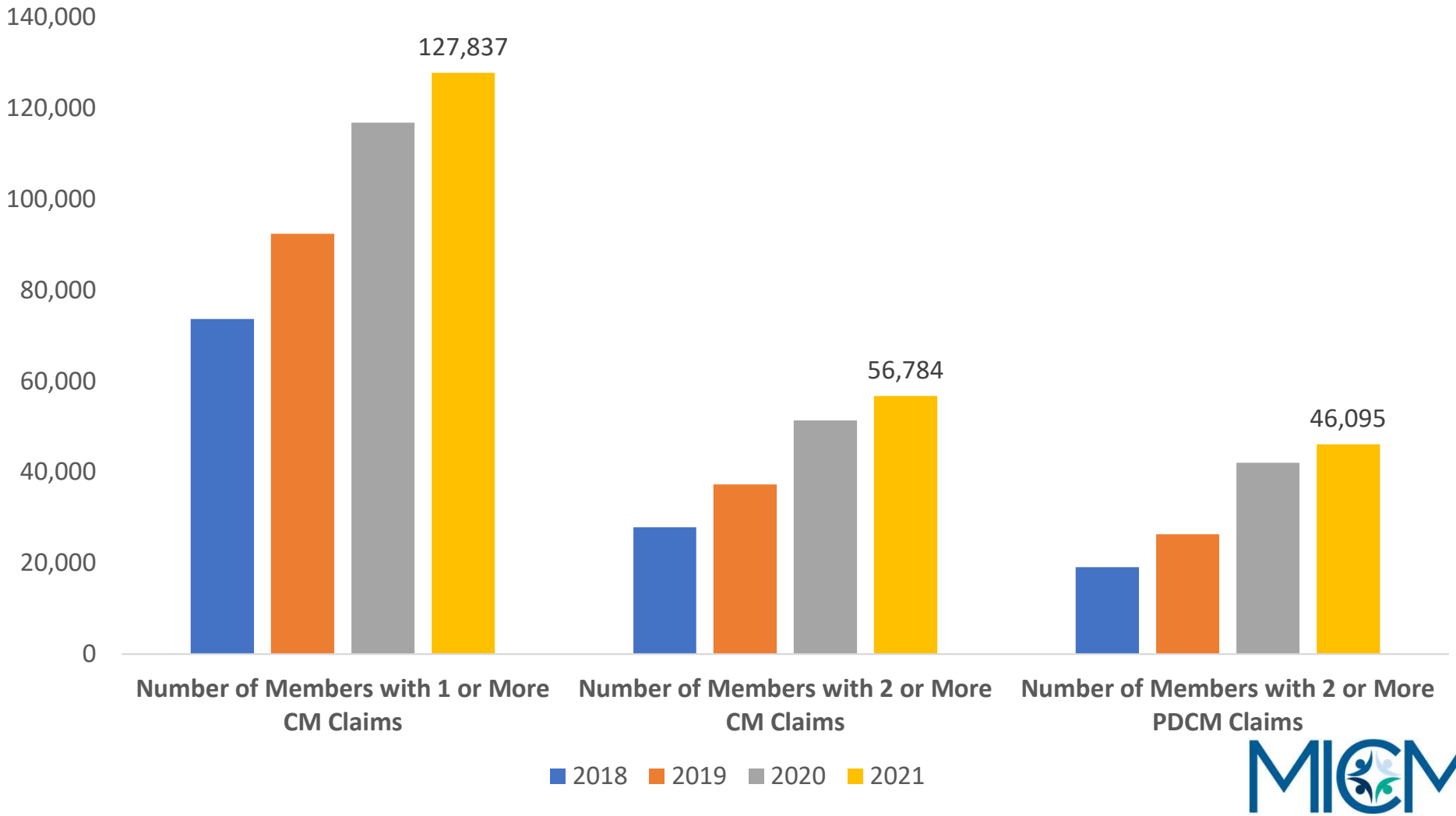
*Care Managers counted who were reported active at least one day in year.

