Special Note: This guide is an iterative document which will be added to and amended at the PCMH Initiative continues implementation. The Department strongly encourages users to access this guide and associated materials through the MDHHS website rather than downloading and/or printing local copies to ensure that the most up-to-date information is always used.
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Introduction and Background

This guide was written to support Physician Organizations (POs) and Practices who are participating in the 2017 State Innovation Model (SIM) Patient Centered Medical Home (PCMH) Initiative. State Innovation Models are Centers for Medicare and Medicaid Services (CMS) initiatives awarded to states to provide financial and technical support to states for the development and testing of state-led, multi-payer health care payment and service delivery models that will improve health system performance, increase quality of care, and decrease costs for Medicare, Medicaid and Children’s Health Insurance Program (CHIP) beneficiaries—and for all residents of participating states.

Reinventing Michigan’s health care system is one of the State’s top priorities. The ambitious vision is shared by individuals and organizations across the State who desire to both improve the health of all Michiganders and have a health care system that provides better quality and experience at lower cost.

Within Michigan's Operational Plan approved by CMS in August 2016, the State lays out, in detail, the core innovative models for reinventing Michigan’s health care system. The Michigan SIM Operational Plan is organized into the following 3 core components:

- Population Health
- Care Delivery
- Alternative Payment Models

To enable implementation of the core components, a wide range of governance, stakeholder engagement, health information technology and other activities have also been defined. These supplemental supporting processes, infrastructure and oversight will ensure the components’ and overall goals are fully met. Health Information Technology (HIT) will play a particularly critical role in supporting patient and provider attribution, standard performance metrics, payment model reforms and other critical system interoperability.

The Patient Centered Medical Home (PCMH) Initiative is the core component of the SIM strategy for coordinated care delivery, focusing on the development and testing of multi-payer health care payment and service delivery models in order to achieve better care coordination, lower costs, and improved health outcomes for Michiganders.

The SIM PCMH Initiative both enables Medicaid funding for patient-centered transformation and is an opportunity to increase the number of practices involved in multi-payer primary care transformation.
Initiative Payment Models

Participating payers in the 2017 PCMH Initiative include 11 Michigan Medicaid Health Plans (managed care organizations). Additionally, the Initiative team is working with Blue Cross Blue Shield of Michigan and Priority Health to finalize participation which will be centered on multi-payer data sharing in addition to shared care delivery model and HIT/HIE priorities. Additional payers may be added over time as well. Payment for SIM PCMH Initiative beneficiaries attributed to practices will be provided to the participant (the entity that signed the Participation Agreement) (PO or practice).

Participants will receive payments for attributed Medicaid beneficiaries; these payments will be made directly by each applicable MHP no less often than quarterly. (At this time, the Initiative anticipates every Medicaid health plan will make payment on a quarterly basis.) PCMH Initiative participants will receive practice transformation payment to support needed investment in practice infrastructure and capabilities at a PMPM rate of $1.25 for all attributed Medicaid beneficiaries. Participants will receive care management and coordination payment to support embedded care coordination services as a PMPM rate of:

- $3.00 for General Low Income Beneficiaries (TANF)
- $5.00 for Healthy Michigan Plan Beneficiaries (HMP)
- $8.00 for Aged, Blind and Disabled Beneficiaries (ABD)

Even though Medicaid funding is structured as a PMPM, practices will be required to submit care management and coordination G and CPT tracking codes to provide insight into the type and intensity of Medicaid member services.

Some SIM PCMH Initiative practices will also be participants in the Comprehensive Primary Care Plus (CPC+) program, a CMS initiative that will began in 2017 and will be in place for five years in partnership with BCBSM and Priority in Michigan. SIM PCMH practices who are also in the CPC+ program will receive variable PMPM amounts from the Medicare program, based on patient characteristics. Practices had to apply for CPC+ and be selected to participate, similar to the PCMH Initiative.

CPC+ is one gateway to Medicare funding for care management. Because some CPC+ practices will also participate in the SIM PCMH Initiative, the following table was constructed as an aid to understand the payment streams for practices who are:

1) in the SIM PCMH Initiative only (column 2 below);
2) in the CPC+ Initiative only (column 3 below); or
3) in both the CPC+ and SIM PCMH Initiatives (Column 4 below).
<table>
<thead>
<tr>
<th>Payer Population Column (1)</th>
<th>SIM PCMH Initiative Only Column (2)</th>
<th>CMS CPC+ Only Column (3)</th>
<th>CMS CPC+ AND SIM PCMH Initiative Columns (4)</th>
</tr>
</thead>
</table>
| Medicaid (for benefit types not excluded) | • Practice transformation and care management and coordination payments on a PMPM basis  
• Practice transformation payment = $1.25 per attributed beneficiary  
• Care management and care coordination at a PMPM rate of:  
  o $3.00 for low income beneficiaries (TANF)  
  o $5.00 for Healthy MI Plan beneficiaries (HMP)  
  o $8.00 for Aged, Blind and Disabled beneficiaries (ABAD)  
• Paid to practice or PO depending on Participation Agreement signature | No | Column (2) Medicaid payment for SIM PCMH attributed patients |
| Medicare | • Practice/organization may bill Medicare Fee for Service for care management/coordination codes such as:  
  o Chronic care management (99490)  
  o Complex care management (99487/99489 proposed for 2017)  
  o Transitional care management (99495/99496)  
  o Non-face-to-face prolonged evaluation and management services (proposed for 2017)  
  o Behavioral health collaborative care codes (proposed for 2017) | Payment of Track 1 or 2 CMS rate arrangement | See Column (3) |
| Commercial payers (BCBSM and Priority Health) | • **BCBSM** supports multipayer care management and reimburses for care management services in PGIP PCMH practices for eligible commercial BCBSM patients with a PDCM benefit. Billing can be submitted for eligible commercial BCBSM patients with a PDCM benefit in PGIP PCMH practices. For further details, practices should contact their PO representative.  
• **Priority Health** supports multipayer care management and reimburses for care management services for Priority Health patients in PCMH-designated practices in Michigan. Billing can be submitted for eligible commercial Priority Health patients. You’ll find care management billing details in Priority Health’s [online provider manual](#). | Payment of Track 1 or 2 CMS rate arrangement | See Column (3) |
Technology

About the Relationship and Attribution Management Plan (RAMP)

The Relationship and Attribution Management Plan has been created to support the identification and capture of relationships between patients/consumers and their healthcare delivery team members, to facilitate the active exchange of necessary information between these identified individuals and organizations, and to provide an infrastructure that is necessary for the PCMH Initiative and the CPC+ program to be effective.

The Michigan Health Information Network Shared Services (MiHIN), the state-designated entity for health information exchange in Michigan, has been engaged in the RAMP project to leverage the widespread interoperability network MiHIN has established in the State of Michigan, along with multiple tools and services to support the goals of this large undertaking.

Summary of SIM Use Cases

This work described above includes a number of “use cases” created by MiHIN to facilitate statewide exchange of health information. These uses cases are described below.

Active Care Relationship Service

The Active Care Relationship Service tracks patient-provider attributions by identifying which healthcare providers have “active care relationships” with patients/consumers. This service acts as the basis of the RAMP process by allowing RAMP to match patients/consumers with their attributed care team members.

This mechanism supports exchange of information between members of the extended healthcare delivery team, including the patient. In addition to tracking patient/consumer relationships to providers, the Active Care Relationship Service also captures key physician organization, practice unit, and additional provider information to support the hierarchical relationships within the Health Provider Directory (discussed below).

Health Provider Directory Service

While multiple organizations track physicians and information on how to contact them (“20th century information” such as name, address, specialty, national provider identifier, or specific credentialing information), the MiHIN Health Provider Directory also includes the electronic service information required to know how and where health information is to be delivered electronically for each healthcare provider. This unique feature of the Health Provider Directory is refreshed every thirty days with continuous data from ACRS submissions.
Quality Measure Information
The Quality Measure Information use case enables providers and payers to consolidate and standardize the electronic exchange of quality-related data and performance results. With this use case, providers gain the ability to send one supplemental clinical quality data file in one format and have it distributed to multiple locations, if and as needed.

