Agenda

- MiPCT March Launch meetings
- Care Management Update
- Performance Incentive Six Month Metrics
- MiPCT Quarterly Reporting
- Patient Experience Survey Opportunity
- Questions and Discussion
Launch Meetings

• Three Regional Sessions
  ▫ March 13 – Gaylord
  ▫ March 28 – Troy
  ▫ March 29 – Grand Rapids

• Who Should Attend?
  ▫ PO representatives
  ▫ Practice representative (e.g., a physician, care manager or practice manager)
  ▫ Participating payers
  ▫ MiPCT steering committee members
  ▫ Supporting purchasers

• Register at www.mipctdemo.org (link on home page)
Register Today at www.mipctdemo.org

MiPCT Demonstration Project
Improving care through patient centered medical homes

The Michigan Primary Care Transformation Project (MiPCT) is a three-year multi-payer project aimed at improving health in the state, making care more affordable, and strengthening the patient-care team relationship. The MiPCT is state-wide in scope and is the largest Patient-Centered Medical Home (PCMH) project in the nation. Five hundred primary care practices and 1800 primary care physicians that are affiliated with one of 41 physician/physician hospital organizations (POs/PHOs) are eligible to receive payments.

Assistance and support for practice transformation will take place through a collaborative network of POs/PHOs and shared learning opportunities facilitated by the MiPCT administrative staff. Focus areas for transformation under the demonstration include care management, self-management support, care coordination and linkages to community services.

Register Today to be Part of the All-Partner MiPCT Launch Meetings in March

WHO SHOULD ATTEND?: Practice Champions, PO and Practice representatives, participating payers, purchasers and other key stakeholders. Space is limited, but we will attempt to accommodate all registrants.

CLICK HERE TO REGISTER NOW!!

THE DETAILS: Continental breakfast and lunch will be provided. Check out our Launch Page, under the "PROJECT PARTNERS" above for more information, including the meeting agenda, distance charts to help you decide which launch to attend, hotel options, etc.). Given the state-wide reach of the project, we will hold regional meetings (you need only attend one) as follows:

• March 13 – Northern Region (Otsego Club & Resort, Gaylord)
• March 28 – Southeast Michigan Region (Petruzello's, Troy)
• March 29 – Western Region (Frederik Meijer Gardens, Grand Rapids)

We hope you will be able to join us, and are grateful for your partnership in this exciting project.
Michigan Primary Care Transformation Project

Care Management Update
# Review on Role Comparison: Moderate Risk Care Manager, Complex Care Manager

<table>
<thead>
<tr>
<th></th>
<th>Moderate Risk Care Manager (MCM)</th>
<th>Complex Care Manager (CCM)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patient Population</strong></td>
<td>Moderate risk patients identified by registry, PCP referral for proactive and population management.</td>
<td>High risk patients identified by PCP referral and input, risk stratification, patient MiPCT list.</td>
</tr>
<tr>
<td><strong>Patient Caseload</strong></td>
<td>Caseload 500 (approx. 90 - 100 active patients); one MCM per 5,000 patients.</td>
<td>Caseload 150 (approx. 30 - 50 active patients); one CCM per 5,000 patients.</td>
</tr>
<tr>
<td><strong>Focus of Care Management</strong></td>
<td>Proactive, population management. Work with patients to optimize control of chronic conditions and prevent/minimize long term complications.</td>
<td>Targeted interventions to avoid hospitalization, ER visits. Ensure standard of care, coordinate care across settings, help patients understand options.</td>
</tr>
<tr>
<td><strong>Duration of Care Management</strong></td>
<td>Typically a series of 1 to 6 visits</td>
<td>Frequency of visits high at times, duration of months</td>
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</table>
MiPCT Complex Care Manager
Train the Trainer Program

MiPCT Leadership Team

- CCM Master Trainer
  - 4 CCM Clinical Leads
- CCM Master Trainer
  - 4 CCM Clinical Leads
- CCM Master Trainer
  - 4 CCM Clinical Leads
- CCM Master Trainer
  - 4 CCM Clinical Leads
Master Trainer Complex Care Manager Role

- Oversight of 3-4 Complex Care Manager (CCM) Clinical Leads
- Does not have a patient caseload
- Leadership role in providing CCM professional development through mentoring, coaching and education
- Gathers data, populates and analyzes specified CCM activity reports for region
- Collaborates with MiPCT leadership and MiPCT clinical subcommittee to assess, study, and refine CCM training and interventions as needed
- Presents educational offerings for CCMs in small group setting as well as a statewide audience
Complex Care Manager (CCM) Clinical Lead Role

• Preceptor for CCMs in a defined region, has reduced patient caseload

• Leads small group discussions, facilitates networking, sharing best practices

• Contributes to ongoing CCM curriculum development by assisting Master Trainers with CCM education, workflow support, and resources

• Collaborates with CCM Master Trainer, MiPCT leadership, MiPCT clinical subcommittee to assess CCM interventions
Update on Complex Care Manager Train the Trainer Model

