SIM PCMH Initiative Newsletter

A publication of Michigan's State Innovation Model

May 2018

In this Issue

About the Initiative

The Patient Centered Medical Home (PCMH) Initiative is a core component of the State Innovation Model (SIM) strategy for coordinated care delivery, focusing on the development and testing of health care payment and service delivery models in order to achieve better care coordination, lower costs, and improved health outcomes for Michiganders. For more information and resources, check out our webpage.

Contact Us

Questions can be sent to:
MDHHS-SIMPCMH@michigan.gov

Links

SIM Initiative website

SIM Population Health webpage

SIM Care Delivery webpage

Welcome to the 2018 Patient Centered Medical Home Initiative monthly newsletter. Each month we will bring together all the updates, news and upcoming events relevant to PCMH Initiative Participants.

You will continue to receive other regular communications and event reminders from the PCMH Initiative. This newsletter has been developed as a method to share information in one common location. Previous editions of the newsletter can be found here.

Program News and Updates

Care Coordination Collaborative: Virtual Event Coming!

The Care Coordination Planning Committee is hard at work planning for the first virtual Care Coordination Collaborative event in early/mid June. These events are designed to "optimize the effective partnering of plans, practices, provider organizations, community organizations and CHIRs (i.e., the multi-stakeholder partners) for the purposes of: 1) addressing and closing patient/member/beneficiary social determinant health needs; and 2) improving population overall health status, efficiency and effectiveness of delivery care." We have engaged a wide variety of stakeholders to make this collaborative as meaningful as possible. Please be on the lookout for an upcoming save-the-date!

PCMH Initiative Quarter 1 Progress Report

The PCMH Initiative Quarter 1 Progress Report was released on March 26, 2018. The link to the electronic submission has been distributed to your organization's key contact. Submission deadline is **Monday, April 30, 2018 by 5pm**. Compared to the 2017 quarterly progress report, this report added several new requirements to better align with other statewide programs. You can download and preview the requirements in the report template here.

May Office Hours: Care Management and Coordination Benchmarks

On Wednesday May 16 from 12:30-1:30, the PCMH Initiative Team with present the plan for monitoring and compliance around the Care Management and Coordination Benchmarks as outlined in the 2018 Participation Agreement. We encourage Initiative Participants to come with questions regarding this new requirement. REGISTER HERE to reserve your spot.

Pediatric Office Hours: Adverse Childhood Experiences (ACEs) and Social Determinants of Health Screening – How to Have the Conversation

The second in our series of Pediatric Office Hours sessions is scheduled in June! This session is specifically designed for Pediatric practices, but all are welcome. Please bring your questions.
Date: Wednesday, June 6th 11 am-12 pm
Topic: "ACEs and SDOH Screening – How to Have the Conversation"
Presenter: To be announced
REGISTER HERE

Save the date for additional Pediatric Office Hours: September 13th from 12pm-1pm. The Pediatric Office Hours is open to all.

PCMH Initiative Upcoming Compliance Audits

Ongoing monitoring will begin in May to ensure all provider organizations or practices (if participating separately from a provider organization) are utilizing PCMH Initiative performance measure dashboards/reports for quality improvement no less often than quarterly. Information on compliance requirements, including upcoming audits, will be available in the April update of the Participation Guide which was released on Friday, April 13, 2018.

Upcoming Michigan Data Collaborative Deliverables

SIM PCMH Dashboard Release 4.0 Coming Soon!
Michigan Data Collaborative (MDC) plans to post release 4.0 of the Dashboard at the end of April. The updates for this release include:

1. **The addition of Quality Measure Information (QMI) data**
   Participating organizations have been submitting Clinical/EMR data to Michigan Health Information Network (MiHIN) in support of the QMI use case. The new outcome measures are reliant on clinical data receipt, and MDC is adding it to the majority of the Quality Measures. MiHIN has provided MDC the clinical data for 24 organizations. Note that some organizations have submitted QMI data to MiHIN, but this data is being processed and will be included in future releases.