Admission-Discharge-Transfer Notifications
Admission-Discharge-Transfer (ADT) notifications are widely regarded as a keystone to improve patient care coordination through exchange of health information. ADT messages are sent when a patient is admitted to a hospital, transferred to another facility, or discharged from the hospital. These alerts are sent to update physicians, care management teams, and payers on a patient’s status; to improve post-discharge transitions; to prompt follow-up; to improve communication among providers; and to support patients with multiple or chronic conditions.

Active Participation in RAMP
PCMH Initiative Participants are required to actively participate in RAMP. To be considered actively participating in the RAMP use case the following must occur:

- All legal on boarding must be complete,
- Kick off calls with MiHIN must be conducted
- A connection to MiHIN must be established.

The ACRS use case is the foundation for several other use cases, including HPD, ADT and QMI. Therefore participation is crucial, active participation in the ACRS Use Case requires the submission of a valid ACRS 2.0 file to MiHIN. The following process indicates the flow of information to ensure the RAMP is progressing:

- Successful submission of a valid ACRS 2.0 file
- The valid ACRS file will populate the HPD on the senders' behalf.
- The ACRS file is then used for routing information for ADT messages and QMI messages.

Active participation in the Statewide ADT Use Case a receiver of the ADT messages must be received by the receiver and used for care coordination.

Active participation in the QMI Use Case requires the submission of a valid Quality data to MiHIN.

ACRS Legal Onboarding Action Plan
NOTE: Participating organizations may begin legal and technical onboarding tracks simultaneously.
Physician organizations and practice units selected to participate in the PCMH Initiative must complete the following legal agreements to participate in SIM Use Cases:

1. Simple Data Sharing Organization Agreement (SDSOA)
2. Master Use Case Agreement (MUCA)
3. Use Case Exhibits
   a. Active Care Relationship Service
   b. Admission, Discharge, Transfer Notifications
   c. Health Provider Directory
   d. Quality Measure Information
4. Common Key Service Pilot Activity Exhibit

These legal agreements collectively form the SIM legal packet. This packet is distributed to physician organizations and practice units via email by the MiHIN legal team.

Upon receipt of the packet, all interested participants should review and sign all legal agreements and return the executed copies to the MiHIN legal team at legal@mihin.org. The MiHIN legal team will, in turn, review the documents, countersign all documents (if deemed acceptable), and then consider the SIM legal agreement to be “Fully Executed.”

**ACRS Technical Onboarding Action Plan**

**NOTE:** legal and technical onboarding tracks may be completed simultaneously.

Steps required to complete technical onboarding for each of the MiHIN use cases are outlined below.

Note: MiHIN considers itself “transport agnostic”, meaning we offer multiple options for organizations to establish technical connectivity to transport data to MiHIN. Organizations should select one or more connectivity methods for message transport based on their technical capabilities, and put in a service request at https://mihin.org/requesthelp.

Currently MiHIN accepts the following transport methods:

- LLP over IPsec VPN – Lower-Layer Protocol over Internet Protocol Security Virtual Private Network
- DSM – Direct Secure Messaging
- sFTP - Secure File Transfer Protocol

For VPN connectivity, two VPNs are required. A primary VPN will facilitate regular traffic, and a secondary VPN will be established for fail-over purposes.
Additional transport methods may be added in the future. These may include NwHIN, XCA, REST/RESTFUL APIs, and others. For information on these additional methods, please contact MiHIN at https://mihin.org/requesthelp.

ACRS Technical Onboarding
The following steps are necessary to complete the technical onboarding for the Active Care Relationship Service (ACRS) use case. Legal documents should be reviewed and executed with MiHIN simultaneous to the technical onboarding process.

- MiHIN will conduct an “onboarding kickoff” meeting with new participating organizations to go through each of these steps in detail and answer any questions
  - Exchange contact information
  - Distribute MiHIN care package (implementation guides, ACRS template, and other reference material as requested)
  - MiHIN and the participating organization will determine method for ACRS file upload (DSM or sFTP)
  - MiHIN will provide the participating organization with a destination address for DSM, or MiHIN will configure an sFTP account if needed
  - The participating organization will securely send an ACRS file(s)
  - MiHIN will validate the ACRS file(s) and supply feedback
  - Once ACRS file is deemed valid, the organization is considered in production

Health Provider Directory Service Technical Onboarding
The following steps are necessary to complete onboarding for the Health Provider Directory (HPD) use case. Legal documents should be reviewed and executed with MiHIN simultaneous to the technical onboarding process.

- MiHIN will conduct an “onboarding kickoff” meeting with new participating organizations to go through each of these steps in detail and answer any questions
  - MiHIN will conduct a live demo and overview of the HPD
  - MiHIN will collect a list of participating organization users of the HPD
  - MiHIN will set up and provide HPD user profiles
  - MiHIN will provide appropriate access rights to identified users of the HPD; providing ability to view appropriate provider populations and data

---

1 Please note, if an organization agrees to onboard these use cases at the same time, there would only be a need for one “onboarding kickoff” meeting. However, if they agree to the use cases at different times, there will be a need for multiple meetings.
MiHIN will provide training on HPD functionality and usability per the SIM requirements.

**Quality Measure Information Technical Onboarding**

The following steps are necessary to complete onboarding for the Quality Measure Information use case. Legal documents should be reviewed and executed with MiHIN simultaneous to the technical onboarding process.

- MiHIN will conduct an “onboarding kickoff” meeting with new participating organizations to go through each of these steps in detail and answer any questions.
  - Exchange contact information
  - Distribute implementation guides and other reference material as requested
  - The participating organization selects one or more supported message transport methods and establishes connectivity with MiHIN
  - Test messages are sent by the participating organization to MiHIN
  - MiHIN will perform a message schema validation
  - If valid, MiHIN will pass messages on to the state

**Admission-Discharge-Transfer Notifications Technical Onboarding**

The following steps are necessary to complete technical onboarding for Admission, Discharge, Transfer (ADT) Notifications. Legal documents should be reviewed and executed with MiHIN simultaneous to the technical onboarding process.

- MiHIN will conduct an “onboarding kickoff” meeting with new participating organizations to go through each of these steps in detail and answer any questions.
  - Exchange contact information
  - Distribute the ADT Notifications care package
  - Distribute message transport forms and subscription checklist
- MiHIN and the participating organization will exchange required documents, including:
  - Transport document
  - Subscription checklist
- MiHIN and participating organizations will exchange information for mapping tables
- The participating organization will securely send an ACRS file(s)
- MiHIN will validate the ACRS file(s).
- MiHIN and the participating organization will establish transport method/connectivity (e.g. via HIE, VPN, or Direct).
  - Go live!
  - MiHIN will confirm message traffic.
MiHIN Additional Resources

- For all support issues: via https://mihin.org/requesthelp/
- Legal onboarding: legal@mihin.org
- For more information: www.mihin.org
- Technical onboarding contact information:

<table>
<thead>
<tr>
<th>Lindsey Weeks</th>
<th>Megan Herbst</th>
<th>Maureen John</th>
</tr>
</thead>
<tbody>
<tr>
<td>Production Manager</td>
<td>Onboarding Coordinator</td>
<td>Onboarding Coordinator</td>
</tr>
<tr>
<td>517-588-8373</td>
<td>586-549-1674</td>
<td>517-944-1786</td>
</tr>
<tr>
<td><a href="mailto:lindsey.weeks@mihin.org">lindsey.weeks@mihin.org</a></td>
<td><a href="mailto:megan.herbst@mihin.org">megan.herbst@mihin.org</a></td>
<td><a href="mailto:maureen.john@mihin.org">maureen.john@mihin.org</a></td>
</tr>
</tbody>
</table>