Care Management Billing

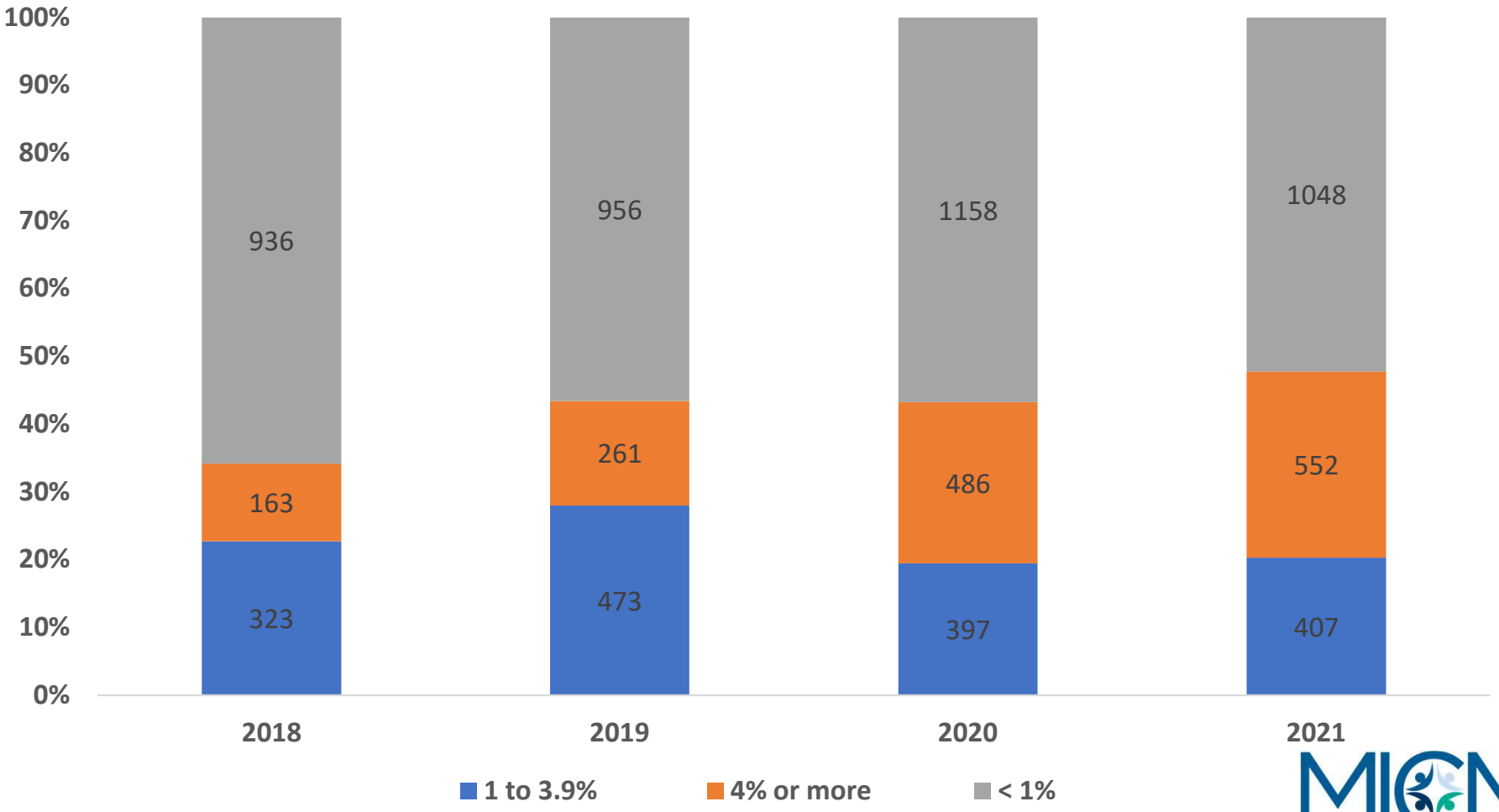
Care Management Claims
PGIP PCP and Mixed Practices



Care Management Members PGIP PCP and Mixed Practices



PCMH Practices with PDCM-Attributed Members that Achieved Encounters on x%



Physician Organizations Achieving at Least 4% with Two CM Encounters

- Great Lakes OSC, LLC
- Holland PHO
- Huron Valley Physicians Assoc PC
- IHA
- Integrated Health Partners
- Jackson Health Network, L3C
- LPO, LLC
- Medical Network One
- Northern Michigan Care Partners
- Oakland Physician Network Services
- Olympia Medical LLC
- St. Mary's PHO, LLC
- United Physicians, Inc
- University of Michigan Health