   When viewing the dashboard, the Visualization option (graph) displays combined claim and clinical (QMI) results. When you select the Data option, the results are displayed in a table that includes separate numerator and denominator columns for Claims, Clinical, and Combined.

2. **New Measures and Chronic Conditions**
   Details about the new measures/chronic conditions will be included in the release email announcement and in the release notes.

3. **Patient-level data**
   Users can drill down to patient-level information for Quality and Utilization Measures. For example, at the Practice level users can click a measure to view a list of the patient names included in the numerator and denominator. Additional demographic information will be displayed as it is available.

4. **Data Updates**
   - Twelve-month reporting period with dates of service between January 1, 2017 and December 31, 2017
   - Paid claims through February 28, 2018
   - Attribution using the December 2017 filtered SIM Participant File (SPF) and Provider Hierarchy Files

   Additional information will be provided in the email announcing Release 4.0, the Release Notes, and the related support documents.

Updates to the PCMH Patient Lists
MDC is including additional elements in the Patient Lists starting in May 2018. The following fields will be added to the end of the PCMH Patient List (PPL) layout:

- Social Security Number - Last 4 digits
- Patient Address Line 1
- Patient Address Line 2
- Patient City
- Patient Zip

Additionally, the following existing fields will be populated with data:

- number of visits to any PCP (This field will include the number of visits over the newest 12 months of available data—currently displays 6 months.)
- Most Recent PCP visit date

You can view more details in the PCMH List Information Guide.

Dashboard Training
MDC created online training tutorials to help users complete the setup steps to access the Dashboard. The following tutorials are posted on the SIM PCMH Support page:

- Dashboard Access Step 1: Setting Up Duo
- Dashboard Access Step 2: Setting Your Level-2 Password
- PCMH Dashboard Access Step 3: Setting Up Citrix Receiver to Access the SIM PCMH Dashboard

You can view an up-to-date list of upcoming deliverables on the SIM PCMH page of the MDC website.

Professional Medical Corporation Highlight

Professional Medical Corporation has a dedicated focus on improving overall quality and cost of care. The SIM program has enabled PMC to further enhance the ability to achieve better results in quality and cost through the implementation of a fully staffed care management team. PMC has built a care delivery team that provides the required embedded care management component, but also the addition of a centralized care team. The centralized care team includes a dietitian, pharmacist, and behavioral health counselor that serve the managed Medicaid population. In addition to this team is a panel manager and care coordinator, who serves as the catalyst to coordinating PMC's population health efforts.

The panel manager on PMC's team is an integral team member who identifies high-risk patients through review of the extensive data received, that may otherwise not have been found. This full-time position focuses on utilizing all payer and program data that indicates patient-specific utilization and risk level, in addition to registry information and gaps. PMC's list of roughly 30,000 Medicaid SIM patients is significantly narrowed down, so the embedded care manager can focus on the list of patients who would best be served by care management services.

To ensure that the follow-up after discharge metric is met, PMC also utilizes a care coordinator. This centralized team member monitors SIM practice ADT feeds for hospital discharges of SIM-attributed patients. When a discharge occurs, the care coordinator reaches out to the patient to ensure the patient is comfortable with their discharge and to coordinate the patient's follow-up visit. In addition, PMC is enlisting SIM leadership to follow-up with the practice at month-end to review if the patient showed for their follow-up visit and how they documented and billed the claim. All activity by the care management team is tracked, monitored and reviewed to ensure goals, targets, and results are achieved.

In assisting and walking practices through new care management and billing concepts, PMC is not only ensuring that grant requirements are being met, but also promoting more proactive population health in more than just managed Medicaid patients.

