SIM PCMH Initiative Newsletter

A publication of Michigan's State Innovation Model

February 2019

In this Issue

- Program News and Updates
- Upcoming Events and Initiative Resources

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

Links

SIM Initiative website

SIM Care Delivery webpage

SIM Population Health webpage

Welcome to 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.

Program News and Updates

2019 PCMH Initiative Agreement Process—Update

The 2019 PCMH Initiative Agreements are currently under MDHHS legal review. The MDHHS Bureau of Purchasing will email the 2019 Agreements for signature to the key contact and signatory authority will be listed on the Intent to Continue Participation application (copied the organization's key contact). Agreements must be signed and returned via email to the Bureau of Purchasing (MDHHS-BOP-MOU@michigan.gov). If you do not receive an agreement, but were expecting one, or if you have any questions regarding the process or Agreement itself, please email the PCMH Initiative team at MDHHS-SIMPCMH@michigan.gov with the subject line "2019 Agreement [organization name]".

PCMH Initiative Evaluation—Patient Experience Survey

Child Health Evaluation and Research Center (CHEAR), who is contracted to conduct the Patient Experience Survey for the PCMH Initiative, completed the first round of mailed surveys to clients served within PCMH Initiative practices. The patient sample included 3,345 patients (from an eligible population of approximately 18,000) whose claims indicated a visit to a PCMH Initiative Provider from mid-September to end of October 2018. These surveys are currently being collected and analyzed. As part of the survey, patients may indicate a desire to participate in a more extensive phone survey to further assess the service they received and if they have been connected to community resources. Special thanks to those who participated in our webinar last summer to provide feedback on the survey. Please stay tuned for more information regarding the results and next steps. If you have questions or would like further information regarding the Patient Experience Survey, please email the PCMH Initiative team at MDHHS-SIMPCMH@michigan.gov with the subject line "Patient Experience Survey".

MPHI Evaluation Update

The Michigan Public Health Institute (MPHI) has finalized both the Clinical-Community Linkage (CCL) Provider Survey Report and Care Management/Care Coordination (CM/CC) Patient Profile Report. MDHHS leadership and PCMH Initiative stakeholders have been provided the opportunity to offer feedback on each report via the December Office Hour Session on evaluation. The PCMH Initiative released the Provider Survey via the listserv on January 15, 2019. If you would like to review the report but didn't receive it, please email the listserv at MDHHS-SIMPCMH@Michigan.gov. MPHI is also working to produce a final Care Management/Care Coordination report by the end of January that will be disseminated to stakeholders.

Throughout the end of December and the beginning of January, MPHI worked with MDHHS to host several office hour sessions to discuss the CCL Provider Survey and the Individual Level CCL Data Submission process with those PCMH Initiative participants that volunteered their data for the pilot test. MPHI utilized these sessions to answer questions from participants regarding their CCL data collection efforts. MPHI has received test file submissions from participating physician organizations and has provided feedback on those files to better align their reporting format with Individual Level CCL Data Submission framework. Please stay tuned for updates regarding this project in upcoming Newsletters.

2019 SIM PCMH Initiative Pediatric Curriculum Planning Work Group

The SIM PCMH Initiative is supporting a Pediatric Curriculum Work Group to inform Office Hours opportunities, as well as seeking input for Summit sessions and educational topics for 2019. This group will meet periodically to discuss topics, offer speaker suggestions and champion pediatric efforts within the Initiative. To date the work group participants, include: Nancy Robinson (Integrated Health Associates), Tiffany Turner (Huron Valley Physicians Association), Lynn Bryant (Adaptive Counseling), Marie Beisel (Michigan Institute for Care Management and Transformation), Betty Rakowski (Michigan Institute for Care Management and Transformation), Laura Kilfoyle (MDHHS). Work Group progress will be reported within future Newsletters and events will be posted as scheduled.

SIM Care Delivery Planning Groups

Incorporating the perspective and expertise of participating organizations into the curriculum and planning of SIM Care Delivery programming is key to ensuring that resources, training and support provided by SIM is useful to participants. Continuing the tradition begun in 2018 of planning groups for Care Coordination Collaborative (CCC) and Summit, a call for interested members of each group (new and continuing) was issued and we are pleased to announce the following participating representatives as planning group members for the 2019 work:

Care Coordination Collaborative (CCC) Event Planning Group Members

- Gail Warner (Affinia Health Network Lakeshore)
- Samantha Krause (Genesys)
- Jen Berube (Integrated Health Associates)
- Katie Damon (Northern Physicians Organization)
- Cherie Bostwick (Northern Physicians Organization)
- Debbie Shaefer (Spectrum Health Medical Group)
- Michelle Barber (MHC)
- Kerrie Barney (Cherry Health)
- Stacey Bartell (Ascension)
- Ruth Crane (Alcona Health)
- Natalie Harter(Northern Pines)
- Lori Kunkel (Greater Flint Health Coalition)
- Anne Levandoski (UPHP)
- Shannon Lijewski (Everyday Life Consulting LLC & Rural CHW Network)