MICMT

Data Updates

Sandeep Vijan, MD, MS
MICMT, Program Evaluation Team Co-Lead

PDCM evaluation

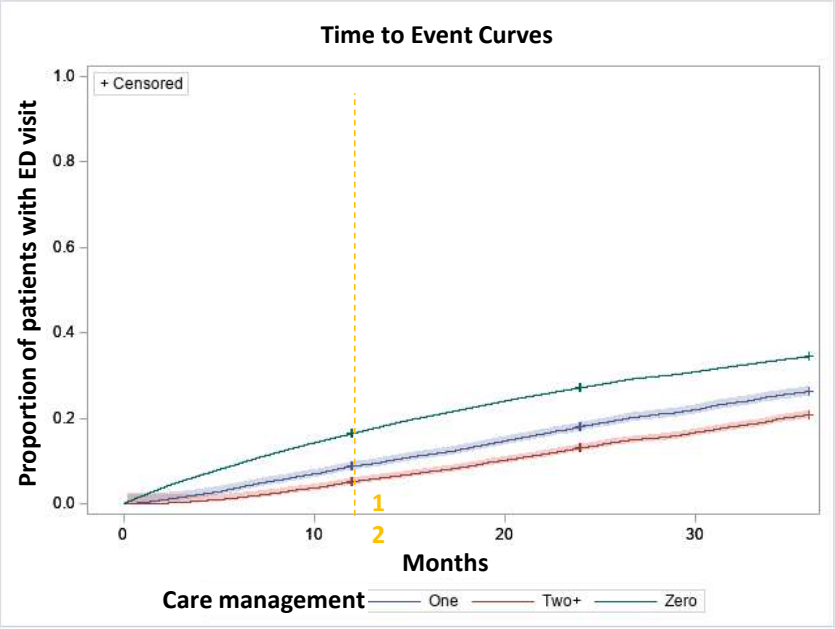
- We have two broad interests in our evaluation group
  - Does care management as currently practiced across the state improve utilization and outcomes?
  - What practice structures are associated with the best outcomes of care management?

PDCM evaluation

- In the April meeting, we reviewed our data on the effectiveness of care management across the state

Time to Emergency Department (ED) Visit

At risk for 1st ED visit



Care management	Proportion with ED visit at 12 months (cumulative)	Ratio compared to the reference
Zero	16.5 %	Reference
One	8.8 %	.535
Two +	5.3 %	.320

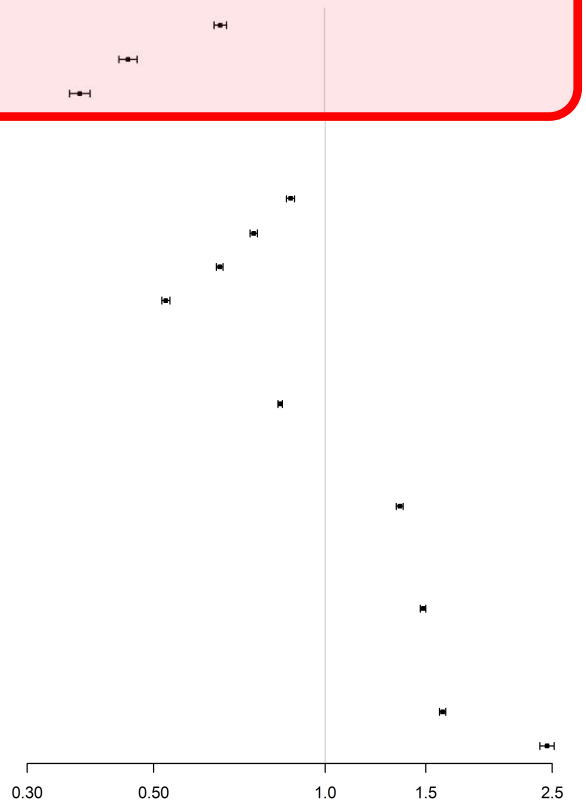
- Within the patients that had one care management encounter, the proportion with an ED visit within the first 12 months of entering the study is 8.8%.
  - This is 53.5% of the ED visit rate for patients with no care management.
- Within the patients that had two care management encounters, the proportion with an ED visit within the first 12 months of entering the study is 5.3%.
  - This is 32.0% of the ED visit rate for patients with no care management.