Upcoming Events and Initiative Resources

MiCMRC 2018 Care Management Educational Webinars

Title: Advance Care Planning 101
Date and Time: Wednesday, May 23rd 2-3 pm
Presenter: Carolyn Stramecki, MHSA
Consultant, Advance Care Planning – Michigan, Michigan Primary Care Consortium
REGISTER HERE

Continuing Education Nursing, Social Work, and CCMC

Title: Michigan Physician Orders for Scope of Treatment (Mi-POST)
Date and Time: Wednesday, June 13th 2-3 pm
Presenter: Carolyn Stramecki, MHSA
Consultant, Advance Care Planning – Michigan, Michigan Primary Care Consortium
REGISTER HERE

For questions, please submit to micmrc-requests@med.umich.edu

MiCMRC Approved Self-Management Course Registration

The MiCMRC Complex Care Management (CCM) course is designed to prepare the healthcare professional for the role of Complex Care Manager. Course content is applicable to all Care Managers in the ambulatory care setting, working with complex patients. For CCM Course details click here

Upcoming CCM course dates and course registration:

May 7-10, 2018 | Lansing MI | REGISTER HERE | Registration deadline: May 3, 2018

June 11-14, 2018 | Lansing MI | REGISTER HERE | Registration deadline: June 7, 2018

NOTES: If you have 15 or more Care Managers in your area and would like the MiCMRC team to provide a regional training at your location please submit your request to: micmrc-ccm-course@med.umich.edu

For questions please contact: micmrc-ccm-course@med.umich.edu

MiCMRC Approved Self-Management Support Courses and Resources Update

To access the list of the MiCMRC approved Self-Management Support courses you may click here. The list of MiCMRC approved Self-Management Support Courses provides a detailed summary of each course, with associated objectives, location, cost and more.

Additionally, MiCMRC has collected resources for Self-Management Support including: websites of interest, publications, tools, videos, and even patient materials. MiCMRC's "Self-Management Support Tools and Resources" document offers an at a glance list and summary of these resources, along with descriptions and

website links for quick access. For “Self-Management Support Tools and Resources” you may click here.

Both of these documents can also be accessed on the MiCMRC website.

The MiCMRC Patient and Family Engagement New eLearning Module is Available!

MiCMRC has launched the eLearning module “Patient and Family Engagement (PFE)”. This new eLearning module is part of a series titled “Basic Care Management Program” available at the Michigan Care Management Resource Center website. Also, you can find resources for Patient Engagement.

Continuing Education for Patient and Family Engagement eLearning Module Nursing and Social Work CE Contact Hours: 1.0

"This continuing nursing education activity was approved by the Ohio Nurses Association, an accredited approver by the American Nurses Credentialing Center’s Commission on Accreditation. (OBN-001-91)".

“Michigan Care Management Resource Center is an approved provider with the Michigan Social Work Continuing Education Collaborative”. Approved Provider Number: MICEC 1102

Navigating the New Care Delivery Website

Our new website layout has officially launched! Our new website can be accessed directly through the link here Once you access the SIM webpage you can click on the tab at the top labeled “Care Delivery”, as circled in the screenshot on the following page.

To access the interactive 2018 calendar, you can click on the blue “Care Delivery Calendar” button on the bottom of the webpage. To access the 2018 resources, you can click on the blue “Resources” button on the bottom of that same webpage. Both buttons are circled on the subsequent page.

In the calendar you are able to click on any existing event and add it to your Outlook calendar and view details about the time it will occur and additional materials. From this page you are able to navigate back to both the Care Delivery main page and the Resource page.

On the resource page you can click on the main accordion headings to view a drop down of all 2018 newsletters, event materials (webinar Q&A, slides, recordings, etc.), and all current participant resources (participation guide, participation agreements, participant list, etc.). From this page you can navigate back to the Care Delivery home page, the calendar, or even access all 2017 resources by clicking on that blue button. We have attached screenshots on the following page to help you locate the items we’ve specified above.

