2018 SIM PCMH Initiative Quarter 1 Progress Report

Deadline for Responses: 5pm, Monday, April 30, 2018

The PCMH Initiative Quarterly Progress Report is intended to assess compliance with the SIM PCMH Participation Agreement and identify opportunities for the Initiative to support participants. The report has been divided into 3 sections.

Content includes:

1. Participant information

2. Participation requirements information, updates and attestation
   2.1 Core Primary Care (PCMH)
   2.2 Care Management and Coordination
   2.3 Health Information Technology and Exchange
   2.4 Clinical Practice Improvement Activities

3. Participation experience, strengths and challenges

Respondent Information (the person who can be contacted regarding this report)

- O Name _____
- O Phone _____
- O Email _____

Please select your organization (PO/PHO or independent practice) from the list below:

▼ AFFINIA HEALTH NETWORK LAKESHORE (44) ... WEXFORD PHO (85)

1. Participant information

An Excel document with the information needing verification has been sent to the organization's primary contact. Please review and update the excel document as appropriate and save the updated document with your organization name in the following manner "OrgName_Q1_2018" and upload in the "Participant information" section below.

There are two tabs in the file, so please make sure each spreadsheet has been reviewed and updated before submission. Below is a description of each tab:

- "Contact": This spreadsheet is aimed at capturing PO and/or practice contacts and champions changes. Please review and update the information in the spreadsheet entitled "Contact". Please note any change in a different color text or by highlighting a cell.
- "MHP": Please verify the contracting information for each of the practices in the spreadsheet entitled "MHP". Please note any change in a different color text or by highlighting a cell.

Please upload the updated participant information:

2. Participation requirements information, updates and attestation

2.1 Core Primary Care (PCMH)

Q2.1.1 Has there been any change in the PCMH designation status of your organization's participating practice(s)?

- O No
- O Yes, please describe _____

Q2.1.2 Do all of your organization's participating practice(s) provide 24/7 access to a care team practitioner?

- O Yes
- O No, we have a centralized call-center for our health system (after-hours coverage for all practices in the system)
- O No, we have a formal coverage arrangement with another organization
- O No, we do not provide 24/7 coverage. Please describe (Skip to Q 2.1.4)

_____

Q2.1.3 Is 24/7 coverage provided with real-time access to the EHR?

- O Yes
- O No, please describe _____

Q2.1.4 Do all of your organization's participating practice(s) have 30% of available appointments are reserved for same-day care across the patient population?

- O Yes
- O No, please describe _____

Q2.1.5 Do all of your organization's participating practice(s) provide at least one alternative to traditional office visits to increase access to care team and clinicians in a way that best meets the needs of the population? Alternatives include e-visits, phone visits, group visits, home visits,

alternate location visits (e.g., senior centers and assisted living centers), and/or expanded hours in early mornings, evenings, and weekends.

- O Yes
- O No, please describe _____

Q2.1.6 Use the table below to indicate what percentage of your participating practice(s) regularly offer one or more of the alternative to traditional office visits listed (can include a single practice in multiple categories, the aggregate percentage does not need to equal 100%)

	Percent of Practices Offering Service (%)
Office visits on the weekend, evening, or early morning	
Video-based conferencing (i.e., telehealth or tele-medicine)	
Medical visit over an electronic exchange (i.e., phone or, e-visit, portal).	
Group visits	
Home visits	
Visits in alternative locations (e.g., nursing facilities, urgent care centers, senior centers)	
Other, please specify	

Q2.1.7 How many of your patients who could benefit from of the following alternative approaches received it?

	None	Some	Most	All
Office visits on the weekend, evening, or early morning	O	O	O	O
Video-based conferencing (i.e., telehealth or tele-medicine)	O	O	O	O
Medical visit over an electronic exchange (i.e., phone or, e-visit, portal).	O	O	O	O
Group visits	O	O	O	O
Home visits	O	O	O	O
Visits in alternative locations (e.g., nursing facilities, urgent care centers, senior centers)	O	O	O	O
Other, please specify	O	O	O	O

Q2.1.8 Do all of your organization's participating practice(s) have planned Care Team(s) meeting at least monthly (or, alternatively, team huddles more frequently) with time dedicated to reviewing practice and panel level data from payers and internal monitoring, and use this data to guide tactics to improve care and achieve practice goals?

