Integrated Models for Better Primary Care:
A National Perspective and Current Michigan Initiatives

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National Perspective

The Institute of Medicine (IOM) convened a 17-member committee to explore the topic of integrating primary care and public health. The committee issued its report in 2012: *Primary Care and Public Health: Exploring Integration to Improve Population Health*.

The report established the following and, according to our own staff experts within MDCH, it is reflective of what is being discussed at the national level:

- **Definitions** of terms that are widely used in this conversation.
- Identification of **key principles** the IOM believes is necessary for the integration of primary care and public health.
- **Recommendations** that would assist the CDC, HRSA and HHS in supporting the broader application of the identified principles.
IOM Definitions

**Primary Care**
Adopted an earlier IOM definition as “the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community.” (IOM Report, 2012)

**Public Health**
Adopted an earlier IOM definition as “fulfilling society’s interest in assuring conditions in which people can be healthy.” (IOM Report, 2012)

**Integration**
“The linkage of programs and activities to promote overall efficiency and effectiveness and achieve gains in population health.” (IOM Report, 2012)
The rise in healthcare costs has led many to explore innovative ways to reduce costs and improve health.

It is possible to achieve sustainable improvements in population health.

Primary care and public health share a common goal of ensuring a healthier population.

The Affordable Care Act provides many opportunities to pursue integrated care.

IOM Principles for Integration

The IOM report states that the following principles are essential for successful integration of primary care and public health:

“Starting is more important than waiting until all are in place.” (IOM, 2012)

IOM Recommendations: Agency Level

- Link staff, funds and data at the regional, state and local levels
- Create common research and learning networks
- Develop the workforce needed to support integration

IOM Recommendations: Department Level

HHS should direct several of its own agencies to:

• Leverage their ability to support pilots that better integrate primary care and public health
• Provide incentives for research and capture of data
• Encourage the creation of linkages between primary care providers and local health departments.

HHS should work with all agencies in the department to develop a national strategy and investment plan.

Integration Opportunities Offered Through the ACA

- Community Transformation Grants
- Community Health Needs Assessments
- Medicaid Preventive Services
- Community Health Centers
- National Prevention, Health Promotion and Public Health
- Council and the National Prevention Strategy
- CMS Innovation Center
- Accountable Care Organizations
- Patient-Centered Medical Homes
- Primary Care Extension Program
- National Health Service Corps
- Teaching Health Centers

State of Michigan Initiatives Integrating Public Health and Primary Care

- Michigan Primary Care Transformation
- Michigan Pathways to Better Health
- State Innovation Model Design
- Integrated Care for Dual Eligibles
Michigan Primary Care Transformation

- MiPCT is the largest statewide multi-payer patient centered medical home demonstration (www.mipctdemo.org)

- It is built on a model in which primary care is seen as the building block for healthcare transformation, with Primary Care teams – including Care Managers – who coordinate care for complex and moderately complex patients within the Medical neighborhood and into the community.

- Over 375 practices are participating, covering over one million Michigan residents.
Michigan Pathways to Better Health

- A partnership between the Michigan Public Health Institute (MPHI), the Michigan Department of Community Health, and the Community Health Access Project of Ohio

- Addresses population health through ‘hot-spotting’ analysis to identify patients who are high utilizers of healthcare services, and target outreach that pairs individuals with community health workers (CHWs) who will link them to medical care as well as community services that address social determinants of health

- The model includes Community Hubs which monitor CHW outcomes and reduce service duplication. Additionally links are being created between the CHWs and primary care based clinical Care Managers
State Innovation Model Design

- Michigan is one of 19 states funded to produce a State Healthcare Innovation Plan to design a community integrated health system for Michigan.

- Michigan’s model recognizes that better health is only achievable when the health system, businesses and communities act together for collective impact.

- The model includes a plan for supporting Community Health Innovation Regions - leveraging requirements for non-profit hospitals and public health departments to conduct community health needs assessments.

