SIM PCMH Initiative Newsletter

A publication of Michigan's State Innovation Model

November 2018

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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 Care Delivery webpage

SIM Population Health 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

PCMH Initiative Quarter 3 Progress Report

The PCMH Initiative Quarter 3 Progress Report was released on September 26, 2018 and the submission deadline is Wednesday, October 31, 2018 by 5:00pm. The link to the electronic submission was distributed to your organization's key contact. You can preview the requirements and instructions to complete the report in the report guide. Please note: there is a "care manager lead" section in the "contact" spreadsheet, which will support Care Coordination Collaborative connections at the practice level. Please only provide the care manager lead information rather than a comprehensive care manager list in this section.

2019 PCMH Initiative Intent to Continue Participation

The Intent to Continue Participation will be released on October 26, 2018 and the submission deadline is November 14, 2018 by 5:00pm. The link to the electronic submission was distributed to your organization's key contact. As compared to last year's ITCP, a "care management team composition" section has been added to the spreadsheet. You can preview the requirements and instructions to complete the ITCP in the ITCP Guide. The application must be filled out by current program participants that wish to continue into year three of the PCMH Initiative. The application process is not binding but will help inform the contractual process for the MDHHS Bureau of Purchasing—the department that administers the formal PCMH Initiative Agreements.

Evaluation Updates

The evaluation team is in the process of analyzing the data from the provider survey and has/will have aggregate reports for participants at the Regional Summits. We are also excited to announce that work on the Clinical-Community Linkages (CCL) Data Partnership is underway. We're looking forward to leveraging participant data to assess changes in Medicaid costs and utilization related to patients' participation in CCLs. Finally, the Patient Experience Survey will be administered this Fall. More information will follow.

Regional Summit Registration Now Open!

One of our regional summit dates is still open for registration. If you missed our Northern Summit in Gaylord, and our Western Summit in Muskegon, you still have one more chance to learn alongside us in Ann Arbor!

Summit Southeast – Ann Arbor, MI
The Kensington Hotel
Thursday, November 8, 2018
Ann Arbor Summit Register Here

Continuing Education Nursing, Social Work and CCMC

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 110216

This program has been pre-approved by The Commission for Case Manager Certification to provide continuing education credit to Complex Care Management (CCM) board certified case managers. The course is approved for 4.5 CE contact hour. Activity code: S00033447 Approval number: 180003131
To claim these CEs, log into your CCMC Dashboard at www.ccmcertification.org

For continuing education questions email micmrc-requests@med.umich.edu

Visit the SIM MDHHS Summit webpage for an agenda for each location and learning objectives. Questions about Summit registration may be directed to Veralynn Klink at vklink@med.umich.edu. Other questions about the Summit may be sent to MDHHS-SIMPCMH@michigan.gov

Summit Evaluations

Did You Attend the MI SIM PCMH Initiative Summit in Gaylord or Muskegon? If yes, we would like to hear from you! Please complete the Summit evaluation by November 30, 2018 which is the date all Summit evaluations will close. If you have questions related to the evaluation, please contact micmrc-requests@med.umich.edu.

PCMH Initiative Summit/Care Coordination Collaborative 2019 Planning Committees

The SIM PCMH Initiative would like to express thanks to the 2018 Summit and Care Coordination Collaborative Planning Committee members. These members have played an integral part in ensuring the success of the 2018 Summits and of the first two meetings of the Care Coordination Collaborative—without them we would not have made the progress we have. Many thanks! These members signed on for a one-year term that will be concluding at the end of 2018 and while we hope many of them will want to continue, we also want to open the opportunity for others to become involved. Therefore, we are looking for volunteers for the 2019 Summit and 2019 Care Coordination Collaborative Planning Committees. These committees are for those who have a desire to shape the theme, speakers, locations and other essential parts of the Summit and the Care Coordination Committees. We need you! The commitment includes participating in monthly calls (usually around 1 hour, but calls may be longer/more frequent closer to events dates), following up on specific related tasks (such as reaching out to speakers or other contacts) and serving as a key contact during the events. If this is something you're interested in, please email MDHHS-SIMPCMH@michigan.gov with "Planning Committees" in the subject line for more information. Please be sure to indicate which committee you're interested in joining in the body of the email. Let's make the 2019 events the best they can be!

Care Coordination September 24th Virtual Event - Highlights

The Care Coordination Collaborative (CCC) is a series of virtual and in-person events designed by and for SIM participants and thought leaders. It is aimed at optimizing effective partnering of plans, practices, POs, community organizations and Community Health Innovation Regions (CHIRs) 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.

The September 2018 CCC Virtual Event focused on "Overcoming Challenges and Barriers in Care Coordination". Roseanne Paglia, and Drs. Stacey Bartell and Anatoly Tomchinsky, PhD from Ascension's South Lyon Medical Center shared the creative ways that they have developed partnerships among care team members to serve the biopsychosocial needs of patients. Impressively, they shared how they successfully made the case for adding new kinds of experts to the care team. They now partner faculty physicians, Family Medicine residents, and psychiatry residents with behavioral care specialists and students, Nurse Practitioners, Nurses, Care Managers, Medical Assistants, the practice manager, quality coordinator and Patient Family Advisory Committee (PFAC). They offered tips for practices who would like to expand their care team resources as well.

