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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 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](mailto:MDHHS-SIMPCMH@michigan.gov)

## Links

[SIM Initiative website](#)

[SIM Care Delivery webpage](#)

[SIM Population Health webpage](#)

Welcome to the final edition of the 2019 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](#).

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## Program News and Updates

### Semi-annual Practice Transformation Report

The Semi-annual Practice Transformation Report will be released December 16th with a submission deadline of Wednesday, January 15, 2020 by 5:00pm. The link to the electronic submission will be distributed to your organization's key contact. You can preview the requirements to complete the report in the downloadable template found on the first page of the report. If you have any questions, please email the PCMH Initiative Team at [MDHHS-SIMPCMH@michigan.gov](mailto:MDHHS-SIMPCMH@michigan.gov).

### Care Management Training Audit

The final care management initial and longitudinal training audit will occur in late November/early December. If a practice is selected for audit, provider organizations will be asked to provide certificates for trainings for all care managers and care coordinators that serve the practice. Requirements can be found in the 2019 [Participation Guide](#). If you have any questions, please contact the PCMH Initiative Team at [MDHHS-SIMPCMH@michigan.gov](mailto:MDHHS-SIMPCMH@michigan.gov).

### Upcoming Michigan Data Collaborative Deliverables

Michigan Data Collaborative (MDC) plans to release the following deliverables in the coming weeks:

- November 2019 PCMH Patient Lists and Provider Reports – late November
- True-Up Care Coordination and Claims Detail Reports – early December
  - MDC will reprocess the 4Q18, 1Q19, and 2Q19 reports at the end of the year to include any claims received after the original reports were generated.
  - The SIM PCMH team calculates the final percentage by summing the numerators for the three quarters and averaging the population in the denominator.

- June 2019 – August 2019 Care Coordination and Claims Detail Reports – mid December
- December 2019 PCMH Patient Lists and Provider Reports – late December

**Note:** If applicable, the following data will be removed from the Care Coordination reports:

- Retroactive providers and associated beneficiaries
- Beneficiaries who died in 2018
- October, November, and December 2018 beneficiaries that were incarcerated, deceased, or in a skilled nursing facility (these will be applied during End of Year Reprocessing)

You can view an up-to-date list of upcoming deliverables on the [SIM PCMH page](#) of the [MDC Website](#).

### **December Office Hour: Project Close Out**

Our last SIM PCMH Initiative office hour will be held on December 19 from 1:00-2:00 p.m. The SIM PCMH Initiative team will walk through close out procedures and next steps related to: final payments, final reporting, post-project communication pathways, data destruction guidelines, and SIM evaluation results and sharing. We strongly urge you to hold time on your calendars to participate so you are able to ask questions during the webinar. If you are unavailable, we encourage you to review the recording afterwards. Each participant will be responsible for following all close out procedures at the conclusion of the demonstration period. We anticipate providing various reminders about close out activities in addition to this webinar. Reserve your spot and [REGISTER HERE](#).

### **IMPORTANT UPDATE: One-time Funding Opportunities**

It was reported during the October Quarterly Update Webinar that MDHHS was working with CMS to pursue potential one-time funding opportunities for PCMH practices and Physician Organizations within the final SIM program period. Applications for Capacity Building: Clinical-Community Linkages Data Sharing and Practice Transformation: Behavioral Health Integration were anticipated to open in November. CMS subsequently denied funding for these opportunities and therefore both application processes have been discontinued.

### **2019 SIM Summit Highlights: Capturing Key Lessons for the Future and Continuing Best Practices**

On November 12<sup>th</sup>, over 250 SIM participants gathered in Lansing for the capstone annual summit of the initiative. Achievements made possible through the SIM were celebrated, including fewer emergency department and preventable emergency department visits, increased cervical cancer screenings, and substantial improvements in the breadth and robustness of social determinant of health screening in Michigan primary care practices.

Dr. Stacey Bartell from Ascension delivered the plenary keynote address and provided valuable lessons and practical tips for enhancing team-based care and organizational effectiveness. She shared the population health tools she has found most useful and the approaches used in her practices in the SIM demonstration to creatively make the most of resources to successfully sustain whole-person care.

Dr. Jill Rinehart from the University of Vermont Children's Hospital, who was an architect of the patient-centered pediatric model in Vermont, was a special speaker at the Summit. Her experience in pediatric practice, and patient and family engagement compelled audience members.

In addition:

- Morning breakout sessions featured ways that community organizations have partnered with practices to better serve patients, how to move beyond measuring social determinants of care needs toward utilizing findings to address and fill gaps, and how we can better connect to patients and caregivers.
- Afternoon breakouts provided a look at progress in SIM evaluation and its effect in our state, recognizing

and constructively helping patients to deal with adverse childhood events through building resiliency, and working with depression in our youth.

