MiPCT – Moving Beyond the Demonstration

Mary Ellen Benzik,MD

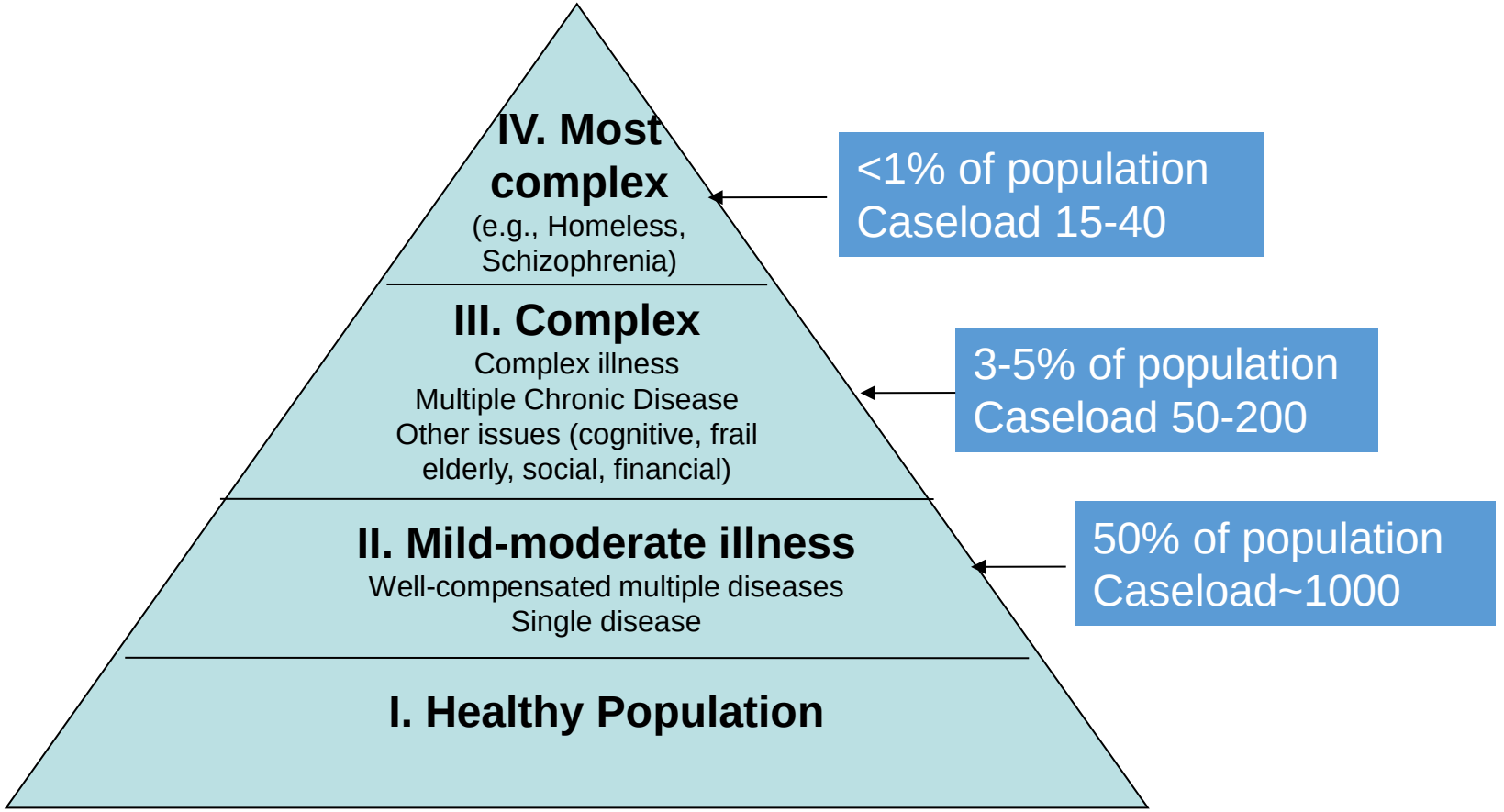
Co-Associate Medical Director

Michigan Primary Care Transformation Project (MiPCT)