- 4 Master Trainers
- Adult CCM
  - 13 Clinical Leads
- Pediatric Care Managers
  - 3 Pediatric Clinical Leads
  - 2 open positions
  - In development – Curriculum, Pediatric Care Manager job description
  - Physician Lead: Dr. Jane Turner
Adult CCM Master Trainers, Clinical Leads Attend Geisinger Training

• First wave 2/6/12 – 2/24/12:
  ▫ 3 Master Trainers, 6 Clinical Leads

• Second wave 3/5 – 3/23:
  ▫ 1 Master Trainer, 5 Clinical Leads
## MiPCT Adult Clinical Leads and Master Trainers

<table>
<thead>
<tr>
<th>Adult CCM Geisinger Training for Master Trainer and Clinical Lead</th>
<th>location</th>
<th>time line</th>
</tr>
</thead>
</table>
| 1 week didactic, 2 weeks embedded with case Geisinger manager | PA       | MI trainees 9: 2/6/12 - 2/24/12  
MI trainees 6: 3/5/12 - 3/23/12 |
| Geisinger Preceptor & Practice Assessment                       | MI       | April – May 2012 (scheduling is in progress) |
Adult CCM MiPCT Training

Required training for Adult CCM:

- MiPCT provided Complex Care Management training program
- Completion of self management program
  - Must be from MiPCT-approved list
MiPCT Adult CCM Training - Michigan Roll out

*To Be Held Regionally:*

- April 23, 2012
- May 2012
- June 2012
- Thereafter monthly or as needed based on demand

Required training for Adult MiPCT Complex Care Managers (CCM) and Hybrid Care Managers (HCMs)
Moderate Risk Care Manager Training

• Background
  • Michigan-based MCM training programs – several existed prior to MiPCT
  • New MCM training programs have also been developed

• MCM Training
  • Required
    ▫ Self Management training – program MiPCT approved
      ▫ List of MiPCT approved self management training programs can be found at www.mipctdemo.org
      ▫ Several approved self management programs also offer broader care management topics
  • Recommended
    ▫ MCM training topics identified by MiPCT Clinical subcommittee
Getting Started- Orientation suggestions for Care Managers

- Complete a MiPCT approved self management training program
- Orientation is guided by PO or Practice Leadership
  - MiPCT Care Manager orientation outline
    - Content developed by MiPCT Clinical Leads
  - In progress - orientation checklist
    - Development by Master Trainers
    - Available in 2 weeks
Getting Started- Orientation suggestions for Care Managers

• Become familiar with role and responsibilities of health care team members
• Navigating the Medical neighborhood
  • Develop relationships: ex. Inpatient case managers, Home Health Agencies, Behavioral health resources, - Meet and establish relationship with team
• Identify and review the Clinical Guidelines used by PO/Practice
• Identify/learn HIT used by Practice
  ▫ EMR
  ▫ Registry
Michigan Primary Care Transformation Project

Performance Incentive Program

6 Month Metrics
Performance Incentive Process

- $3.00 PMPM paid into incentive pool*
- Performance incentive metrics are assessed and all funds paid out every 6 months
  - 1st period for April starters is 3 months
  - Payments will be made about 2 months after performance period ends
  - Payment range is 82% to 118% of mean ($18.00 per member) or $14.76 to $21.24

* All BCBSM and part of BCN performance incentive funds have been credited and will be paid through their respective incentive programs
Payment Distribution

- POs retain approved portion (not to exceed 20%)
- POs distribute remaining funds to participating practices. Can choose to distribute funds
  - Equally: a fixed dollar amount times the number of beneficiaries
  - Or
  - Variable amounts: dollar amount is based on additional performance criteria
    (method must be preapproved by MiPCT)
Program/Performance Metrics Focus

Year 1 (2012) - Develop primary care practice infrastructure

Year 2 (2013) - Optimize care management
    - Improve quality metrics
    - Avoid high cost care

Year 3 (2014) Achieve the “Triple Aim”
    - Improved quality of care
    - Improved patient and primary healthcare team experience of care
    - Reduced /stabilized costs of care
## 2012 Six Month Metrics

<table>
<thead>
<tr>
<th>Metric</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. 30% same day appointments</td>
<td>10</td>
</tr>
<tr>
<td>2. Appointments outside regular hours: 8 hrs/week</td>
<td>10</td>
</tr>
<tr>
<td>3. All patient electronic registry functionality</td>
<td>10</td>
</tr>
<tr>
<td>4. Moderate care managers (MCM) trained and working *</td>
<td>10</td>
</tr>
<tr>
<td>5. Complex care managers (CCM) trained and working*</td>
<td>10</td>
</tr>
</tbody>
</table>

50

*Attribute hybrid managers to MCM and CCM by % FTE
## Access Measures

<table>
<thead>
<tr>
<th>Metric</th>
<th>Data Source</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Maximum Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. 30% same day appointments</td>
<td>SRD report (5.7)</td>
<td>Number of practices in PO with capability</td>
<td>Number of practices in PO</td>
<td>10</td>
</tr>
<tr>
<td>2. Appointments outside regular hours: 8 hrs/week</td>
<td>SRD report (5.3)</td>
<td>Number of practices in PO with capability</td>
<td>Number of practices in PO</td>
<td>10</td>
</tr>
</tbody>
</table>
## Registry Functionality Measure