MiHIN Use Case Implementation Guides

The published MiHIN use case implementation guides for the identified SIM use cases may be accessed via following web pages on MiHIN.org:

- Active Care Relationships: https://mihin.org/active-care-relationship-service/
- Health Provider Directory: https://mihin.org/health-provider-directory/
- ADT Notifications: https://mihin.org/ADT-Notifications/
- Common Key Service: https://mihin.org/common-key-service/
- Quality Measures Information: https://mihin.org/quality-measure-information/ (under development)
PCMH Initiative Performance Monitoring and Compliance

The PCMH Initiative has partnered with Michigan Data Collaborative (MDC) a non-profit data collection, enrichment, and provisioning organization, established at the University of Michigan to facilitate Participant Performance Monitoring. MDC will support care delivery transformation initiatives across the state. For the purposes of the PCMH Initiative, MDC will:

- Collect the following types of data:
  - Claims, eligibility, immunization and lead screening data
  - Clinical/EHR
  - Patient population
- Build a claims and clinical database (initially including Medicaid data, and including commercial payer data in the future)
- Calculate Quality, Cost, and Utilization measures
- Calculate Initiative-defined Care Management and Coordination Measures
- Provide participants with monthly Patient Lists through a secure portal
- Generate a measures dashboard and downloadable reports

The PCMH Initiative will utilize aggregated data from the participating payers across medical claims, pharmacy claims and eligibility files to monitor participant performance and compliance. The PCMH Initiative has made every effort to mirror the measures determined by the Physician Payer Quality Collaborative. The PPQC “Core Set” of 27 measures has significant overlap between all or most national and local quality reporting programs. These aligned measures have been broken into two focus areas:

- **Performance Monitoring**: Monitor PCMH Initiative participant quality of care, health outcome, utilization and cost performance using a defined set of metrics to report Initiative progress/successes and enable quality and process improvement.
- **Compliance**: Ensure PCMH Initiative participants operate in accordance with the requirements of the Initiative upon selection and on a continuous basis while participating.

The release of the metrics will follow a progressive continuum from metrics that are claims based to those that are reliant on clinical data, such as quality measures that will support the QMI use case and goal to report once. Therefore:

- Measures dashboard releases will begin with Medicaid claims data
- Commercial payer claims data will be added as soon as it is available
- Clinical data (through the QMI Use Case) will be added in the final release
Performance Monitoring

Performance Monitoring Metrics will be focused on Quality of Care and Health Outcome Measures (including condition prevalence measures), Utilization and Cost Measures, and Initiative-defined Care Management and Coordination Measures. Table 1: Quality of Care and Health Outcome Measures indicates the measures that the PCMH Initiative will focus on to monitor participant quality of care performance in 2017. Table 2: Utilization, Cost, and Care Management Metrics illustrates the measures that will be applied to assess utilization efficiency. These measures have been grouped by their anticipated release date.

Table 1: Quality of Care and Health Outcome Measures

<table>
<thead>
<tr>
<th>First Release</th>
<th>Second Release</th>
<th>Third Release</th>
<th>Fourth Release</th>
</tr>
</thead>
<tbody>
<tr>
<td>CDC: A1c Testing</td>
<td>Adolescent Well-Care Visits</td>
<td>Anti-Depressant Medication Management</td>
<td>CDC: A1c Poor Control</td>
</tr>
<tr>
<td>CDC: Eye Exam</td>
<td>Chlamydia Screening</td>
<td>Follow-Up Care for Children Prescribed ADHD Medication</td>
<td>CDC: Blood Pressure Control</td>
</tr>
<tr>
<td>CDC: Attention for Nephropathy</td>
<td>Childhood Immunization</td>
<td>Diabetes Prevalence</td>
<td>Controlling High Blood Pressure</td>
</tr>
<tr>
<td>Cervical Cancer Screening</td>
<td>Adolescent Immunization</td>
<td></td>
<td>Weight Assessment and Counseling for Nutrition and Physical Activity</td>
</tr>
<tr>
<td>Breast Cancer Screening</td>
<td>Well Child Visits (15 Months)</td>
<td></td>
<td>Adult BMI Assessment</td>
</tr>
<tr>
<td>Use of Imaging Studies for Low Back Pain</td>
<td>Well Child Visits (3-6 Years)</td>
<td></td>
<td>Tobacco Use Screening and Cessation</td>
</tr>
<tr>
<td>Hypertension Prevalence</td>
<td>Well Child Visits (Adolescent)</td>
<td></td>
<td>Screening for Depression and Follow-Up</td>
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<tr>
<td>Asthma Prevalence</td>
<td>Lead Screening</td>
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<tr>
<td>Obesity Prevalence</td>
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### Table 2: Utilization, Cost, and Care Management Metrics

<table>
<thead>
<tr>
<th></th>
<th>First Release</th>
<th>Second Release</th>
<th>Third Release</th>
<th>Fourth Release</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Cause Acute Inpatient Hospitalization Rate</td>
<td>Percent of Attributed Patients Receiving Care Management</td>
<td>Total PMPM Cost</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency Room Visit Rate</td>
<td>Timely Follow-Up with a PCP After Inpatient Discharge</td>
<td>Preventable Emergency Room Visits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>30 Day Re-Admission Rate</td>
<td></td>
<td>Ambulatory Care Sensitive Hospitalizations</td>
<td></td>
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### Care Management and Coordination Metric Benchmarks

As outlined in the 2017 PCMH Initiative Participation Agreement, all Participants are required to maintain care management and coordination performance above benchmarks established by the Initiative, on the following two metrics:

- The percentage of a Practice’s attributed patients receiving care management and coordination services; and
- The percentage of a Practice’s attributed patients receiving a timely (within 14 days) follow-up visit with a Primary Care Provider following a hospital inpatient discharge.

### 2017 Benchmark

- **Any patient who has had a claim with one of the applicable codes during the reporting period**
  - Eligible Population
  - 2.0%

- **Any patient who sees a PCP within 14 days of the last discharge date on a room and board claim in the measurement period.**
  - Eligible Population with an inpatient claim*
  - XX%

*Exclude any member who had an inpatient stay in a psychiatric facility.

### Calendar for Deliverables

MDC will maintain the target dates for upcoming deliverables (i.e. Patient Lists, Aggregate Deports, Dashboard releases, etc.) on the [SIM PCMH page](#) of our website.
Interface and Participant Use

The PCMH Initiative will build upon and continue work with the Michigan Data Collaborative (MDC) to support the participants by providing reports and a dashboard for the measures described above. Dashboard releases will include interactive functionality that is enhanced over time. The Dashboard will include both visualizations and charts.

To further support participants, MDC will also distribute a PCMH Patient List and aggregate patient count reports, which will be accessed via the secure portal. MDC will maintain access control for participants wishing to view reports and dashboard displays of the PCMH measures, or to download appropriate lists for their Physician Organization (PO) or Practice. The MDC Portal User Acknowledger (responsible contact for a participating organization) will affirm who should have access to the MDC portal from their participating PO or Practice. Those affirmed will be provided access as an MDC Portal User to download patient lists and other reports and view the measures Dashboard (when available).

Some of the resources that will be available through the MDC secure portal include:

**PCMH Patient List:**
Each month, participants will be provided with a list of patients that have been assigned or attributed to their practice (similar to the All Payer Patient List previously available for MiPCT practices, but with fewer data elements). This list will reflect the patients who are attributed for both payment and care management and coordination services delivery purposes. The patient list will also include additional helpful information (once it is available) such as the number of hospitalizations and emergency department visits a patient has had over a given period.