CMS Multi-Payer Advanced Primary Care Practice (MAPCP) Demonstration 2012-2014

- *Centers for Medicare & Medicaid Services* is participating in state-based PCMH demonstrations
  - Assessing effect of different payment models
- CMS Demo Stipulations
  - Must include Commercial, Medicaid, Medicare patients
  - Must be budget neutral over 3 years of project
  - Must improve cost, quality, and patient experience
- 8 states selected for participation, Michigan is largest with approximately 50% of MAPCP practices
  - Michigan Primary Care Transformation (MiPCT)
  - Michigan start date: January 1, 2012

Managing Populations: Stratified approach to patient care and care management



Michigan Primary Care Transformation Project
Advancing Population Management

PCMH Services

Complex Care Management ***Functional Tier 4***	All Tier 1-2-3 services plus: ▪ Home care team ▪ Comprehensive care plan ▪ Palliative and end-of life care
Care Management ***Functional Tier 3***	All Tier 1-2 services plus: ▪ Planned visits to optimize chronic conditions ▪ Self-management support ▪ Patient education ▪ Advance directives
Transition Care ***Functional Tier 2***	All Tier 1 services plus: ▪ Notification of admit/discharge ▪ PCP and/or specialist follow-up ▪ Medication reconciliation
Navigating the Medical Neighborhood ***Functional Tier 1***	▪ Optimize relationships with specialists and hospitals ▪ Coordinate referrals and tests ▪ Link to community resources

Prepared Proactive Healthcare Team
Engaging, Informing and Activating Patients

PCMH Infrastructure

Health IT
- Registry / EHR registry functionality *
- Care management documentation *
- E-prescribing (optional)
- Patient portal (advanced/optional)
- Community portal/HIE (adv/optional)
- Home monitoring (advanced/optional)

Patient Access
- 24/7 access to decision-maker *
- 30% open access slots *
- Extended hours *
- Group visits (advanced/optional)
- Electronic visits (advanced/optional)

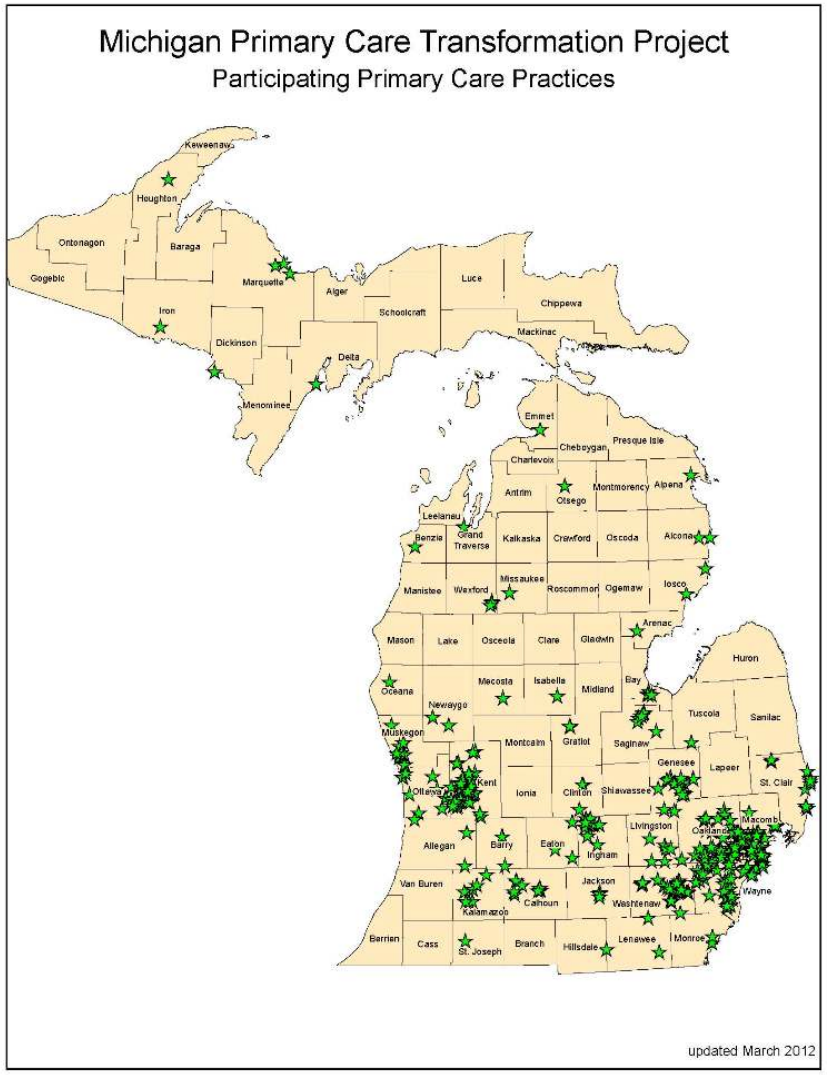
Infrastructure Support
- PO/PHO and practice determine optimal balance of shared support
- Patient risk assessment
- Population stratification
- Clinical metrics reporting