Maureen Braun and Andy Pritchard from Integrated Healthcare Associates described their thoughtful approach to several kinds of alternative visits (e.g., home visits, e-visits, shared medical appointments, visits at skilled nursing and extended care facilities, etc.). They explained the way that they designed and piloted the introduction of each alternative type of visit and real-life experience with implementation challenges they encountered, as well as the solutions that they used to overcome the challenges. They are real innovators in the journey to ensure that patients have access to primary care services when they need it in a way that works for them.

The national and international literature on what is known about overcoming challenges to care coordination challenges was also summarized with "take-home" lessons for Care Coordination Collaborative attendees including:

- Separating responsibility for panel (population) management from care management;
- Participating in regular team huddles;
- Deliberately focusing on good relationships with physicians and external facilities;
- Maintaining and improving motivational interviewing (MI) skill (e.g., starting a monthly call where care managers and coordinators practice role playing with each other to practice techniques for helping patients with many challenges); and
- Practicing self-care (e.g., yoga, meditation, etc.) to relieve stress and increase resiliency so practice team members have energy to partner with patients

2019 Care Coordination Collaborative In-Person Event In Planning: Make Your Voice Count

Planning is underway for the next CCC event, which will be an in-person session in April or May of 2019. We are interested in your thoughts about what you would like to see, and whether you have any suggestions for wonderful presenters. A short survey is available at 2019 In-Person Care Coordination Collaborative. If you have not done so yet, take a moment to share your thoughts and preferences.

November Audits

An audit of care management initial and longitudinal training will take place in November. Approximately fifteen practices will be randomly selected, and the provider organizations representing these practices will be contacted. Because we no longer require care management details in the quarterly reports, provider organizations will be asked to provide basic demographic information on each care manager/coordinator in the

practice. In addition, we will request the names and dates of training completed to meet both the initial training requirements and the 2018 12-hour longitudinal training requirement. In addition to the care management training audit, an audit of dashboard and patient list access will be performed. POs who do not pass the audit will be contacted. If you have questions, please contact MDHHS-SIMPCMH@michigan.gov.

PCMH Initiative Care Management Tracking Code Reminder

The PCMH Initiative would like to remind all participants of the Care Management and Coordination Tracking Code guidance provided during the March 2018 Office Hours session. During this session the Initiative outlined the tracking codes being used to calculate performance metrics and guidelines to use them. For SIM PCMH Initiative Care Management and Coordination services to be tracked within the Initiative, the following general conditions apply:

- The patient must be within the SIM PCMH Initiative Eligible Population.
  A. Patients have full Medicaid including the following benefit plans:

Included Benefit Plans:	
BMP	Benefits Monitoring Program
MA-HMP-MC	Healthy Michigan Plan – Managed Care
MA-MC	Medicaid – Managed Care
TCMF	Targeted Care Management Flint

  B. Patients must be attributed to a participating practice and provider within the SIM PCMH Initiative. A patient's eligibility can be verified on both the PCMH Patient Lists produced by the Michigan Data Collaborative monthly, or by checking the Community Health Automated Medicaid Processing System (CHAMPS).

- Services must be ordered by a Primary Care Provider within the approved practice; a note indicating these services were ordered must be in the medical record (this can be accomplished through standing orders).
- Services performed must be based on patient need.
- Service is performed by the appropriate qualified, non-physician health care professional employed or contracted with the approved practice or PO.
- Services is billed to participating Medicaid Managed Care Organizations in accordance with Medicaid billing guidelines.
- **There is no cost share (copay, coinsurance or deductible) for Care Management and Coordination services.**

All the codes used within the Initiative are for tracking purposes only, except for those associated with Care Transition (99495 and 99496) which are reimbursable services. See the 2018 Participation Guide pages 20-22 and Appendix C for further information along with the Questions and Answers resource created after the webinar. Additional information can also be found within the MDHHS Electronic Submissions Manual. If you have questions regarding Care Management and Coordination Tracking codes email MDHHS-SIMPCMH@Michigan.gov .

Upcoming Michigan Data Collaborative Deliverables

Care Coordination Report Reprocessing

In December Michigan Data Collaborative (MDC) plans to reprocess the Percentage of Patients with a Care Management Claim reports to include additional claims that MDC received after the previously-released 4Q17, 1Q18, and 2Q18 reports were generated. MDHHS, Medicaid Health Plans, and participating organizations have all made improvements that should lead to a better representation of the care management your organization has provided. We will email a notification when the updated reports are ready to download.