**Care Management Reports:**
Practices will have access to monthly reports showing both overall Care Coordination and Care Management metrics, as well as claim-level detail for patients receiving Care Coordination and Care Management. Measures will include the percentage of patients receiving Care Management (based on incurred Care Management claims incurred in the reporting month) as well as the percentage of patients who received follow-up care with a Primary Care Physician after an inpatient discharge. Measures will be supplied at the Practice level and will be broken out by payer where available. Detail reports will give information on all Care Management claims incurred for their attributed population in the reporting month. These Care Management reports will be available as downloadable reports like the Patient Lists, as opposed to being displayed in Dashboard reports like the other quality, utilization and prevalence metrics.
Quarterly Aggregate Patient Reports:
MDC generates quarterly aggregate patient reports to assist organizations in reconciling their Medicaid Health Plan payments. The reports contain counts of patients attributed to a provider for each practice by each month of the quarter.

MDC Deliverable Notification:
As the various deliverables are posted, including the PCMH Patient Lists and the measures dashboard, MDC will send email notifications directly to participants who have an active MDC account. Additionally, articles will be posted on the SIM PCMH News page of the MDC website.

Support Documentation:
As MDC produces deliverables for the SIM PCMH project, you can find helpful support documentation on the SIM PCMH Support page of the MDC Website. The documentation includes:

- Dashboard documentation
  - User Guide
  - Timeline: Visual graphic showing the historical data included for each measure and chronic condition.
  - Release Notes: Provides details about each dashboard release.

- MDC Portal Connection documentation
  - Accessing the SIM PCMH Dashboard Using Virtual Places (Updated connection method)
  - Accessing SIM PCMH Dashboard (Using the original connection method)
  - Installing Duo to Use Two Factor Authentication
  - Account maintenance documentation (for users and Acknowledgers)

- PCMH Patient List: Information Guide
- Aggregated Patient Report: Quick Reference

Additional Information:
Website: http://MichiganDataCollaborative.org
General Inquiries: MichiganDataCollaborative@med.umich.edu
Account Inquiries: MDC-Accounts@med.umich.edu
PCMH Initiative Progress Reporting

The PCMH Initiative Data will track participant progress towards achieving relevant milestones in healthcare delivery transformation and to ensure fidelity to the Initiative model. The Initiative will use several types of PCMH Initiative participant reporting (described below) to accomplish these tasks.

PCMH Initiative participant reporting will be collected through the Qualtrics system using a combination of survey response style questions and spreadsheet uploads. Reports will be due at different intervals depending on the report type:

**Practice Self-Assessment**
- Frequency: Annually
- Release: 4-6 weeks prior to due date
- Schedule: Due 2/28/17
- Contents: Standardized scale and multi-select survey questions for the purposes of assessing overall PCMH practice capability/maturity and how PCMH capability changes over time.

**Participation Reporting**
- Frequency: Quarterly
- Release: 4-6 weeks prior to due date
- Schedule: Due 4/30/17, 7/31/17, 10/31/17
- Contents:
  - Participating Organization Contacts
  - Care Management and Coordination Staffing Details
  - Participation Requirements Information, Updates and Attestation
  - Participation Experience, Strengths and Challenges

**Practice Transformation Reporting**
- Frequency: Every Six Months
- Release: 8-10 weeks prior to due date
- Schedule: 7/31/17, 12/22/17
- Contents: Includes some survey response style transformation progress questions for response on behalf of multiple practices (if applicable) and a small amount of progress narrative specific to each participating practice’s transformation activity to track completion of required/selected objectives.

**Quarterly Progress Report:**
The quarterly progress report is intended to be a brief report utilized to assess the progress participants are making across multiple areas of the Initiative. The quarterly report will feature spreadsheet-based templates for participating organization to use in uploading both participating organization contacts and care management and coordination staffing details. Once completed, the spreadsheets can be saved between quarterly due dates to expedite subsequent reporting cycles (the spreadsheets will only need to be updated with changes that occurred during the quarter). The participation
requirements section of the quarterly report is attestation-based, providing survey style questions which confirm a participating organization is following all Initiative requirements for compliance purposes. The participation experience section of the quarterly report will feature a small number of short narrative response and survey questions geared toward understanding how elements of the Initiative are impacting participating practices as well as ascertain participant challenges and opportunities for improvement.

Semi-Annual Practice Transformation Report:
These reports will provide detail on the progress on practice transformation related to (a) the required clinical-community linkage objective, and (b) the additional practice-selected objective. Practices may be requested to upload appropriate documentation to substantiate their reports. Provision will be made for POs to report on behalf of multiple practices.

Annual Self-Assessment:
Self-assessment reporting will capture details on existing practice capabilities across a number of domains related to care management and coordination, team-based care, quality improvement, patient engagement, leadership, etc. This annual report will provide the Initiative the ability to assess what the technical assistance and practice support needs are for participants, while also allowing a standardized system for capturing participant growth.

Participant Learning Expectations
The PCMH Initiative will facilitate a number of opportunities for participants to engage in collaborative learning, technical assistance, and peer to peer learning. Many of these opportunities/activities are optional; however, participation in the Initiative Quarterly Updates detailed below is required of all participants. To view a matrix of all of the learning opportunities currently being offered, view this PCMH Initiative Learning Requirements Matrix on the SIM PCMH Care Delivery website.

Quarterly Update Meetings:
The required quarterly update meetings will provide participants with important Initiative updates and resources for successful participation. Participation in these virtual meetings will be required by all participating practices, POs and associated staff. These meetings will not be considered towards meeting the requirement for participation in Initiative led learning activities as described in your Participation Agreement.

While participation in the Quarterly Update Meetings will not be considered towards the requirement for participation in the Initiative led learning activities, there are a number of other Initiative led opportunities described below that will be considered towards
meeting the requirement for all Participating Practices to complete eight (8) hours of Initiative led learning activities in 2017. Practices will meet the requirement by ensuring that at least one representative from the Participating Practice participates in eight hours of activities as outlined below. The same representative is not required to accrue all eight hours individually, multiple Practice representatives can cumulatively achieve the required time for participation.

**Practice Transformation Collaborative**
The optional Practice Transformation Collaborative will provide participants with an opportunity to engage in learning activities to support transformation related to Clinical-Community Linkages and the practice transformation objective that the participant chose during the application. The Practice Transformation Collaborative will provide a series of opportunities for engagement including two day face to face learning sessions, bi-monthly peer coaching webinars, and monthly action period teaching webinars. Details on each of these events, along with registration links, can be found in the SIM PCMH Initiative Practice Transformation Collaborative Event Flyer.

**Billing and Coding Collaborative**
The optional Billing and Coding Collaborative was developed to provide support to financial, billing and coding, and care team staff. The Billing and Coding Collaborative will provide a series of web-based learning opportunities to support participants and provide guidance on billing payers to capture appropriate revenue. Additionally, there is potential for in-person learning activities as needs are further identified. Follow this link for more information on the SIM PCMH Initiative Billing & Coding Collaborative. Furthermore, you may also find the following [2017 PCMH Initiative Care Management and Coordination Tracking Codes Quick Guide](#) useful during while participating in the SIM PCMH Initiative.

**Annual Summit**
The PCMH Initiative will support three regional Annual Summits to accommodate participants across the state of Michigan. The annual summit will be geared towards engaging in networking and opportunities to build on the foundation of regular learning opportunities. These regional summits will be open to participant staff including but not limited to administrative staff, care managers and coordinators, quality improvement staff, and other leaders within participating organizations. General regions of consideration for the annual summit include the Northern Lower Peninsula, Western Lower Peninsula, and South East or Mid-Michigan.

**Affinity Groups**
Optional affinity groups will be developed to facilitate learning across participants. Below is a starting list of the affinity groups that will be convened in 2017. All groups will
convene quarterly unless otherwise noted. Additional affinity groups will be added as needed.