Multivariate analysis to model the time to event (ED visit)

- Care management (CM) reduces the risk of visiting the ED
  - The more care management encounters the patient has, the less likely that the patient will visit the ED

Figure 1. Characteristics associated with Emergency Department visits

Effect	Hazard Ratio
Care Management	
Zero	(ref)
One	0.656
Two	0.452
Three or more	0.372
Age	
18-29	(ref)
30-39	0.869
40-49	0.749
50-59	0.653
60-64	0.525
Sex	
Female	(ref)
Male	0.833
Diabetes	
No	(ref)
Yes	1.351
Hypertension	
No	(ref)
Yes	1.485
Other Comorbidities[a]	
Zero	(ref)
One	1.606
Two or more	2.449



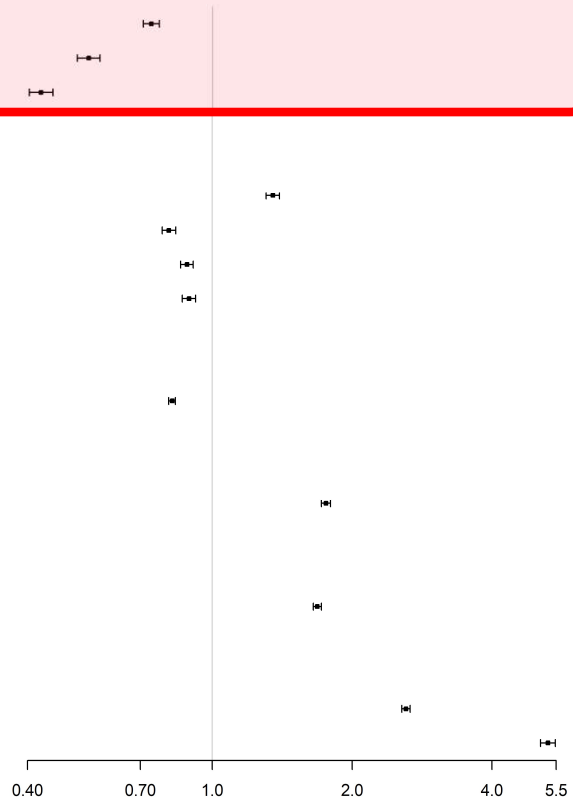
[a]Other comorbidities: CHF, COPD, CAD, asthma, depression, cancer treatment, dialysis

Multivariate analysis to model the time to event (IP admission)

- Care management (CM) reduces the risk of an IP admission
  - The more care management encounters the patient has, the less likely that the patient will have an inpatient admission

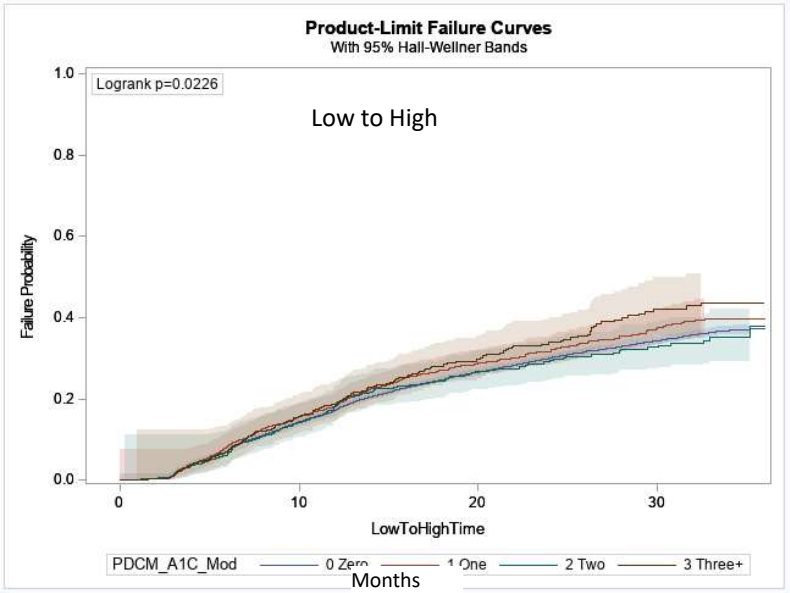
Figure 2. Characteristics associated with Inpatient admissions