- O Yes
- O No, please describe _____

Q2.1.9 Do all of your organization's participating practice(s) empanel (assign responsibility for) the Practice's patient population, linking each patient to a clinician or care team?

- O Yes
- O No, please describe _____

Q2.1.10 Do your organization's participating practice(s) primarily empanel patients by practitioner (i.e., each MD, DO, PA, or NP) or by care team (i.e., practitioner-led teams)?

- O Practitioner
- O Care team

2.2 Care Management and Coordination

Q2.2.1 Is there a Care Manager and/or Care Coordinator assigned and embedded within every participating practice? Note that it does not have to be 1 FTE.

- O Yes
- O No, please describe _____

Q2.2.2 What type of clinician and staff is/are primarily responsible for each of the following care management and coordination activities, in the majority of your participating practices? (Select all the activities that apply)

	None	Primary Care Provider (i.e., MD, DO, NP, PA)	Care manager (e.g., RN, LPN, LMSW, etc.)	Care Coordinators and other clinical staff (e.g., MA/CMA, CNA, BSW, CHW, etc)	Non-clinical staff (e.g., admin, front desk)
Developing and monitoring care plans	☐	☐	☐	☐	☐
Assessing and reassessing patient risk status	☐	☐	☐	☐	☐
Providing patient education and self-management support	☐	☐	☐	☐	☐
Routine medication reconciliation at scheduled visits	☐	☐	☐	☐	☐
Medication reconciliation during transitions of care (hospital, ED discharges)	☐	☐	☐	☐	☐
Management of care transitions (hospital, ED discharges)	☐	☐	☐	☐	☐
Coordinating and communicating with specialty care	☐	☐	☐	☐	☐
Navigating patients to community and social services	☐	☐	☐	☐	☐

Q2.2.3 In the table below, please tell us how a majority of your participating practice(s) stratify patient risk and identify patients for care management. Report approximate percentages/numbers based on the end of the reporting quarter (i.e. March for Q1 2018).

Level of Risk (highest risk at the top)	Approximate Percent of patients in this tier	Number of patients in this tier under longitudinal care management	Is this tier used to target patients for care management? (Yes/No)

Q2.2.4 Indicate how the majority your organization's participating practice(s) identify patients for longitudinal care management. This refers to intensive, ongoing, relationship-based care for patients at highest risk for adverse, preventable outcomes. (Select all that apply)

- ☐ Practitioner or care team referral
- ☐ Hospital admission or discharge
- ☐ ED visit
- ☐ Skilled Nursing Facility (SNF) discharge
- ☐ New health condition (e.g., cancer diagnosis, accident, chronic condition)
- ☐ New clinical instability in a chronic condition, including change in medications
- ☐ Life event (e.g., death of spouse, financial loss)
- ☐ Initiation or stabilization on a high-risk medication (e.g., anticoagulants)
- ☐ Other, please specify _____

Q2.2.5 Indicate how the majority your organization's participating practice(s) identify patients for episodic care management. This refers to short-term, goal-directed care management for

patients who are not already in longitudinal care management as a result of their risk status. (Select all that apply)

- ☐ Practitioner or care team referral
- ☐ Hospital admission or discharge
- ☐ ED visit
- ☐ Skilled Nursing Facility (SNF) discharge
- ☐ New health condition (e.g., cancer diagnosis, accident, chronic condition)
- ☐ New clinical instability in a chronic condition, including change in medications
- ☐ Life event (e.g., death of spouse, financial loss)
- ☐ Initiation or stabilization on a high-risk medication (e.g., anticoagulants)
- ☐ Other, please specify _____

Q2.2.6 Among patients under longitudinal care management, how many have a care plan?

- O All
- O Most
- O Some
- O None

Q2.2.7 How do a majority of your organization's participating practice(s) document and store care plans?