- Ways that the State is supporting the continuation of best practices throughout SIM practices and beyond.
- Briefings from Medicaid Managed Health Plans in Michigan about their forward planning for 2020 and the opportunities for practices to build on the good work of the SIM PCMH Initiative.

Our SIM Care Delivery Summit webpage has links to the full day's [slides](#) and the [post-summit evaluation](#).

### **Webinar Opportunity Presented by Health Leads**

Health Leads is hosting a 60-minute webinar titled: Merging Parallel Tracks: Integrating Behavioral Health and Social Health to Provide Whole-Person Care. This webinar will discuss opportunities for alignment between behavioral health and social health integration to reduce fragmentation in primary care transformation. Three leaders in primary care will share strategies and personal examples of how they have transformed their own practice care models to meet the needs of their patients. To register and learn more, [click here](#).

### **Success Story**

#### **Care Management Success Story**

Submitted by: Great Lakes Physicians Organization

An adult male arrived for a visit at his primary care practice and met with the Care Manager (CM). He let the CM know that he had been homeless since January 2019. They discussed areas the patient felt would be helpful to address related to being homeless.

He had been living in his car during the coldest part of the year and staying with friends off and on. Some nights the temperature would drop below zero degrees. He was only eating one meal per day from the dollar menu at fast food restaurants as that was all he could afford. He had been diligent with taking his medications, including his insulin, while not eating properly. The cost of medications did not leave him much money for food. He was doing laundry and personal care in public restrooms and at a friend's house when he was able to stay there. His relationship with nearby family was strained and he was unable to seek assistance from them.

Together the CM and patient discussed the patient's identified needs the areas he would like to address. The CM provided him with resources to a local soup kitchen, local food banks, nearby emergency housing, and personal care and clothing banks. He agreed to enroll in the local farmer's market nutrition program that provided \$10 in coupons to the farmer's market for each class he attended.

He spoke with a friend, acknowledged all of his issues and provided her with the same resource information we provided him. She agreed to let him live with her. According to the patient, she was also struggling with food and personal care items and stated that they have both benefited from the provided resources. He now lives near a local soup kitchen that is open for breakfast and lunch and provides boxed meals to cover evening meal needs. The soup kitchen also provides him with a large box of non-perishable foods on Tuesdays with no questions asked. The box is available to anyone.

He has been attending the farmer's market program and is purchasing fresh food weekly. He has visited the local food banks to receive assistance. He has contacted resources regarding personal care and was provided with needed items such as shampoo, soap, and bedding for his new room at his friend's house where he is currently staying. He went to the clothing bank and was able to get better clothing than he had as well as a voucher to a local store for a new pair of blue jeans and 3 new shirts. He also received emergency housing information. So far he has not needed the emergency housing information, since his current arrangement is working well for him and his friend.

A follow up phone call was conducted 1 week after the initial meeting. He stated that he was glad that he told the CM he was homeless, although he was worried about the reaction/stigma. The CM continued with follow up phone calls every other week for 6 weeks. According to the patient, all needs are being met at this time. He told the CM that she “fixed him” and he could not be happier with everything in his life now. He has a 2 month follow up appointment scheduled and the CM will reassess for any further needs or resources he may require.

## [Upcoming Events and Initiative Resources](#)

### **MICMT Self-Management Support Course Registration**

The Michigan Care Management Transformation (MICMT) Self-Management Support course is designed to prepare the healthcare professional in providing self- management support to patients in the primary care and specialty care physician offices.

Course content is applicable to all Care Management team members and healthcare professionals in the ambulatory care setting, working with patients. The MICMT Self-Management Support curriculum prepares healthcare professionals on how to talk with patients about their health using motivational interviewing as they assist patients with health-related goals.

### **Upcoming SMS course dates and course registration:**

December 5 | Dimondale | [REGISTER HERE](#) | Registration deadline: November 27, 2019

To view additional MICMT SMS course dates/locations, click [HERE](#). For questions, please contact: [micmt-requests@med.umich.edu](mailto:micmt-requests@med.umich.edu)

### **Upcoming Complex Care Management Course Dates and Registration**

The MICMT 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 and health care professionals in the ambulatory care setting, working with complex patients. Please note, this course has been updated and the new format consists of self-study modules and a 1-day in person training. For CCM Course details [click here](#).

### **Upcoming CCM course dates and course registration:**

December 9 | Dimondale | [REGISTER HERE](#) | Registration deadline: December 2, 2019

For questions please contact: [MiCMRC-ccm-course@med.umich.edu](mailto:MiCMRC-ccm-course@med.umich.edu)

**For More Information**

[Michigan.gov/SIM](https://Michigan.gov/SIM) | [MDHHS-SIMPCMH@michigan.gov](mailto:MDHHS-SIMPCMH@michigan.gov)