Effect	Hazard Ratio
Care Management	
Zero	(ref)
One	0.738
Two	0.541
Three or more	0.427
Age	
18-29	(ref)
30-39	1.350
40-49	0.806
50-59	0.882
60-64	0.891
Sex	
Female	(ref)
Male	0.820
Diabetes	
No	(ref)
Yes	1.757
Hypertension	
No	(ref)
Yes	1.683
Other Comorbidities[a]	
Zero	(ref)
One	2.612
Two or more	5.280

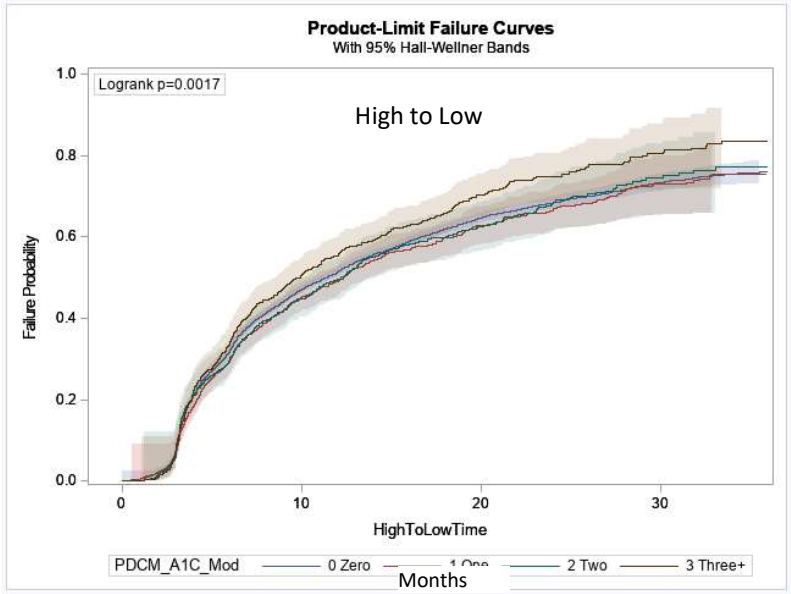


[a]Other comorbidities: CHF, COPD, CAD, asthma, depression, cancer treatment, dialysis