- O Care plans are integrated within the EHR or other health IT in a discrete manner (i.e. dedicated fields, module or template, with actionable data reporting capabilities)
- O Care plans are entered within the EHR or other health IT in a static manner (i.e. scanned, open text, non-reportable fashion)
- O Care plans are documented and stored, but are not integrated with the EHR or other health IT (i.e. paper or other system)
- O Care plans are not documented or stored. Please describe _____

Q2.2.8 Who has real-time/point-of-care access to a patient's care plan in majority of your participating practice(s)? (Select all that apply)

- ☐ Members of the care team within the practice
- ☐ Clinicians outside of the practice (i.e., other specialists who care for the patient)
- ☐ Community and/or social service agencies and practitioners
- ☐ Patient and his/her caregiver(s)
- ☐ Other, please specify _____

Q2.2.9 How do your organization's participating practice(s) identify patients for self-management support? (Select all that apply)

- ☐ All patients with targeted condition
- ☐ General risk status (using the practice's risk stratification methodology
- ☐ Poorly controlled disease
- ☐ Data from a formal self-management assessment tool
- ☐ Patient or caregiver expression of interest
- ☐ Clinician referral/identification
- ☐ We do not systematically identify patients for self-management support
- ☐ Other, please specify _____

Q2.2.10 For which conditions do your organization's participating practice(s) provide condition-specific support for self-management in the last quarter? (Select all that apply)

- ☐ Cardiovascular (CHF, CAD, hypertension, Hyperlipidemia/high cholesterol)
- ☐ Respiratory/Pulmonary (Asthma, COPD)
- ☐ Mental Health (Anxiety, depression)
- ☐ Substance disorder (Alcohol misuse, opioid misuse, tobacco cessation)
- ☐ Chronic pain
- ☐ Obesity/weight loss
- ☐ Diabetes
- ☐ Other, please specify _____

Q2.2.11 How many of your organization's participating practice(s) implement each of the following aspects of self-management support to patients and caregivers?

	None	Some	Most	All
We encourage patients to choose goals that are meaningful to them	O	O	O	O
We include family/caregivers in goal-setting and care plan development	O	O	O	O
We connect or provide patients and caregivers with formal self-management support services at our practice or in the community	O	O	O	O
We measure patients' skills and progress (e.g., How's My Health, Patient Activation Measure [PAM])	O	O	O	O
Our staff are trained in specific self-management support techniques (e.g., motivational interviewing, 5 As, Teach Back, reflective listening)	O	O	O	O

2.3 Health Information Technology and Exchange

Q2.3.1 Has there been any change in the Patient Registry system used by your organization's participating practice(s) or the extent to which the registry is implemented?

- O No
- O Yes, please describe _____

Q2.3.2 Has there been any change in the electronic care management and coordination documentation tool(s) used by your organization's participating practice(s)?

- O No
- O Yes, please describe _____

Q2.3.3 Has there been any change in the Electronic Health Record (EHR) system used by your organization's participating practice(s) or the extent to which the EHR is implemented?

- O No
- O Yes, please describe _____

Q2.3.4 How do majority of your organization's participating practice(s) utilize the statewide ADT use case? (Select all that apply)

- ☐ Support medication reconciliation
- ☐ Revise care plan
- ☐ Improve post-discharge transitions
- ☐ Other, please specify _____

2.4 Clinical Practice Improvement Activities

Q2.4.1 Do all of your organization's participating practice(s) routinely screen your patients for unmet social needs?

- O Yes, we universally screen all patients for unmet social needs
- O Yes, we screen a targeted subpopulation of patients for unmet social needs
- O No, not all of our practice(s) screen patients for unmet social needs. Please specify

_____

Q2.4.2 Are screening tools or questions integrated with your EHR or health IT system?

- O Screening tool is integrated within the EHR or other health IT system in a discrete manner (i.e. dedicated fields, module or template, with actionable data reporting capabilities)
- O Screening tool is entered within the EHR or other health IT system in a static manner (i.e. scanned, open text, non-reportable fashion)
- O Screening tool is documented and stored, but is not integrated with the EHR or other health IT system (i.e. paper or other system)
- O Screening tool is not documented or stored. Please describe

_____

Q2.4.3 Which Social Determinant of Health domains has your organization seen the greatest need amongst the patient population that has been screened? (Select all that apply)