- **Care managers and coordinators:** The Care manager and coordinator affinity group will facilitate networking and promising practice sharing across the state. This group will be open to all Initiative care managers and coordinators offering an opportunity for peer to peer learning. Collaboratively, Care Managers and Care Coordinators will identify areas of interest, topic focus, and prioritize challenges. Potential outcomes include:
  - “What works”
  - “What has been tried and does not work”
  - Shared learning
  - Identification of best practices
  - Identify educational needs

- **Pediatric care managers and coordinators:** The pediatric care management affinity group will facilitate identification of curriculum needs for the pediatric care manager and care coordinators. The PCMH Initiative will support longitudinal educational offerings, based on the identified need. Additionally, the Pediatric affinity group will promote networking and best practice sharing for care managers and care coordinators that work specifically with pediatric patients. Collaboratively, Care Managers and Care Coordinators will identify areas of interest, topic focus, and prioritize challenges. Potential outcomes include:
  - “What works”
  - “What has been tried and does not work”
  - Shared learning
  - Identification of best practices
  - Identify educational needs

To see more detailed information on both the standard and pediatric care manager and coordinator affinity groups, view [this flyer](#) posted on the SIM PCMH Initiative website.

- **Clinical Champions:** The clinical champion affinity group will provide peer support and guidance to clinical champions across the PCMH Initiative. This group will be led by a physician champion at the program level or a physician experienced in practice transformation and care manager/coordinator integration.

- **Participant Leaders:** This group will provide feedback on strategy and program operations. In addition, this group will provide a forum to discuss concerns and issues identified by providers, identify best practices in implementation and
develop a collegial network of participant leadership across the PCMH Initiative to support the ongoing transformation process.

- **Finance/Billing and Coding Support**: The Finance/Billing and Coding Support affinity group will serve as a forum for participant staff that serve in the capacity to provide billing and coding services. This forum will focus on the identified Initiative G and CPT codes, as well as provide guidance on billing payers to capture appropriate revenue.

- **Technology Leaders**: The Technology Leaders affinity group will focus on the health information technology requirements including MiHIN Use Cases for the 2017 Initiative.

- **Quality Improvement Leaders**: The Quality Improvement Leaders affinity group will serve as a forum for participants to explore performance across Initiative requirements and metrics, and to share promising practices in leading and addressing change within the context of the Initiative.
Model of Care

The PCMH Initiative is built upon the joint principles of a Patient Centered Medical Home, agnostic across designating bodies. Particular value is placed in core functions of a medical home such as enhanced access, whole person care, and expanded care teams that focus on comprehensive coordinated care. The 2017 Participation Agreement outlines requirements around enhanced access, and care team composition, while this section provides an overview of Care Management and Coordination staffing and services. The definitions for Care Management and Coordination Services, Care Manager, Care Coordinator, Care Team, etc. as provided within the 2017 PCMH Initiative Participation Agreement, will be referenced and provided additional context.

Goals of Care Management and Coordination

- Improve patient’s functional health status
- Enhance coordination of care
- Eliminate duplication of services
- Reduce the need for unnecessary, costly medical services

Primary Care Population Health Strategies

Adapted from: Ramsey, Rebecca (2011). Implementing Effective Clinical Care Management: Building Care Management Capacity within a Transforming
Key roles of Care Manager and Care Coordinator

Care Managers and Care Coordinators function as key members of the Care Team, fulfilling a number of roles as outlined below:

**Care Manager**

- Identify the targeted population within practice site(s) per PCP referral, risk stratification, patient lists and other strategies. (Including patients with repeated social and/or health crises.)
- Target interventions to avoid hospitalizations and emergency department visits, ensures standards of care, and coordinates care across settings. Focuses on patients with mild to moderate chronic disease and patients with high complexity, high cost, and/or high utilizers of the health care system.
- Ensure patients have timely and coordinated access to medically appropriate levels of health and support services and continuity of care.
- Complete comprehensive assessment of patient’s health conditions, treatments, behaviors, risks, supports resources, values, preferences and overall service needs. This can be done in coordination with other members of the care team.
- Develop comprehensive, individualized care plans; coordinate services required to implement the plan; provide continuous patient monitoring to assess the efficacy of the plan; periodically re-evaluate and adapt the plan, as necessary.
- Provide a range of client-centered services that link patients with health care, psychosocial, and other services, including benefits/entitlement counseling and referral activities assisting them to access other public and private programs for which they may be eligible (e.g. Medicaid, Medicare Part D, Pharmaceutical Manufacturers’ Patient Assistance Programs, and other State or local health care and supportive services); coordination and follow-up of medical treatments; patient-specific advocacy and/or review of utilization of services.
- Conduct medication reconciliation
- Promote patient’s and family caregiver’s active engagement in self-care.
- Coordinate and communicates with all professionals engaged in a patient’s care, especially during transitions from the hospital
- Assist with advance directives, palliative care, hospice and other end-of-life care coordination

**Care Coordinator**

- Determine with the care team, the patient’s needs for coordination, including physical, emotional, and psychological health; functional status; current health and health history; self-management knowledge and behaviors; current treatment recommendations and need for support services.
• Demonstrate knowledge about community resources by providing information on the availability of and, if necessary, coordinate these services that may help support patients’ health and wellness or meet their care goals.
• Jointly create and manage the individualized plan of care with the patient/family, care team and community based organizations, that outlines the patient’s current and longstanding needs and goals for care and addresses coordination needs and gaps in care.
• Contribute to ongoing maintenance, which includes monitoring, following up and responding to changes in the patient’s individualized plan of care.
• Facilitate transitions of care with the practice team members to ensure timely and complete transmission of information and/or accountability
• Support self-management goals to promote patient health
• Align resources with patient and population needs
• Contact patients with identified gaps in care and communicate recommended tests/services to the patient. Provide additional resources to under insured patients.
• Demonstrate administrative skills to organize, evaluate, and present information clearly both verbally and in written communication; maintain documentation according to practice specifications.

Care Manager and Coordinator Hiring
“Care Coordinator” means an individual member of the Care Team, who is not required to be licensed, who provides patients assistance with self-management support, accessing medical services, making linkages to community services, and other related patient supports as appropriate. The following types of professionals are eligible to serve as a Care Coordinator: Bachelor’s Social Worker, Social Services Technician, Certified Community Health Worker, Certified Medical Assistant, or other similar types of health professionals determined by MDHHS.

“Care Manager” means a licensed individual assigned to provide care management services, including targeted interventions to avoid hospitalizations and emergency department visits, ensure standards of care, coordinate care across settings, and help patients understand options. The following types of professionals are eligible to serve as a Care Manager: Registered Nurse, Licensed Practical Nurse, Nurse Practitioner, Licensed Master Social Worker, Licensed Professional Counselor, Licensed Pharmacist, Registered Dietician, Physician’s Assistant, or other similar types of licensed health professionals determined by MDHHS.

A candidate’s years of experience, specialty area, appropriate licensure (as applicable to role) and background are factors to consider. However, the characteristics of the
candidate are also very important. During the interview process assess the candidate for characteristics listed below:

<table>
<thead>
<tr>
<th>Essential characteristics/skills for Care Manager and Care Coordinator</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Strong communication skills</td>
</tr>
<tr>
<td>• &quot;People&quot; skills</td>
</tr>
<tr>
<td>• Critical thinking skills</td>
</tr>
<tr>
<td>• Patient engagement and activation skills</td>
</tr>
<tr>
<td>• Negotiating and conflict resolution skills</td>
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Attributes of Successful Care Models

Successful care management and coordination programs to date have some common key elements: 1) The care manager(s) and coordinators are located in close proximity to the PCP and 2) The care manager(s) and coordinators are considered an integral part of the health care team. Care managers and coordinators working remotely, in isolation of the team; have not been shown to be as effective.

Successful models of care for high need, high cost patients have common attributes. The table below, cited from the Commonwealth Fund, identifies features that describe general content of an intervention (i.e. what it does) and those related to implementation of that content (i.e. how it’s done).