Diabetes (A1C): Time to Event Analysis



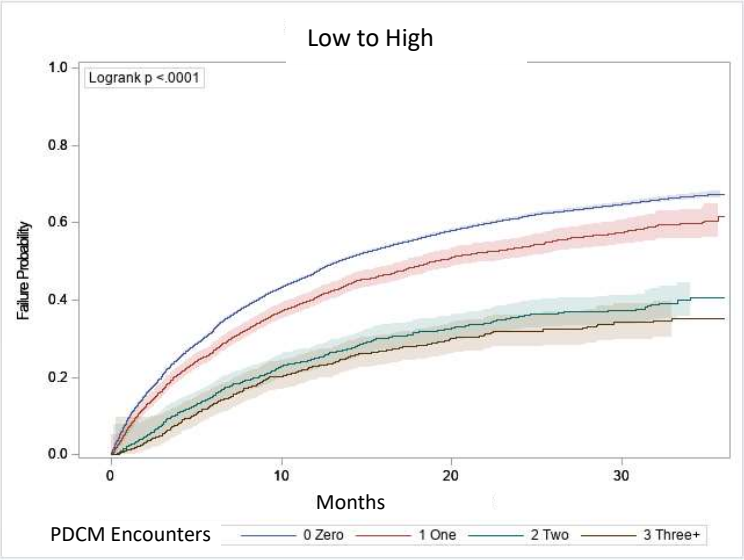
PDCM Encounters

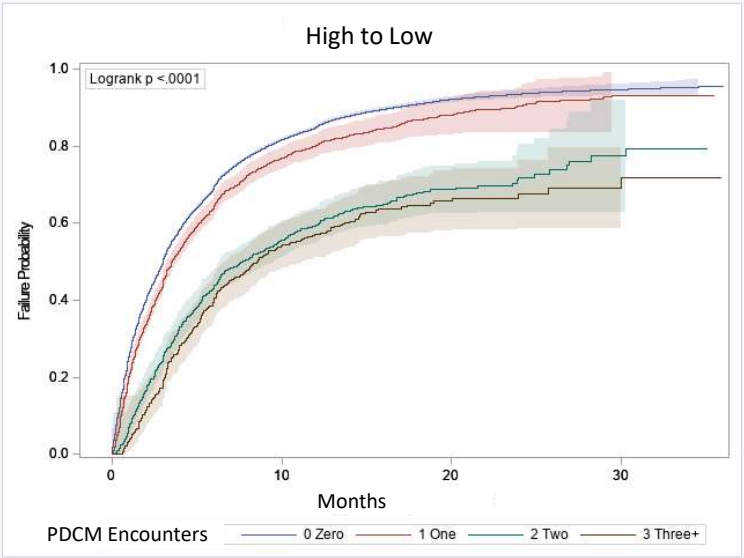


PDCM Encounters

- Patients with low baseline A1c (<8%): no effect from PDCM encounters
- Patients with high baseline A1c (>=8%): 3 or more PDCM encounters increases the likelihood by 12% that the patients A1C value changes to <8% (HR = 1.12, 95% CI: 1.04-1.20)

Hypertension (Systolic): Time to Event Analysis





- The higher the number of PDCM encounters, the less likely for a patient's systolic pressure to change
- Similar trends with diastolic blood pressure

PDCM Evaluation

- We found that care management encounters significantly reduce the likelihood of ED and inpatient utilization

- The relationship between care management and BP and A1c control was less consistent
  - BP control not improved across care management encounters
  - A1c control improved but only with 3 or more encounters
  - A major limitation is that we don't know the reason for the PDCM encounters

- BCBSM has also done a parallel but fully independent analysis showing that care management is associated with significantly lower total costs of care

PDCM Evaluation

- Our next goal was to try and understand how practice characteristics and care management structures may relate to care management outcomes

- This is critical given the variation in efficacy that we found
  - Significant reductions in utilization and costs
  - Significant improvement in A1c control with 3+ touches
  - No improvement in BP control

- This somewhat parallels the limited academic literature in this area
  - A systematic review found that for A1c control, care management was only effective when the care manager had prescribing capabilities (e.g., pharmacists, APPs) and the ability to make independent prescribing decisions

MICMT

PDCM Evaluation

- For several years, we have been conducting surveys of practices to better understand how care management is structured
  - Centralized (e.g., at the PO) vs. embedded
  - Care manager FTEs and hours
  - Care manager profession (e.g., nurses, pharmacists, social workers, dietitians, APPs, MAs)

- We also have data on practice size, and are working to gather data that would help to describe the population served

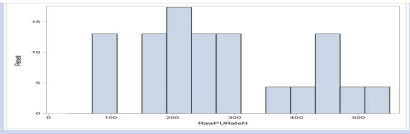
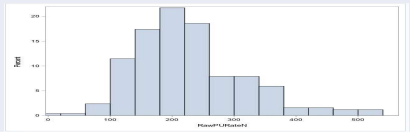
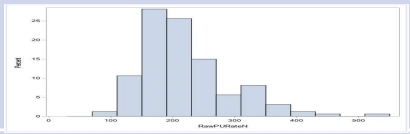
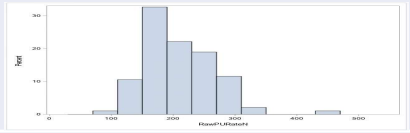
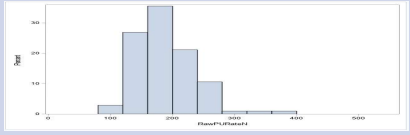
Care Management Teams: 2021

PDCM eligible patients at the practice	Number of practices	Total CM Mean (Median)	Total CM hours Mean (Median)	Average hours per CM Mean (Median)
50 – 99	20	1.4 (1)	15.1 (6.4)	11.2 (5.4)
100 – 499	216	1.5 (1)	21.5 (12.0)	13.8 (8.0)
500 – 999	146	1.8 (1)	38.7 (24.0)	20.1 (18.5)
1,000 – 1,499	92	2.6 (2)	59.9 (40.0)	24.0 (24.0)
1,500 – 6,000	99	3.2 (2)	82.6 (62.0)	27.4 (27.2)