*denotes requirement by end of year 1

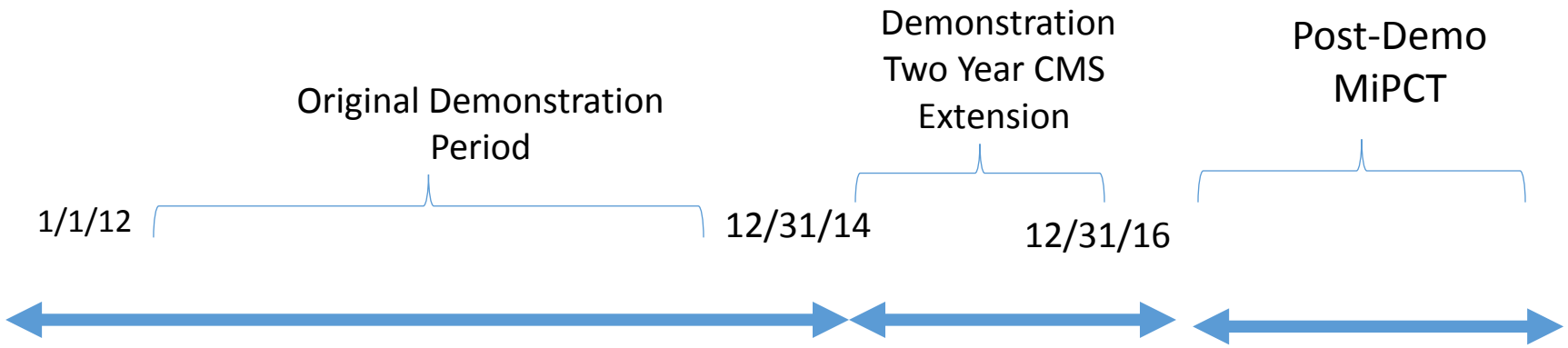
P O P U L A T I O N M A N A G E M E N T

Participants

- 377 practices
- 35 POs
- 1,700 physicians
- 5 Payers
  - Medicare
  - Medicaid managed care plans
  - BCBSM
  - BCN
  - Priority Health