If you have questions or comments on how best to improve our website, we will gladly accept all feedback sent to the SIM mailbox at MDHHS-SIM@michigan.gov or the PCMH mailbox at MDHHS-SIMPCMH@michigan.gov.

State Innovation Model | Care Delivery | Population Health

Care Delivery

The Patient Centered Medical Home (PCMH) Initiative is the core component of the State Innovation Model (SIM) strategy for coordinated care delivery, focused on developing and testing service delivery models to achieve better care coordination, lower costs, and improved health outcomes for Michiganders. The SIM PCMH Initiative is built upon the principles of a patient-centered medical home that generally define the model regardless of the designating organization. Value is placed on core functions of a medical home, such as enhanced access, whole-person care, and expanded care teams that focus on comprehensive coordinated care. To increase value and incentivize healthcare practices to provide high-quality and cost-efficient care, SIM is also working to promote the use of alternative payment models (APMs).

This initiative is aligned with the overall SIM Care Delivery goals of:

Championing models of care that engage patients using comprehensive, whole-person-oriented, coordinated, accessible and high-quality services centered on an individual's health and social well-being.
Supporting and creating clear accountability for quantifiable improvements in care processes and quality, as well as health outcomes.
Creating opportunities for Michigan primary care providers to participate in increasingly advanced APMs.

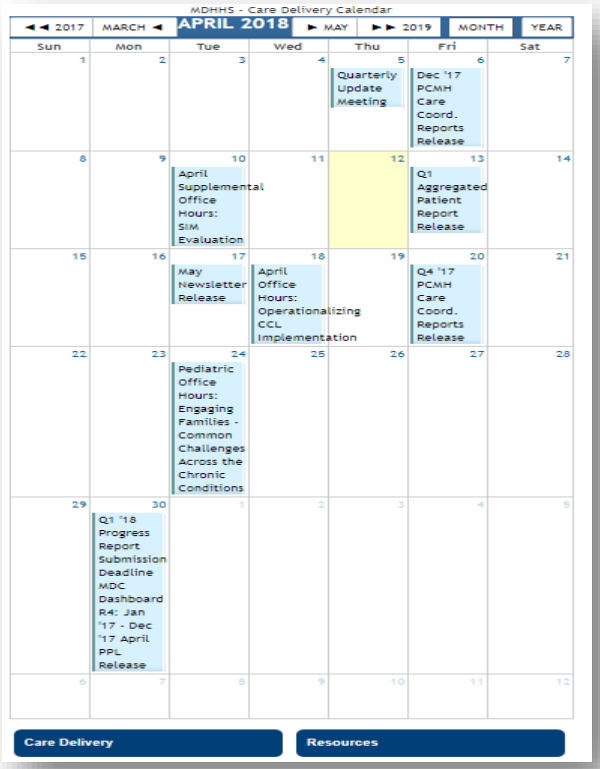
If you have questions about the PCMH Initiative, please contact the SIM team at MDHHS-SIMPCMH@michigan.gov.

Newsletters
March 2018
February 2018
December 2017
View all newsletters

Upcoming Events
Dec '17 PCMH Care Coord. Reports Release
April Office Hours: Operationalizing CCL Implementation
REGISTER HERE

Q1 Aggregated Patient Report Release
View all events

Resources | Care Delivery Calendar



Care Delivery Resources

PCMH Initiative newsletters, materials shared at Care Delivery and PCMH Initiative events, and Care Delivery component background materials can be found below.

Newsletters
Event Materials
Resources

2018 PO Participation Agreement
2018 Practice Participation Agreement
2018 Participation Agreement Summary of Changes
2018 PCMH Initiative Participation Guide (Version 2)
Self-Assessment Questions Template
2018 January Participant List

Care Delivery | Calendar
2017 Resources

For More Information

www.michigan.gov/SIM | MDHHS-SIMPCMH@michigan.gov

SIM MDHHS State Innovation Model