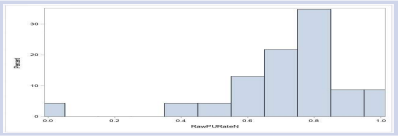
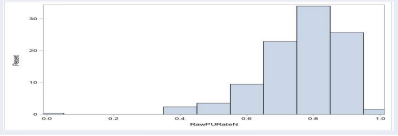
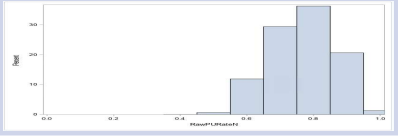
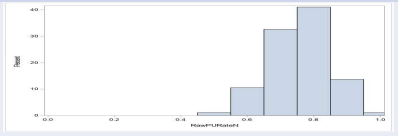
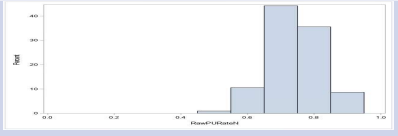
Care Management Teams:
% of practices with at least one CM by type & practice size 2021

	50 to 99	100 to 499	500 to 999	1000 to 1499	1500 to 6000
Nurse	85%	83.8%	82.9%	91.3%	89.9%
Social Worker (SW)	20%	9.3%	17.2%	30.4%	34.4%
Pharmacist	5%	8.3%	14.4%	25%	23.2%
Dietitian	0%	0.5%	4.8%	12%	13.1%
Medical Assistant (MA)	0%	9.7%	9.6%	12%	5%
Nurse Practitioner (NP)	0%	6%	5.5%	3.3%	3%
Other	5%	6.9%	8.9%	12%	19.2%

Emergency Department: Utilization at practice level by practice size

PDCM eligible patients at the practice	Mean	Median	Min	Max	Histogram
50 – 99	278.0	241.2	84.3	540.9	
100 – 499	228.2	211.9	17.9	663.0	
500 – 999	220.5	209.3	91.5	535.3	
1,000 – 1,499	207.7	202.8	98.8	447.6	
1,500 – 6,000	188.5	180.0	109.2	386.1	

Blood Pressure:
HEDIS measure at practice level by practice size

PDCM eligible patients at the practice	Mean %	Median %	Min	Max	Histogram
50 – 99	70.7	76.9 %	0	96.7	
100 – 499	76.2	79.1	0	98.4	
500 – 999	76.9	76.5	46.1	97.0	
1,000 – 1,499	75.1	75.3	52.9	96.4	
1,500 – 6,000	73.8	72.9	53.2	94.0	

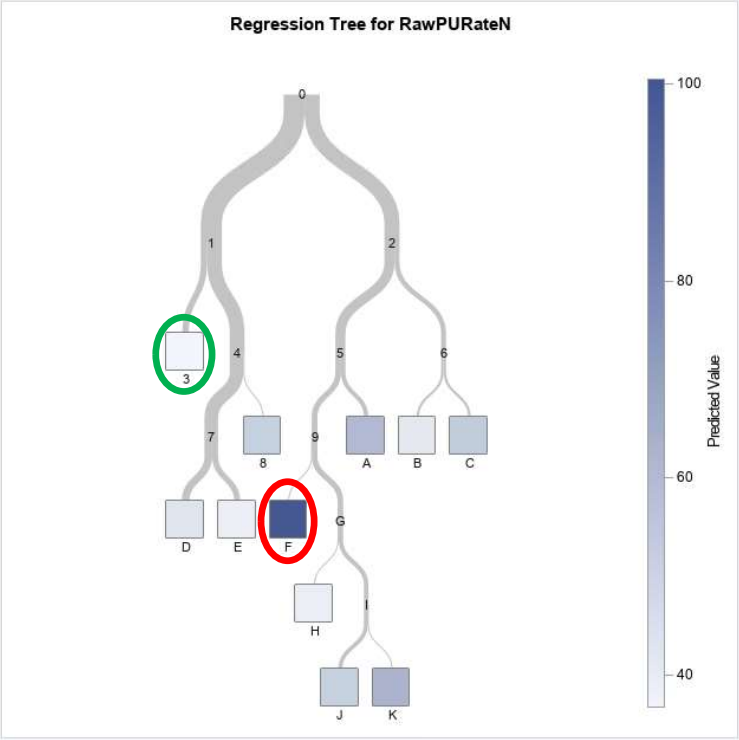
PDCM Evaluation

- We are also interested in identifying practices that have good and less good outcomes of care management to try and better understand the factors that lead to good care management

- We started by developing tree classifications that group practices into higher and lower performance tiers

- The goal is to learn what works and what doesn't so that we can consider how to better train and support practices' deployment of care management