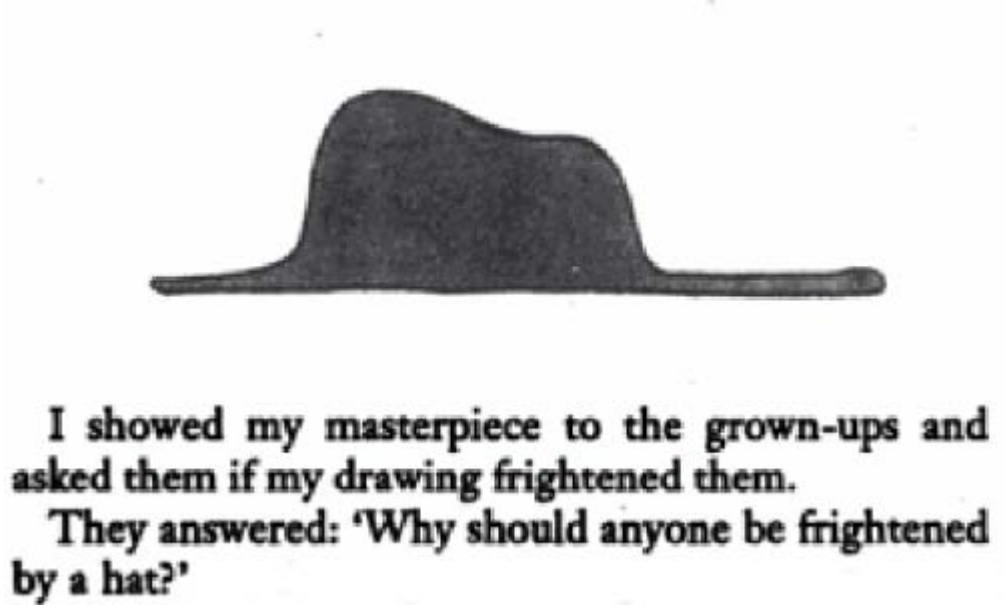
MiPCT Demonstration Timeline



GOAL: To sustain our gains (effective, efficient team-based care with embedded Care Managers) post-demonstration period

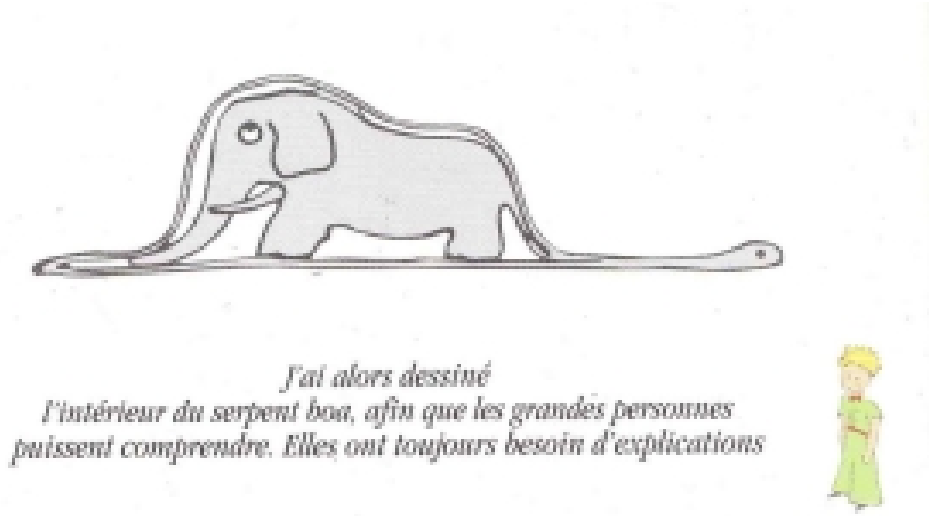
Where do we go from Demonstration?

- Key areas to be addressed
  - Social determinants of health
  - Integration of Behavioral health



I showed my masterpiece to the grown-ups and asked them if my drawing frightened them.

They answered: 'Why should anyone be frightened by a hat?'