<table>
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<th>Denominator</th>
<th>Maximum Points</th>
</tr>
</thead>
</table>
| 1. Electronic patient registry functionality | MiPCT Quarterly Report for numbers 1 & 2 | Sum of the points each practice received for registry capability.  
1. Practice has electronic registry**  
2. Registry has interface capability  
3. Incorporates evidence-based care guidelines  
4. Identifies individual attributed practitioner  
5. Information available and used by the practice unit team at the point of care  
6. Used to generate communications to patients regarding gaps in care  
7. Used to flag gaps in care  
8. Patient demographics  
9. Registry identifies and tracks care for patients with at least 2 of the following:  
   - diabetes  
   - asthma  
   - cardiovascular disease  
   - pediatric obesity | Number of practices in PO | 10 |
| | SRD Reports for 3 = 2.3  
4 = 2.5  
5 = 2.4  
6 = 2.6  
7 = 2.7  
8 = 2.8  
9 = up to 2 points for  
a. Diabetes (SRD 2.1)  
b. Asthma (SRD 2.10)  
c. Cardio-vascular Disease (SRD 2.11)  
d. Pediatric Obesity (SRD 2.17) | \* | \* | N/D |

- 0 points for entire metric if registry is not electronic
- 1 point each for numbers 1-8
- Up to 2 points for number 9
# Care Management Metrics

<table>
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<tr>
<th>Metric</th>
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<th>Numerator</th>
<th>Denominator</th>
<th>Maximum Points</th>
</tr>
</thead>
</table>
| **1. Moderate care managers (MCM) trained and working*** | MiPCT Quarterly report | 1. Number of MCM hired/contracted by practices and/or PO  
2. Number of MCM within PO that have completed the required training | 1. Number of required MCM per PO**  
2. Number of MCM hired/contracted | 10  
1. N/D x 5 plus  
2. N/D x 5 |
| **2. Complex care managers (CCM) trained and working*** | MiPCT Quarterly report | 1. Number of CCM hired/contracted by practices and/or PO  
2. Number of CCM in PO that have completed the required training | 1. Number of required CCM per PO**  
2. Number of CCM hired/contracted | 10  
1. N/D x 5 plus  
2. N/D x 5 |

* Attribute “hybrid” care managers to Moderate and Complex categories according to their FTE assignment.

** Number specified and approved in the MiPCT Implementation Plan
Go to www.mipctdemo.com for

1. MiPCT Performance Incentive Program Description

2. Six Month Metrics

12 Month Metrics will be available soon
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Quarterly Reporting
Components

- **Financial Report**
  - Template on MiPCTdemo.org
  - Webinar archive #4 – available: MiPCTdemo.org

- **Narrative Status Update**
  - Detail will vary by quarter
    - 6 and 12 month report require practice level detail
    - 3 and 9 months, brief PO-level overview
  - Avoids duplication of SRD and Quarterly PGIP Progress reports

- **Care Management Activity Reporting**
Narrative Status Update

- Content: based on year 1 requirements and priorities
  - Care Manager hiring progress and barriers
  - Infrastructure implementation progress across practices
    - Electronic registry functionality
    - Care Management documentation
    - Transition notifications
  - Opportunity to communicate barriers and successes
Care Management Activity Reporting

• Minimum core data:
  ▫ Number of encounters per care manager, by payer

• Will be required beginning third quarter 2012

• Necessary for reporting to participating payers and MDCH

• Need to understand PO/practice reporting capacity to minimize burden
Submission

• Due dates for quarterly reporting
  ▫ May 1
  ▫ July 31, 2012
  ▫ October 31, 2012
  ▫ January 31, 2013

• Submission: email to mipctdemo@michigan.gov

More information: March 22 webinar
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Patient Experience Survey
PCMH CAHPS Survey

• To be collected on a representative sample of MiPCT and comparison beneficiaries
• Multi-modal (mail with phone follow-up)
• Content areas:
  ▫ Access
  ▫ Communication
  ▫ Coordination
  ▫ Comprehensiveness
  ▫ Shared decision making
  ▫ Self-management support
MiPCT Patient Experience Survey

Goals

• Statewide benchmarks, representative of patients by payer source and chronic disease status
• Enable statistical analysis of relationships:
  ▫ Practice transformation/PCMH domains → patient experience of similar concepts
  ▫ Change in patient experience from year 1 to year 3 by patients of MiPCT and non-MiPCT practices
• MiPCT patient survey will NOT necessarily get statistically reliable estimates at practice/PO level
Opportunity to Collaborate

• Consider provision of additional funding to enhance sample size at PO level
• Could collaborate to compare alternative administration mechanisms, or shortened questionnaires

• Contact information:
  Clare Tanner, PhD
  MPHI Program Director and MiPCT Evaluator
  ctanner@mphi.org or (517) 324-7381
Questions and Discussion