<table>
<thead>
<tr>
<th>Common Attributes of Successful Care Models</th>
</tr>
</thead>
<tbody>
<tr>
<td>Content/Features</td>
</tr>
<tr>
<td>• Targeting individuals most likely to benefit from intervention</td>
</tr>
<tr>
<td>• Comprehensive assessment of patients’ health-related risks and needs</td>
</tr>
<tr>
<td>• Evidence-based care planning and routine patient monitoring</td>
</tr>
<tr>
<td>• Promotion of patients’ and family caregivers’ engagement in patient self-care</td>
</tr>
<tr>
<td>• Coordination of care and communication among the patient and care team</td>
</tr>
<tr>
<td>• Facilitation of transitions from hospital to post-acute care and referral to community resources</td>
</tr>
<tr>
<td>• Provision of appropriate care in accordance with patients’ goals and priorities</td>
</tr>
</tbody>
</table>

Reference: McCarthy Douglas; Ran, Jamie; Klein, Sarah “Models of Care for High-Need, High-Cost patients: An evidence Synthesis”, Commonwealth Fund pub 1843 Yo 31; October 2015
Embedded Care Management/Coordination Staff
The PCMH Initiative requires Care Management and Coordination staff to be embedded within the participating practice in which they are serving. While POs or multi-site practices can hire care management and coordination staff across participating practice locations, the requirement for care management and coordination staff to be embedded remains. The use of the term “embedded” means the care management and coordination staff spends some portion of their time in the physical participating practice location. Face to face time with patients and the practice team is known to contribute to increased success for positive care management outcomes. The care manager should be physically located in the practice and have a work station for the allotted FTE identified for that practice. While the use of telehealth is allowed, it should be used rarely and only for a very limited amount of time (telehealth care by the Care Manager should not be the norm). The care manager needs to be physically in the practice and accessible to meet with patients in person and communicate with physicians and practice team members. Understanding the practice’s patient population needs to be considered when allocating the amount of time the care management and coordination staff spends in the physical participating practice. Due to the variation of population needs for each participating practice, there is no set minimum amount of time for the care management and coordination staff to be physically located in the participating practice. Care management staff can be shared across practices, as long as the required ratio, as outlined in the 2017 Participation agreement is maintained.

Participants may allocate the care manager and care coordinator staff FTE for each participating practice based on the need of the patient population. It is expected that needs of the patient will guide the staffing model and allocation of FTE for the care manager and care coordinator staff.

SIM Care Management and Coordination Learning Requirements
Please refer to the 2017 Participation Agreement for requirements around Care Management and Coordination learning requirements. Training for PCMH Initiative Participant Care Managers and Coordinators is available via the Michigan Care Management Resource Center (MiCMRC). Information such as training descriptions and schedules can be found at www.micmrc.org.

Initial Training Requirements
Both Care Coordinators and Care Managers are required to complete a MiCMRC approved Self-Management Training course within the first six months of hire. The MiCMRC has identified a number of approved Self-Management training programs; however, if this course is completed through the approved vendor, MICCSI, then the PCMH Initiative will cover the cost of the course. Care Managers are additionally required to complete the MiCMRC led Complex Care Management Training course within the first six months of hire. The cost of this course for new, or yet to be trained
Care Managers will also be covered by the PCMH Initiative. The table below provides an illustration of the training requirements for Care Managers and Coordinators.

**Initial Learning Requirements for Care Managers and Care Coordinators**

<table>
<thead>
<tr>
<th>Initial Required Training</th>
<th>Care Coordinator</th>
<th>Care Manager</th>
</tr>
</thead>
<tbody>
<tr>
<td>MiCMRC Approved Self-Management Support Course</td>
<td>X</td>
<td>X*</td>
</tr>
<tr>
<td>MiCMRC CCM Course</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>SIM Overview Recorded Webinar</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>PCMH, Chronic Care Model, and ACOs Recorded Webinar</td>
<td>X</td>
<td>X**</td>
</tr>
<tr>
<td>Team Based Care Recorded Webinar</td>
<td>X</td>
<td>X**</td>
</tr>
<tr>
<td>Introduction to Social Determinants of Health Recorded Webinar</td>
<td>X</td>
<td>X***</td>
</tr>
<tr>
<td>The Role of Care Managers &amp; Care Coordinators in Developing and Maintaining Community Linkages Recorded Webinar</td>
<td>X</td>
<td>X***</td>
</tr>
<tr>
<td>Social Determinants of Health and the Implications for Care Management eLearning Module</td>
<td>X</td>
<td>X***</td>
</tr>
<tr>
<td>Social Determinants of Health Case Study eLearning Module</td>
<td>X</td>
<td>X***</td>
</tr>
</tbody>
</table>

*Care managers are strongly encouraged to complete this course prior to registering in the MiCMRC CCM Course.

**Recorded webinar content is included in the CCM course. If a care manager attends the CCM course after January 2017, they do not need to complete the PCMH, Chronic Care Model, and ACO or the Team Based Care recorded webinars. However, Care Coordinators do need to complete.

***SDOH recorded webinars and eLearning modules are included in the CCM course content. If the care manager attends the CCM course after July 2017, they do not need to complete the recorded webinar or eLearning Modules. However, Care Coordinators do need to complete.

To access the above initial learning requirements, [click here](#).

Existing Care Coordinators and Care Managers that have completed the Initial Training requirements as outlined above will not be required to attend the courses again. Completion of the Initial Social Determinates of Health online required training consist of the following:

- Introduction to Social Determinants of Health Recorded Webinar
- The Role of Care Managers and Care Coordinator in Developing and Maintaining Community Linkages Recorded Webinar
- Social Determinants of Health and the Implications for Care Management eLearning Module
- Social Determinants of Health Case Study eLearning Module
For SIM Care Managers and Coordinators:

- CMs and CCs who are currently working in their practice need to complete the Initial Social Determinants of Health online education within 6 months (i.e. to be completed by 1/31/18)
- CMs and CCs newly hired will need to complete the Initial Social Determinants of Health online education within 6 months of their hire date.

However, the SIM PCMH Initiative Overview Module and the Social Determinants of Completion of the Social Determinants of Health online required training is within 6 months of its availability for established Care Managers and Coordinators and within 6 months of hire for new Care Managers and Coordinators.

To access the SDOH online required training [here](http://mcmrc.org).

**Longitudinal Learning Activity Requirements per Year**

The PCMH Initiative maintains the expectation that all Care Managers and Coordinators will maintain their current licensure/certification, including the requirements to seek continuing education approved by the appropriate professional organization/association. To support this expectation, the Initiative requires each Care Manager and Care Coordinator must complete a total of twelve (12) hours of education per year. The requirement of training throughout the year is termed “longitudinal learning activity.” This can be satisfied by either:

- Twelve (12) hours of PCMH Initiative-led Care Manager and Care Coordinator webinars/sessions (e.g., topic based live and recorded webinar trainings, web based interactive self-study eLearning modules – Basic Care Management, in person Summit, etc.), OR
- Six (6) hours of PCMH Initiative-led Care Manager and Care Coordinator webinars/sessions PLUS six (6) hours of PO-led, or other related learning activity events. No preapproval is necessary for PO-led care manager, care coordinator training sessions.

The MiCMRC hosts live, topic-based webinars and trainings throughout the year, many of which provide continuing education credits. Additionally, MiCMRC maintains a library of recorded trainings (many offering continuing education credits) and various resources ranging from sample tools, articles and resources that can be accessed on demand. Live webinars, recorded trainings, and resources can be accessed at [http://mcmrc.org](http://mcmrc.org).

Please note, the completion of the initial required training, as stated above, is not included as part of the hours for the required training per year. For example, the
Complex Care Management course is not counted as part of the twelve (12) hours of longitudinal training. If a Care Coordinator and/or Care Manager is hired during the calendar year, the twelve (12) hours of longitudinal training requirement is prorated based on the date of hire.

A general guide for prorating the longitudinal learning requirements will be completion of one hour of longitudinal training per month, using hire date within the calendar year.

Practice Transformation
The objective of the PCMH Initiative’s practice transformation objectives and payment model is to support the advancement of infrastructure within (or accessible to) PCMH practice environments. Practice transformation in this context is not focused on (or funded to support) the act of delivering a service to an individual patient. Rather, practice transformation support in the PCMH Initiative is geared toward building capability and developing structures which make the work of a PCMH participating practice more effective in the required and selected objective focus areas.