J'ai alors dessiné
l'intérieur du serpent boa, afin que les grandes personnes
puissent comprendre. Elles ont toujours besoin d'explications

Creating the Model – Engaging with the POs

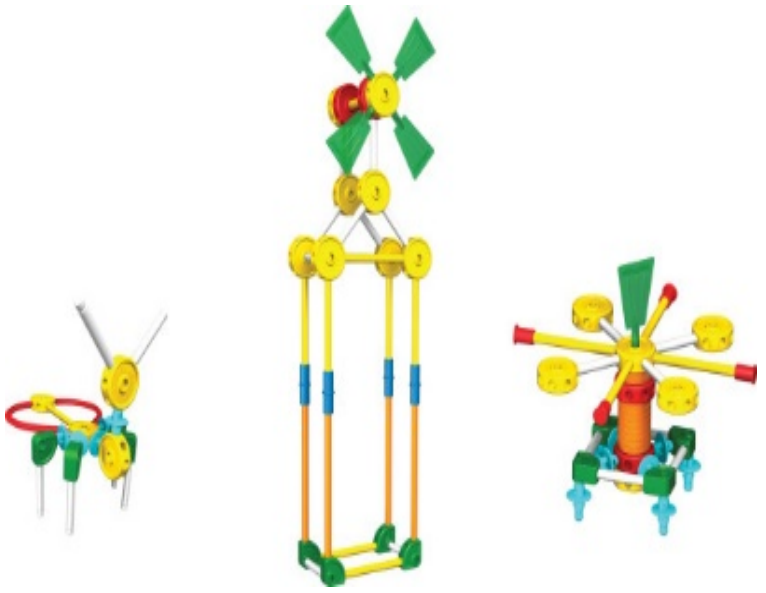
- Created Tiger Teams to address each area
- Representatives from PO, practices, payers , and state wide

Expertise on these topics

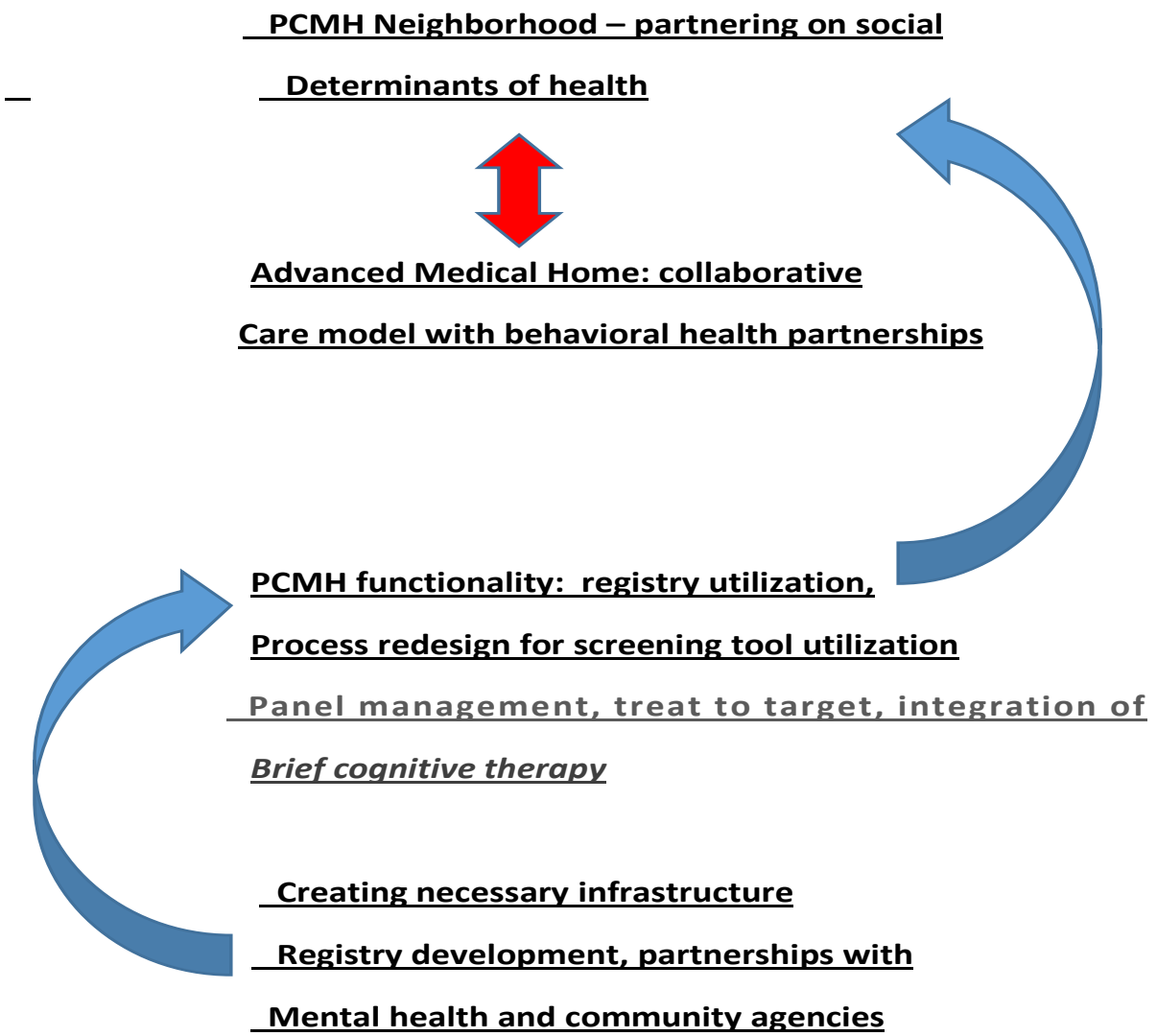
- Met monthly – every other in person
- Created model and tool kits for the addressing