- Collaboration for the needs assessment, with joint accountability to implement an action plan is a key requirement for participation.
Integrated Care for Dual Eligibles

• A CMS funded demonstration to strengthen services and supports for individuals who are dually eligible for Medicare and Medicaid

• In the demonstration, services and supports for persons who are dually eligible will be delivered by newly created Integrated Care Organizations (ICOs) and currently existing Prepaid Inpatient Health Plans (PIHPs)

• ICOs will be responsible for the provision of all physical health, long term care, and pharmacy services, while PIHPs will be expected to cover behavioral health and habilitative services for people with developmental disabilities, mental illness, or substance use issues

• The ICOs and PIHPs will be connected through the Care Bridge, a care model that requires the coordination of services and supports between the two entities and involved providers
Advancing Community-Clinical Linkages to Advance Payment and Delivery Reform in Maryland

Karen Matsuoka, PhD
Director, Health Systems and Infrastructure Administration
Maryland Department of Health and Mental Hygiene
Non-Medical Determinants of Health

Integration of public health and the medical delivery system is required if our goal is to improve health of the individual and population.

Source: Steven A. Schroeder, New England Journal of Medicine, Sept 20, 2007
Advantages of Community-Integrated Approaches

• Promotes Access to Cost-Effective Care
• Enables Underlying Social, Behavioral, and Environmental Determinants of Health to be Addressed
• Promotes Efficiency in Resource Use

The Cost Continuum

Inpatient/Acute Settings  ➔  Outpatient Settings  ➔  Community Settings

↑ savings potential  ↑ upstream care
### Strategic Approach

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<th>Three Key Components</th>
<th>Three Key Initiatives</th>
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<td>1. Promote wellness and community health</td>
<td>State Health Improvement Process</td>
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<td>2. Address pockets of intense health disparities</td>
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<td>3. Use mapping, hot-spotting, and data analysis to support robust primary care and community outreach</td>
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Strategic Approach

Three Key Components

1. Promote wellness and community health
2. Address pockets of intense health disparities
3. Use mapping, hot-spotting, and data analysis to support robust primary care and community outreach

Three Key Initiatives

1. State Health Improvement Process
2. Health Enterprise Zones
3. The State Innovation Model
State Health Improvement Process (SHIP)

- Framework and resources to align local action to continuously improve population health and health equity

- 18 Local Health Improvement Coalitions
  - Typically Co-Chaired by Hospital and Public Health leaders and include cross-section of health and human services

- State and Local Accountability
  - 39 measures: health outcomes and determinants
  - State and county baselines and 2014 targets
  - Racial/ethnic disparity information
18 Local Health Improvement Coalitions (LHICs) Across Maryland
Aligned Action in 6 Focus Areas to Increase Life Expectancy

- Healthy Babies
- Infectious Disease Reduction
- Healthy Social Environments
- Prevent and Control Chronic Disease
- Safe Physical Environments
- Improve Health Care Access
Emergency Department Visit Rate Due To Asthma

This indicator shows the rate of emergency department visits due to Asthma per 100,000 population. Asthma is a chronic health condition which causes very serious breathing problems. When properly controlled through close outpatient medical supervision, individuals and families can manage their asthma without costly emergency intervention. In Maryland, there are nearly 50,000 emergency department visit related to asthma each year.

Measurement Period: 2011
Value: 138.4
Strategic Approach

Three Key Components

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Three Key Initiatives

1. State Health Improvement Process
2. Health Enterprise Zones
3. The State Innovation Model
Maryland Average Life Expectancy
Health Enterprise Zones

- **Purpose:** to reduce health disparities, improve health outcomes, and reduce health costs and hospital admissions and readmissions
- **Eligibility:** community (or contiguous cluster of communities) with at least 5000 residents, with demonstrated economic disadvantage and poor health outcomes
- **Broad Range of Incentives and Benefits Available to Health Enterprise Zones including**
  - Loan repayment assistance
  - Tax credits
  - Priority to enter the Maryland Patient Centered Medical Home Program
  - Grant funding from Community Health Resources Commission
HEZ Selection Process

October 2012
Call for Submissions

November 2012
19 Applications Received

December 2012
10 Top Candidates Selected

January 2013
5 HEZs designated
HEZs as “Hot Spots”

* = First 5 designated HEZs
Strategic Approach

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Three Key Initiatives

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Community-Integrated Medical Home