- ☐ Healthcare
- ☐ Food
- ☐ Employment/Income
- ☐ Housing/shelter
- ☐ Utilities
- ☐ Family care (e.g. children, elder care)
- ☐ Education
- ☐ Personal/environmental safety (e.g. domestic violence)
- ☐ Transportation
- ☐ Other, please specify _____

Q2.4.4 What resources does your organization rely on to support linking patients needed services in the community? (Select all that apply)

- ☐ Community Health Innovation Region (CHIR) Community Resource Inventory (Skip to Q2.4.6)
- ☐ Local Community Resource Directory (Skip to Q2.4.6)
- ☐ Michigan 2-1-1 (phone or web) (Skip to Q2.4.6)
- ☐ MI Bridges portal (Skip to Q2.4.6)
- ☐ Internally developed and maintained resource directory
- ☐ Other, please describe _____

Q2.4.5 How frequently is the inventory of social service resources being updated (this question only applies to the internally developed and maintained resource directory)?

- O Ad hoc basis only
- O Less than annually
- O Every 6-12 months
- O Every 2-6 months
- O At least monthly

Q2.4.6 Is the inventory of social service resources integrated with the EHR?

- O Yes
- O No

Q2.4.7 Has your organization identified community partners to address the following domains as identified within the brief screening tool as a part of your Clinical Community Linkage methodology? Selecting “yes” will indicate that your organization has communicated with a partner organization and agreed to a formal or informal referral relationship, and your staff/care teams understand the partner organization services.

	Yes	Partnership explored, resource not available in the community	Partnership explored, resource at capacity	Need for partnership not identified by our patient population
Healthcare	0	0	0	0
Food	0	0	0	0
Employment/Income	0	0	0	0
Housing/Shelter	0	0	0	0
Utilities	0	0	0	0
Family Care	0	0	0	0
Education	0	0	0	0
Personal Environmental Safety	0	0	0	0
Transportation	0	0	0	0
Other, please specify	0	0	0	0
Other, please specify	0	0	0	0

Q2.4.8 (For those in CHIR Regions) Provide a brief summary of how your organization has collaborated with Community Health Innovation Region partners over this reporting period (January 2018 – March 2018).

Note that CHIR Partners could include: CHIR backbone, CHIR governance or committees, other community partners involved in the development and implementation of shared community processes

Q2.4.9 How frequently does your organization review MDC dashboard/reports?

- O At least monthly
- O At least quarterly
- O We do not regularly review this data

Q2.4.10 How helpful are the following types of data (listed below) in quality improvement or population health work at your organization's participating practice(s)? (Rate from 1-5, with 5 being the most helpful and 1 being not helpful at all)

	1	2	3	4	5
Electronic clinical quality measures (eCQMs)	0	0	0	0	0
Claims data feedback from CMS	0	0	0	0	0
Claims data feedback from other payers	0	0	0	0	0
Patient experience data	0	0	0	0	0
Patient-Reported Outcome Measures (PROMs)	0	0	0	0	0
Multi-payer data from Health Information Exchange (HIE), all payer claims databases (APCD), or other data aggregator	0	0	0	0	0
Public health data from county or state government	0	0	0	0	0
Internal practice or system data	0	0	0	0	0
Internal EHR	0	0	0	0	0
Internal patient registry reports	0	0	0	0	0
Other, please specify	0	0	0	0	0

3. Participation Experience, Strengths and Challenges When responding to the following questions, please consider the reporting timeframe of January 1, 2018 – March 31, 2018.

Q3.1 Does your organization have any outstanding challenges with the submission of care management/care coordination service codes?

- O No
- O Yes, please describe _____

Q3.2 Does your organization have any outstanding challenges in submitting required files for the statewide Health Information Exchange (HIE) use cases?

- O No
- O Yes, please describe _____

Q3.3 Does your organization have any outstanding challenges in staffing up and training care managers and/or care coordinators?

- O No
- O Yes, please describe _____

Q3.4 What changes has your organization undergone as a result of participation in the SIM PCMH Initiative?

_____

_____

Q3.5 How has the SIM PCMH Initiative payment model (the Per Member Per Month payment structure) supported your organization in achieving specific transformation goals beyond Patient Centered Medical Home recognition and maintenance?

_____

_____