social determinants and integrating

behavioral health



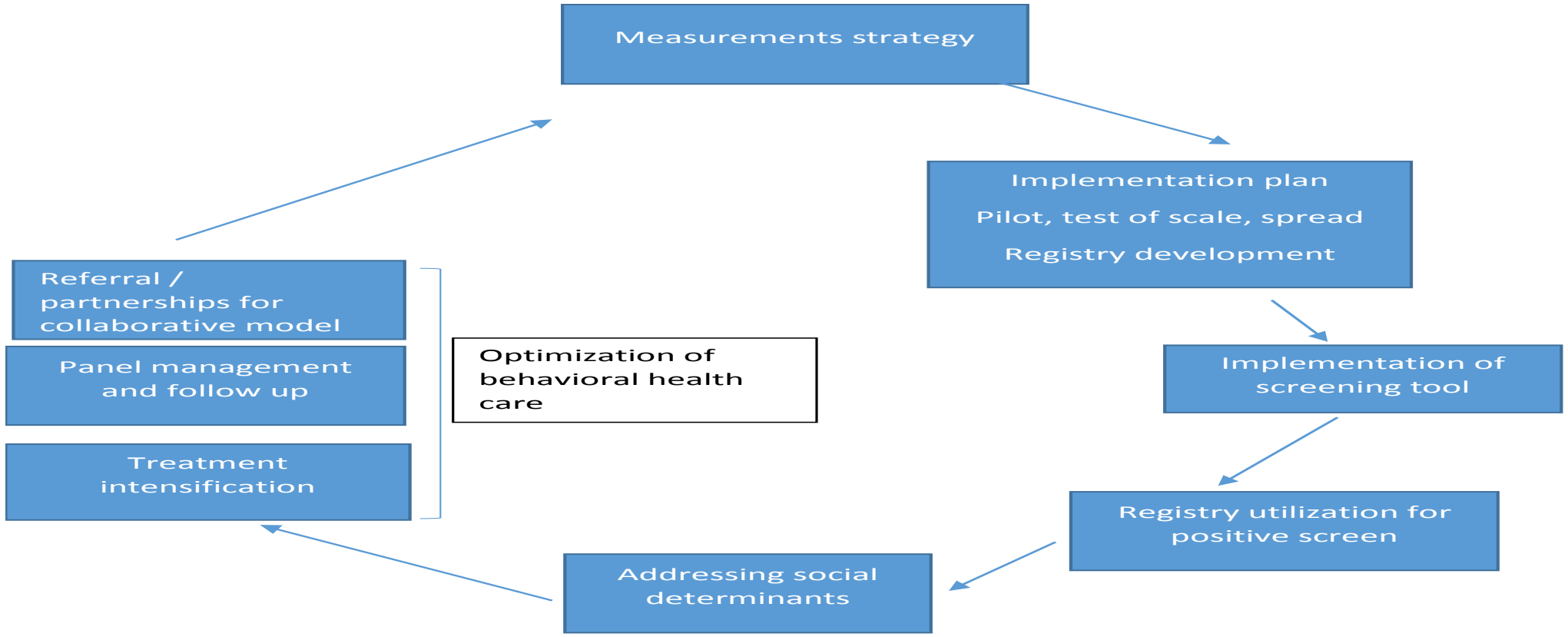
MiPCT INTEGRATION and INTER RELATEDNESS OF MENTAL HEALTH AND SOCIAL DETERMINANTS OF HEALTH