Tree Classification: Inpatient Admission

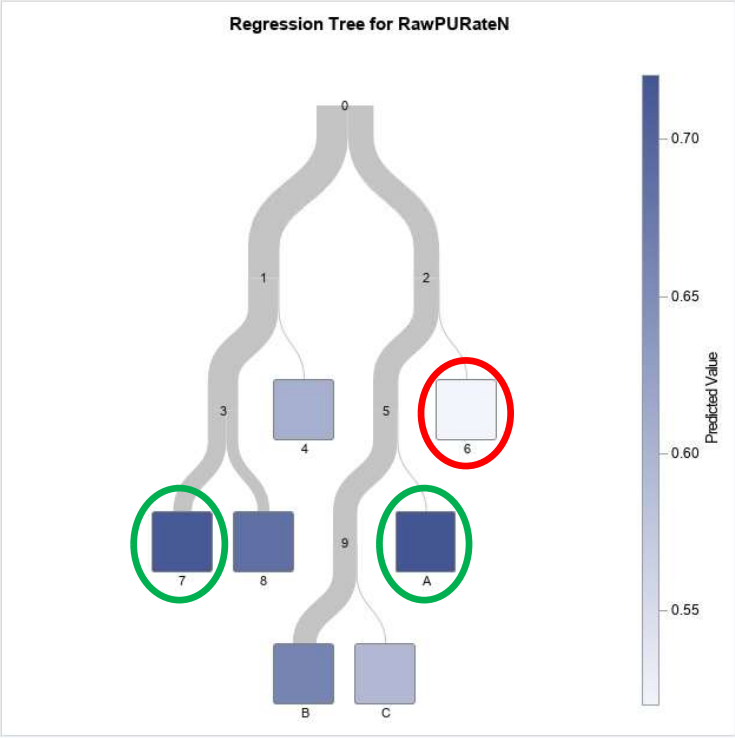


Information used in the classification:
Total CM, total CM hours, average hours per CM, practice size, and year (2020, 2021)

Care Management Team:

- Red – High volume of IP admissions
  - Practice size: 50 – 499
  - Average hours per CM < 1
  - Number of practices: 2
  - Predicted IP admissions per 1000 patients: 100
- Green – Low volume of IP admissions
  - Practice size: 1500 – 6000
  - Average hours per CM = 27.3
  - Number of practices: 181
  - Predicted IP admissions per 1000 patients: 37

Tree Classification: Diabetes



Information used in the classification:
Counts of individual CM types (dietitian, MA, nurse, NP, pharmacist, SW, other), practice size, and year (2020, 2021)

Group description:

- Red – Low percent of controlled diabetes
  - Year: 2020
  - Average hours per CM = 12.6
  - Number of practices: 5
  - Controlled diabetes, mean: 52%
- Green – High percent of controlled diabetes
  - Year: 2020
  - Average hours per CM = 23.3
  - Number of practices: 19
  - Controlled diabetes, mean: 72%

Conclusions / Summary

- Practice size is related to utilization and outcomes
- Larger practices have a more diverse care management team
  - This diversity is associated with better care management outcomes
  - There is also a relationship between time spent on care management tasks and better outcomes
- Care managers are most commonly nurses
  - It is difficult given the lack of variance to assess whether specific types of care managers have better outcomes

MICMT

Future Directions / Work

- We would like to get a more detailed understanding of how care management is implemented in practices that have good and less good outcomes of care management
  - Some of the effect may be population related
  - Some may be structural
- Ideally this would be done through a mixed methods approach
  - Qualitative data
  - Quantitative date (e.g., income/SDOH)
- The goal is not to profile practices, but rather gain understanding about how to best support the delivery of care management across Michigan and optimize the care of our patients

MICMT

Virtual Attendees - Thank You for Joining!
Please complete the evaluation
e-mailed to you after the meeting.

In-Person Attendees – Please Join us for Lunch!

Peer-to-Peer Learning Session

Split into 2 Groups

Share your thoughts and perspectives

Core Operations

- Billing
- Documentation
- Community Health Workers

Innovative Approaches

- Collaborative Care
- Team-Based Care in Specialty Practices
- Next Steps in Team-Based Care

What is working well for your PO & practices?
What are the biggest challenges?
What is your focus for the coming year?

MICMT

Thank You for Joining!

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