Practice Transformation Objectives
All SIM PCMH Initiative practices must fulfill a Clinical-Community Linkage practice transformation requirement. The Clinical-Community Linkage requirement will also help in developing synergies with Community Health Innovation Regions (CHIR) for those practices in SIM regions, which will foster relationships between primary care practices and community resources. Additional detail about the required, and the menu of elective Practice Transformation Objectives can be found below.

REQUIRED OBJECTIVE: Clinical – Community Linkage

The Clinical-Community Linkage requirement can be satisfied by developing documented partnerships between a Practice (or PO on behalf of multiple Practices) and community-based organizations which provide services and resources that address significant socioeconomic needs of the practice’s population following the process below:

a. Assess patients’ social determinants of health to better understand socioeconomic barriers using a brief screening tool with all attributed patients.
   i. **Note:** to support Participants, the Initiative has developed a [template of a brief screening tool](#) that can be used as is, or adapted to meet the needs of the practice environment and the community being served. This template highlights domains important to understanding patients’ socioeconomic barriers.

b. Provide linkages to community-based organizations that support patient needs identified through brief screening, including tracking and monitoring the initiation, follow-up, and outcomes of referrals made.
c. As part of the Practice’s ongoing population health and quality improvement activities, periodically review the most common linkages made and the outcome of those linkages to determine the effectiveness of the community partnership and opportunities for process improvement and partnership expansion.

In addition, practices will select one elective objective from the following table as the second part of the 2017 Practice Transformation requirement:

<table>
<thead>
<tr>
<th>Subcategory</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Telehealth Adoption</strong></td>
<td>• Adopt and use of telehealth services to increase patient access to remote specialty care consults or services.</td>
</tr>
<tr>
<td><strong>Improvement Plans from Patient Feedback</strong></td>
<td>• Collect patient experience and satisfaction data on access to care.</td>
</tr>
<tr>
<td></td>
<td>• Develop of an improvement plan, including outlining steps for improving communications with patients to help patients understand access options.</td>
</tr>
<tr>
<td></td>
<td>• Demonstrate evidence of improvements made as a result of the data collected and improvement plan.</td>
</tr>
<tr>
<td><strong>Medication Management</strong></td>
<td>• Manage medications to maximize efficiency, effectiveness and safety by integrating a pharmacist into the care team and conducting periodic, structured medication reviews.</td>
</tr>
<tr>
<td><strong>Population Health Management</strong></td>
<td>• Implement regular reviews of targeted patient population needs including access to reports that show unique characteristics of the Practice’s patient population.</td>
</tr>
<tr>
<td></td>
<td>• Identify vulnerable patients and demonstrate how clinical treatment needs are being tailored, if necessary, to address unique needs.</td>
</tr>
<tr>
<td><strong>Self-Management Monitoring and Support</strong></td>
<td>• Use tools to assist patients in assessing their self-management skills (e.g. the Patient Activation Measure or How’s My Health).</td>
</tr>
<tr>
<td></td>
<td>• Implement processes that engage patients to strengthen self-management skills and ultimately improve adherence to a patient’s treatment plan.</td>
</tr>
<tr>
<td>Subcategory</td>
<td>Activity</td>
</tr>
<tr>
<td>------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| Care Team Review of Patient Reported Outcomes        | • Implement a technology solution that enables capture of patient reported outcomes (e.g., home blood pressure, blood glucose logs, food diaries, at-risk health factors such as tobacco or alcohol use, etc.) such as certified EHR technology or patient registry  
• Ensure patient reported data is identified for easy care team member recognition and action (as applicable) |
| Integrated Peer Support                             | • Integrate peer support into the care team to enhance care management activities such as providing motivational supports and/or leading patient support groups. |
| Group Visit Implementation                          | • Implement at least one group visit (sometimes called a cooperative healthcare clinic) for chronic conditions (e.g., diabetes) common to the Practice’s attributed PCMH Initiative population. |
| Patient Portal Access                                | • Provide access to an enhanced patient portal or personal health record (PHR) that provides up to date health information and includes interactive features allowing patients to enter health information and/or enable bidirectional communication. |
| Cost of Care Analysis                                | • Build the analytic capability required to manage total cost of care for the Practice population, including training appropriate staff on interpretation of cost and utilization information and using available data regularly to analyze opportunities to reduce cost. |
| Integrated Clinical Decision Making                  | • Develop a formal collaborative relationship with one or more behavioral health and/or substance abuse providers.  
• Implement a shared, integrated clinical decision-making approach which includes:  
  ▪ A combined/holistic health assessment, including sharing health information  
  ▪ Developing a shared treatment plan and goals  
  ▪ Ensuring regular communication and coordinated workflows between clinicians  
  ▪ Conducting regular case reviews for at-risk or unstable patients |
Practice Transformation Reporting

Practice Transformation Reporting is a requirement that happens semi-annually. This reporting exercise provides insight to the SIM PCMH Initiative team on how each participant is approaching this important task, and also allows for the practice to reach out and request support in achieving their chosen and required objectives. Practice Transformation reporting requirements will be released at the same times as the second, and fourth quarter progress reporting dates. Further detail on these dates can be found in the PCMH Initiative Progress Reporting Section earlier in this guide. To get answers to questions, or to provide feedback on any Practice Transformation Reporting related topics, please send an email to SIMPCMH@mail.mihealth.org.

PCMH Initiative Communications

The PCMH Initiative currently maintains a general public facing web presence on the State of Michigan website however, a dedicated website to respond to the needs of participants is currently under development. The website will include resources for implementing the PCMH Initiative, including information on upcoming events and learning opportunities, Summits, archives of newsletters and webinars, guides to billing, coding and payment and contact information should project participants have questions. Once this participant facing web presence is established, official communications and links will be shared with participants.

Official PCMH Initiative communications will be facilitated via the MDHHS “Gov Delivery” system. System development is currently under way, and until it is fully functional the PCMH Initiative will utilize SIMPCMH@mail.mihealth.org to manage official communications. However, the PCMH Initiative is possible through a number of partnerships between the Michigan Department of Health and Human Services and various stakeholders, therefore participants may receive communications from these partners in order to support the overall goals and efforts of the Initiative. These partners include:

1. The Michigan Health Information Network: for information regarding use cases
2. The Michigan Data Collaborative: for information regarding the impact of clinical data on measure results, dashboard access and member list questions
3. The University of Michigan: for information regarding project operations
4. The Michigan Care Management Resource Center: for information regarding Care Manager and Care Coordinator training and education opportunities
5. The Institute for Health Care Improvement: for information and coaching around the Practice Transformation Collaborative and change management

PCMH Initiative Contacts

The PCMH Initiative is grateful for your continued work on behalf of patients and families. We recognize that this work is incredibly difficult and a team is available to
assist you. Below are the best contacts for the various questions you may have throughout the Initiative.

**General Questions:**
SIM PCMH Initiative Mailbox (SIMPCMH@mail.mihealth.org)

**Program Requirements:**
Katie Commey (CommeyK@michigan.gov)
Phillip Bergquist (BergquistP@michigan.gov)

**Care Management and Coordination:**
Marie Beisel (mbeisel@med.umich.edu)

**Participant Reporting:**
Diane Bechel Marriott (dbechel@med.umich.edu)
Amanda First (afirst@med.umich.edu)

**Technology Requirements (Specific to HIE Use Cases):**
MiHIN (help@mihin.org)

**Performance Dashboards and Downloadable Performance Reports:**
Michigan Data Collaborative (MichiganDataCollaborative@med.umich.edu)

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABD</td>
<td>Aged, Blind and Disabled Medicaid</td>
</tr>
<tr>
<td>ACRS</td>
<td>Active Care Relationship Service</td>
</tr>
<tr>
<td>ADT</td>
<td>Admission, Discharge, Transfer Notifications</td>
</tr>
<tr>
<td>CAP</td>
<td>Corrective Action Plan</td>
</tr>
<tr>
<td>CCL</td>
<td>Clinical-Community Linkage</td>
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<td>SNF</td>
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<td>TCM</td>
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Legend
- Personnel/Population
- Organizations
- Reform and Innovation
- Sites of Care
- Payment and Insurance

A

ABD •
Aged, Blind and Disabled Medicaid

ABD Medicaid is for adults 65 and older or anyone who is disabled according to Social Security.