Aggregated Patient Reports Reprocessing

We regret to inform you that a misalignment was found in the Age Group definitions used in the SIM PCMH Aggregated Patient Reports. The correct age range for the Pediatric age group is ages 0-18, and the Adult age group starts at age 19, as outlined within page 6 and 7 of the 2018 PCMH Initiative Participation Guide. However, the 1Q18 and 2Q18 reports used a Pediatric age group of 0-17 and an Adult Age group starting at age 18. **Please note: we have verified that quarterly payments were calculated correctly using the age definitions outlined within the Participation Guide.**

MDC updated their definitions for the 3Q18 reports, which will be posted in mid-October. Additionally, they will reprocess the 1Q18 and 2Q18 reports with the updated definitions and re-post them in November.

We apologize for any confusion this misalignment has caused with your reconciliation processes. MDC will send an email notification when these reports are ready for download.

SIM PCMH Dashboard Release 7.0

MDC plans to post Release 7.0 at the end of February 2019. It will include the following:

- Paid claims through November 2018 (Medicaid data received by 12/15/18)
- A 12-month reporting period of October 2017 – September 2018
- September 2018 filtered SIM Participant File (SPF) and Provider Hierarchy data
- Add trend lines
- All measures will be re-run to account for multiple HEDIS versions and updated measure definitions

We will provide more information as we get closer to the release date.

Upcoming MDC Deliverables

- 2nd Quarter 2018 Care Coordination and Claims Detail Reports - *mid October 2018*
- October 2018 PPLs and Provider Reports - *late October 2018*
- SIM PCMH Dashboard Release 6.0 - *late October 2018*

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

Care Management Success Story

Submitted by: Alisha McCabe, LMSW, in collaboration with Jon Broek, RD and Rachel Sczepanski, Pharm D
Primary Care Practice: Flushing Road Internal Medicine and Pediatrics
Physician Organization: Professional Medical Corporation

A 50-year-old, married male was referred to the embedded Care Manager, (Nurse Practitioner) by the Primary Care Physician for symptoms of depression occurring over the last year and identified during the visit. The patient admitted to spending time in isolation and not interacting with friends and family. He did not feel motivated to socialize nor to take care of his health. He reported having multiple losses over the last two years including 2 close brothers, and his mother and father. Social Determinant of Health concerns include living in a

community that has exposure to violence, limited education, and a long history of untreated mental health issues. Other identified problems included, morbid obesity with unhealthy eating, including binge eating, and non-adherence to his diabetic care plan. At the time the patient was referred, his hemoglobin A1C was 14.1 percent. The patient was known in the office as being non-adherent. He did not always take his prescribed medication. Due to a combination of identified problems, the patient was referred by the Care Manager, to the centralized team within the practice. The centralized team includes a Behavioral Health Specialist, Pharmacist and Dietician.

To address his depression, the patient was prescribed an anti-depressant by the Primary Care Physician. The patient initially declined. The Behavioral Health Specialist began meeting with the patient regularly. Within 2-3 months the patient agreed to take medication for mood after developing trust in his Behavioral Health Specialist. Shortly after the referral, the Behavioral Health Specialist began teaching the patient meditation, calming skills, deep breathing and other relaxation techniques. The patient also began listening to music. He reported feeling the benefit of all these activities and continued practicing positive coping mechanisms. As a result, his follow up Patient Health Questionnaire-9 (PHQ) score showed that his depression was gradually improving.

The patient was able to work with the Dietician on portion control and exercise. The Pharmacist teamed with a local pharmacy to provide bubble dose packaging to help with medication adherence. This also helped the patient understand his medication regimen including the purpose of each medication. The embedded Care Manager kept the provider abreast of the patient's progress and coordinated the care plan among the multiple providers.

Goals were established with the patient by each team member and were entered in the electronic medical record within one care plan. All members of the team were able to see one another's goals and interventions. Team members addressed all goals with the patient, (i.e., the dietician included behavioral health goals when interacting with the patient). Regular communication occurred with the Primary Care Physician. Huddles were sometimes conducted with all team members participating via conference call. Within 3 months, the patent's hemoglobin A1C drastically decreased from 14.1 percent to 7.4 percent. He also adopted a healthier lifestyle which includes healthy eating habits and he no longer binge eats. His PHQ score reflects his depression improving and he reports he is socializing more with others.

Upcoming Events and Initiative Resources

MiCMRC 2018 Care Management Educational Webinars

Title: Depression and Primary Care
Date and Time: Wednesday, December 12, 2018 2-3 pm
Presenter: Sarah Fraley, LMSW
MiCMRC Project Manager
REGISTER HERE
For questions, please submit to micmrc-requests@med.umich.edu

MiCMRC Approved Self-Management Course Registration

To access the list of the Michigan Care Management Resource Center (MiCMRC) approved Self-Management Support courses. 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. Click here for "Self-Management Support Tools and Resources".

Both of these documents can also be accessed on the MiCMRC website home page http://micmrc.org/

Upcoming Complex Care Management Course Dates and 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

November 12-15, 2018 | Lansing | REGISTER HERE | Registration deadline: November 8, 2018

December 10-13, 2018 | Lansing | REGISTER HERE | Registration deadline: December 6, 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

For More Information

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