Community Health
- Local health departments
- Community organizations
- Social services
- Hospitals
- Other providers

Primary Care
- Primary care physicians
- Nurse practitioners
- Allied health professionals
- Community pharmacists

Shared Data

Care Manager
Community Health Worker
Ex: Community-Integrated Asthma Intervention

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<tr>
<th>Community</th>
<th>Clinical</th>
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<tr>
<td>• Assessment &amp; maintenance of indoor air quality (in home/school)</td>
<td>• Medication provision &amp; reconciliation</td>
</tr>
<tr>
<td>• Patient/family education</td>
<td>• Develop asthma action plan</td>
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<tr>
<td>– inhaler technique</td>
<td>• Care coordination between primary care and secondary/tertiary care</td>
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<tr>
<td>– appropriate use of medication (long-term vs quick relief)</td>
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<td>– Use of peak-flow meter</td>
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<td>– When to go to ER vs PCP</td>
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Lessons Learned

• The Importance of Financial Alignment
• The Importance of Organizational/Structural Alignment

• The Importance of Data
  – For primary purposes of care coordination
  – For community and state-level planning
  – For performance monitoring
  – For continuous quality improvement
Modernizing the Waiver

• Goal: to align incentives for the hospital-sector with the three-part aim of improving outcomes, lowering costs, and improving patient experience

**Current Approach**
- **Focus**: keeping prices per admission low
- **Unintended consequence**: volume increased to compensate for lower prices, increasing overall hospital costs

**Modernized Approach**
- **Focus**: reducing overall hospital costs
- **Intended consequence**: by eliminating incentive to inflate volume, hospitals will have incentive to participate in community-based strategies to avoid preventable hospitalizations
Health Systems and Infrastructure Administration

• Resides within the Department of Public Health Services
• Created in July 2012 in anticipation of health reform implementation
• Three main areas of focus:
  – Access to care
  – Improving the value of the care Marylanders receive
  – Improving population health and lowering cost
    • closer integration between public health and medicine
    • continuous quality improvement through the effective use of data
Health Systems and Infrastructure Administration

DHMH Public Health

Health System and Infrastructures Administration

Primary Care Access and Workforce
Population Health and Quality
School Health
Local Health Department Core Funding
Data Infrastructure

Example: CRISP (Chesapeake Regional Information System for our Patients)

Data feeds from all hospitals in Maryland and growing numbers of labs and imaging centers

Primary Data Purposes

• Encounter Notification System: primary care providers are alerted in real-time whenever their patients are admitted, discharged, or transferred

Secondary Data Purposes

• Performance monitoring
• Mapping for health care planning and priority-setting
Inpatient Utilization by Census Tract

Chesapeake Regional Information System for Our Patients

Visits per 10k Residents
Nov. 2012 - Apr. 2013

- 0 - 148: Annapolis
- 149 - 245: Competent Care Connections
- 246 - 316: Greater Lexington Park
- 317 - 377: Prince George's
- 378 - 436: West Baltimore Primary Care Access Collaborative
- 437 - 495: West Baltimore Primary Care Access Collaborative
- 496 - 563: West Baltimore Primary Care Access Collaborative
- 564 - 644: West Baltimore Primary Care Access Collaborative
- 645 - 746: West Baltimore Primary Care Access Collaborative
- 747 - 970: West Baltimore Primary Care Access Collaborative
- 871 - 1035: West Baltimore Primary Care Access Collaborative
- 1036 - 1339: West Baltimore Primary Care Access Collaborative
- 1340 - 1743: West Baltimore Primary Care Access Collaborative
- 1744 - 2744: West Baltimore Primary Care Access Collaborative
- 2745 - 5357: West Baltimore Primary Care Access Collaborative
Inpatient Utilization, Prince George's
Inpatient Utilization
Capitol Heights Area (Obscured Data)
Challenges & Next Steps

- Attributing impact in comprehensive, multi-modal interventions
- The challenge of defining “populations” for “population health”
- Culture change is always difficult
- Challenge Grant proposal to help advance the science
- RWJF Grant to map and compare public health approaches with health care approaches
- Planning for Access
- Navigator Program
Thank you!

Connect with us on the Internet

http://hsia.dhmh.maryland.gov