ACRS •
Active Care Relationship Service

ACRS provides the ability to link patients with their care team members (providers who have declared an active care relationship with that patient).

Learn more

ADT •
Admission, Discharge, Transfer Notifications

Patients transition from one provider or healthcare setting to another as the patients’ health care needs require. These transitions trigger Electronic Health Records to generate ADT notifications that identify the patient along with important details that provide insight to an extremely complex set of care decisions being made by care teams, families and the patient.

Learn more

C
CAP • 
Corrective Action Plan
A response to a compliance warning notification from MDHHS. CAP describes exactly how a SIM PCMH participant will resolve the issue in order to meet the PCMH-SIM compliance.

CCL • 
Clinical-Community Linkage
CCLs support referral processes and coordination between clinical care and community-based social services to improve population health.

CCSI • 
Center for Clinical Systems Improvement
Also known as Mi-CCSI. CCSI is an organization supports its stakeholders and their communities to deploy models that deliver better care for individuals, improved population health and lower cost, promote initiatives supporting clinical integration, and develop and provide care management training.
Learn more

CCM • 
Complex Care Management
CCM is a set of activities designed to more effectively assist patients and their caregivers in managing medical conditions and co-occurring psychosocial factors.
Learn more

CHAP • 
Community Health Accreditation Partner
CHAP is an independent, nonprofit accrediting body for home and community-based health care organizations.
Learn more

CHIR • 
Community Health Innovative Region
CHIRs are small number of regional governing bodies launched by the SIM program to define regional health priorities, support regional planning, increase awareness of community-based services, and increase linkages between community and health entities in Michigan.

CHW • 
Community Health Worker
CHW is front-line public health worker has a close understanding of the community served, serves as a liaison between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery, and builds individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support and advocacy.
CM/CC •
Care Management and Coordination
CM/CC are activities that care manager and care coordinator partner with the practice care team to; effectively empower patients and their families, engage patients in self-management and health behavior change, positively affect patient self-care practices and decision-making, provide comprehensive assessment and care planning using shared decision making, implement evidence based interventions and advocate for the right care, at the right time and in the right place.

CMRC •
Care Management Resource Center
MiCMRC provides training and support for the statewide Care Management initiatives.

CKS •
Common Key Service
The Common Key Service use case provides a consistent and reliable way to match patients across multiple organizations, applications and services, ensuring patient safety and high data integrity when data is shared.

CPC+ •
Comprehensive Primary Care Plus
CPC+ is a national advanced primary care medical home model that aims to strengthen primary care through regionally-based multi-payer payment reform and care delivery transformation. CPC+ includes two primary care practice tracks with incrementally advanced care delivery requirements and payment options to meet the diverse needs of primary care practices in the US.

FFS •
Fee-For-Service
System of payment in which providers receive reimbursement for each service they perform.

FQHC •
Federal Qualified Health Center
Clinics offering comprehensive health care to an underserved population and receive Medicare and Medicaid payment.

H•
Health Information Exchange
Electronic infrastructure that allows health care professionals and patients to appropriately access and securely transmit a patient’s vital medical information across sites of cares in many geographic regions of the country.

Learn more

HMP •
Healthy Michigan Plan
The HMP is a new category of eligibility authorized under the ACA. The benefit design of the Healthy Michigan Plan ensures beneficiary access to quality health care, encourages utilization of high-value services, and promotes adoption of healthy behaviors.

HPD•
Health Provider Directory
HPD is a foundational service within MiHIN’s road map to standardize electronic communications among providers and anyone empowered to access protected health information.
Learn more

I
IHI •
Institute for Healthcare Improvement
IHIH is an independent not-for-profit organization which promotes care improvement worldwide.
Learn more

M
MHP •
Medicaid Health Plans

MiCHWA •
Michigan Community Health Worker Alliance
MiCHWA is the CHW information hub for the state of Michigan.
Learn more

MiHIN •
Michigan Health Information Network Shared Services
MiHIN is Michigan’s initiative to continuously improve health care quality, efficiency, and patient safety by promoting secure, electronic exchange of health information.
Learn more

MPI •
Master Patient Index
MPI is an electronic medical database that holds information on every patient registered at a healthcare organization. It may also include data on physicians, other medical staff and facility employees.
MSA • Medical Services Administration
MSA oversees the operation of Medicaid plans in Michigan.

MU • Meaningful Use
MU is a CMS Medicare and Medicaid program that awards incentives for using certified electronic health records to improve patient care.

P
PMPM • Per Member Per Month
PMPM is a capitation payment that payers provide to providers.

PPL • PCMH Patient List
PPL provides a current list of patients who are attributed to a practice and participating in the SIM PCMH project.

PPQC • Physician Payer Quality Collaboration
The PPQC is a physician-led activity that engages government and commercial payers in an effort to focus quality improvement efforts around a core set of measures and standardize performance report and feedback with health plans.

PT • Practice Transformation
PT in the SIM-PCMH context refers to building capability and developing structures which make the work of a PCMH participating practice more effective in the required and selected objective focus areas.

PTO • Practice Transformation Objectives
PTO refers to the Clinical-Community Linkage requirement and one selected PT requirement in the SIM-PCMH context.

Q
QMI • Quality Measure Information
QMI use case contains multiple scenarios for sending, receiving, finding and using quality measure information for different quality reporting programs.
Learn more

QQO • Qualified Organization
RAMP • Relationship and Attribution Management Plan
RAMP has been created to support the identification and capture of relationships between patients/consumers and their healthcare delivery team members, to facilitate the active exchange of necessary information between these identified individuals and organizations.

RHC • Rural Health Clinics
RHCs are clinics located in rural areas that provide outpatient primary care services and basic laboratory services for Medicaid and Medicare patients.

SDoH • Social Determinants of Health
SDoH are conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels.

SIM-PCMH • State Innovation Model-Patient Centered Medical Home
SIM focuses on the development and testing of multi-payer health care payment and service delivery models in order to achieve better care coordination, lower costs, and improved health outcomes for Michiganders. The SIM-PCMH Initiative is the core component of the SIM strategy for coordinated care delivery, focusing on the development and testing of multi-payer health care payment and service delivery models in order to achieve better care coordination, lower costs, and improved health outcomes for Michiganders.

SNF • Skilled Nursing Facility
SNF is a type of nursing home recognized by the Medicare and Medicaid systems as meeting long term health care needs for individuals who have the potential to function independently after a limited period of care.

TANF • Temporary Assistance for Needy Families
TANF program provides temporary financial assistance for pregnant women and families with one or more dependent children. TANF provides financial assistance to help pay for food, shelter, utilities, and expenses other than medical.
TCM • Transitional Care Management
TCM includes services provided to a patient whose medical and/or psychosocial problems require moderate or high-complexity medical decision making during transitions in care from an inpatient hospital setting, partial hospital, observation status in a hospital, or skilled nursing facility/nursing facility, to the patient’s community setting.

Revision History

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<td>Katie Commey</td>
<td>All</td>
<td>Initial Release</td>
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<td>2.22.2017</td>
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<td>Justin Meese</td>
<td>• PCMH Initiative Performance Monitoring and Compliance</td>
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<td>5.22.2017</td>
<td>V3</td>
<td>Justin Meese</td>
<td>• Abbreviation (Acronyms) list and definitions</td>
<td>Provided additional detail and linked to important resources found on the SIM PMCH Initiative website.</td>
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