Planning steps for integration of at the PO level	Mental Health integration	Addressing Social Determinants
Financial analysis and business plan	1. Business case for behavioral integration monograph PDF 2. Business case proforma 3. AIMS Center U of W , implementation guide step 2 4. *http://www.integration.samhsa.gov/financing/Sustainability_Checklist_revised_2.pdf* 5. *http://www.integration.samhsa.gov/financing/billing-tools* 6. *http://www.integration.samhsa.gov/financing/Michigan.pdf*	Addressing Patient's Social Needs: Business Case **ADDRESSING PATIENTS' SOCIAL NEEDS: An Emerging Business Case for Provider Investment.** **Reasons to invest in social determinants, examples and strategies of various projects/programs payment models.** http://www.commonwealthfund.org/~/media/files/publications/fund-report/2014/may/1749_bachrach_addressing_patients_social_needs_v2.pdf
Assessment of current state of integration	Integrated tool #1 Compass self-assessment OATI #4 Collaborative care principles and components - AIMS center	
Assessment of resources at practice, PO and community	*CMS funding brief DBM reference* Identification of the relationships with psychiatric partners for developing care collaborative model	Practical Playbook; Primary Care and Public Health Together **Community Commons Interactive Maps:** Poverty levels, education and more by census tract.(Log in is required). See Maps and Data Tab http://assessment.communitycommons.org/Footprint/
Current state assessment of community partnerships and joint planning of intervention	Partnership checklist OATI tool 1	Frieden: Health Impact Pyramid Linking with your community health team works
Current state assessment for readiness for change	OATI tool 3 administrative readiness tool or AIMS Center Organizational readiness worksheet	GROW Pathway Planning Worksheet
BUILDING INTEGRATION ON A FRAMEWORK OF ADVANCED MEDICAL HOME CAPABILITY PRESENT IN MIPCT PHYSICIAN ORGANIZATIONS AND PRACTICES		

Planning steps for integration of at the practice level	Behavioral Health integration	Addressing Social Determinants
Financial analysis and business plan	SBIRT basics utilization and financial aspects	
Assessment of current state of integration	MeHAF Integrated practice assessment tool (IPAT) CHIS framework *American Academy of Pediatrics integration tool Bright Future*	Assessing Chronic Illness Care (ACIC) particularly sections 2, 7
Assessment of resources at practice, PO and community	CHIS quick start decision tree section workforce and clinical practice	
Current state assessment of community partnerships and joint planning of intervention	Same as PO **assessment of health literacy , cultural competency – see SD tool kit*	
Current state assessment for readiness for change	AIMS center organizational readiness	GROW Pathway Planning Worksheet **AAP MH Practice Readiness Inventory** http://pediatrics.aappublications.org/125/Supplement_3/S129.full.pdf
BUILDING INTEGRATION ON A FRAMEWORK OF ADVANCED MEDICAL HOME CAPABILITY PRESENT IN MIPCT PHYSICIAN ORGANIZATIONS AND PRACTICES		

Doing the work at the Practice Level – Defining new Workflow



Toolkit for the Practices to Change Workflow

		Social determinants of health			
Practice level steps – operationalizing the change	**Tools to support (*more in website – these starting documents)***	Poverty	Behavioral factors (smoking, at risk substance use)	Adverse childhood events	Integration of behavioral health
Overview document		Community Commons Interactive Maps		The Childhood Adversity Narratives CAN.	**http://www.improvingprimarycare.org/work/behavioral-health-integration**
Measurement strategy	GROW tool		Capturing Social and Behavioral Domains and Measures in EHRs: Phase 2. Measuring *Vital Signs*		**http://integrationacademy.ahrq.gov/atlas/overviewofmeasures#reviewmeasures**
Implementation plan				Strengthening Families- A Protective Factors Framework	https://aims.uw.edu/collaborative-care/implementation-guide Guidebook for professional practices for implementation Suicide prevention tool kit
Screening tools		HealthBegins Social screening tool V6		Resiliency and ACES Assessment Tool.(pdf)	Depression tool kit Community care North Carolina SAMSA screening tools

Toolkit for the Practices to Change Workflow

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Practice level steps – operationalizing the change	**Tools to support** (*more in website – these starting documents)*	Poverty	Behavioral factors (smoking, at risk substance use)	Adverse childhood events	Integration of behavioral health
Registry utilization					http://aims.uw.edu/sites/default/files/ClinicalWorkflowPlan.pdf http://aims.uw.edu/collaborative-care/implementation-guide/plan-clinical-practice-change/identify-population-based
Treatment intensification					AIMS Center – commonly prescribed psychotropic meds Primary Care Psychiatry –Pocket Guide V. 1.5 Feb 2014
Panel management and follow up					http://aims.uw.edu/collaborative-care/implementation-guide/plan-clinical-practice-change/create-clinical-workflow
Referral partnerships for advanced services	**MiICCSI Community Resources Directory** Click on Community Resources link at http://www.miccsi.org/CareManagement.html				

Addressing Team Factors: Health Literacy and Cultural Competency

Team based factors impacting integration	Framework / toolkits	Assessment of PO/ practice capabilities	PO/practice care team process/ tools and training	Patient Tools / educational materials
Health literacy	AHRQ Health Literacy Universal Precautions Toolkit The Health Literacy Environment of Hospitals & Health Centers: Making Your Healthcare Facility Literacy-Friendly	Ten Attributes of Health Literate Health Care Organizations The Health Literacy Environment Activity Packet: First Impressions and A Walking Interview Measures to Assess a Health-literate Organization	In Plain Words - Tr Effective Communication Tools for Healthcare Professionals (Tr video) National Network of Libraries of Medicine: Health literacy (Tr – info to include in training)	Ask Me 3- Partnership for Clear Health Communication—**Ask Me 3** - http://www.npsf.org/?page=askme3
Ethnicity/Cultural Competency			Effective Communication Tools for Healthcare Professionals (tr video) *Guide to Providing Effective Communication and Language Assistance Services?* National Standards for Culturally and Linguistically Appropriate Services http://minorityhealth.hhs.gov/omh/browse.aspx?lvl=2&lvlid=53 https://www.thinkculturalhealth.hhs.gov/Content/clas.asp	

Thank You

- Mary Ellen Benzik

mebenzik@gmail.com

Mipctdemo.org

Resources tab

Clinical areas

Social Determinants