- Lori Lynn (Metro Health Integrated Network)
- Erica Ross (MedNetOne)
- Shannon Saksewski (Aetna)
- Theresa Landfair (MDHHS)
- Diane Marriott (University of Michigan)
- Marie Beisel (University of Michigan)
- Laura Kilfoyle (MDHHS)
- Lyndsay Tyler (Michigan Public Health Institute)

Summit Planning Group Members

- Roseanne Paglia (St. John Providence Partners in Care)
- Kristin Jervis (Jackson Health Network)
- Leah Corneail (Michigan Medicine)
- Laurisa Cummings (Children's Medical Group of Saginaw Bay)
- Lisa Nicolaou (Northern Physicians Organization)
- Beth Oberhaus (WEXFORD PHO)
- Laura Stuursma (Spectrum Health)
- Diane Marriott (University of Michigan)
- Marie Beisel (University of Michigan)
- Laura Kilfoyle (MDHHS)
- Lyndsay Tyler (Michigan Public Health Institute)

We look forward to working with each group on 2019 SIM Care Delivery program planning and thank the members for their expertise and time.

February Office Hour: SIM Community Health Innovation Region Updates

We are excited to announce that for our next office hour session we will be bringing together our MDHHS Community Health Innovation Region (CHIR) team to provide updates on the latest CHIR activities and events. If you'd like to find out more about our CHIR partners this will be an exciting opportunity to ask questions and learn how you can further align your SIM-related work! Make sure to reserve your spot on February 13 from 12-1pm by registering HERE.

"Move Your Way": A Physical Activity Campaign from U.S. Department of Health and Human Services

Physical activity is an important component of staying healthy for everyone but is especially important in the health care plan of patients diagnosed with pre-diabetes. "Move Your Way" is a physical activity campaign from the U.S. Department of Health and Human Services to promote the recommendations from the Physical Activity Guidelines for Americans, and is based on the second edition of the Physical Activity Guidelines for Americans. This campaign seeks to help individuals with busy schedules realize the health benefits of physical activity, and to emphasize that no matter who you are, you can find safe, fun ways to get and stay active.

The Move Your Way campaign provides tools, videos, and fact sheets on tips that make it easier to get a little more active. These tools and resources are for both adults, and for parents to help their children get moving. For both adults and children, this resource starts out discussing how physical activity can make daily life better, how much activity is needed, and then provides an interactive tool to build a weekly activity plan when the patient is ready to get started.

To access these tools and resources, and for more details please access https://health.gov/moveyourway/

Implementing Optimal Team-Based Care to Reduce Clinician Burnout: Article Review

A team is a group of individuals who coordinate their actions for a common purpose, which in health care is the prevention or treatment of disease and the promotion of health. [1] More specifically, this article defines team-based health care as the provision of care by two or more health clinicians who work collaboratively with patients and their caregivers to accomplish shared goals. [2]

The authors discuss evidence that points to how team-based care provides an opportunity to achieve key aims of high-quality health care. This is especially urgent due to the increasingly fragmented and complex health care landscape, and in light of the shift from fee-for-service (FFS) payment to value-based payment models. The evidence that connects optimal teamwork and improved patient outcomes is promising and includes studies in various settings, including ambulatory care. For example, a 2015 review of 52 studies of team-based care for hypertension found that teams achieved controlled blood pressure in 12 percent more patients than routine care did.[6] While the relationship between team-based care and clinician burnout is not as well defined in the literature, existing evidence shows an overall positive association, and high-performing teams may act as a resource to support clinicians in providing safe patient care. Successful team-based care has the potential to improve patient outcomes, the efficiency of care, and the satisfaction and well-being of clinicians.[1]

While effective health care teams may vary in their composition, involving a wide range of team members in various settings, they all possess key features that make them successful. These include shared team identity, values, and goals; leadership; defined and complementary roles; continuity and regular meetings; adequate staffing; shared physical space; psychological safety; open communication, mutual respect and trust; effective help among team members; constructive conflict resolution; task sharing and shifting; team coordination; measurable processes and outcomes; and observation and feedback to promote the function and well-being of the team and its members. [3,4]

Finally, this article discusses teamwork barriers and explores opportunities to overcoming barriers to the implementation of teamwork in health care. They suggest the use of digital health information technology to support more efficient documentation, standardized communication and workflows, and non-geographically located virtual teams. Process improvement methods may identify opportunities to redeploy resources in promotion of team-based care. Team members can be trained in new skills that may add capacity to the existing team. Additionally, the authors support team training and coaching as a means for investing in the continuous professional development of clinicians, keeping them engaged and practicing at the top of their licenses.[1,5]

In conclusion, there is strong evidence that high-functioning teams have tremendous potential to promote clinician well-being and improve patient outcomes.

References

1. Smith, C.D., C . Balatbat, S. Corbridge, A.L. Dopp, J. Fried, R. Harter, S. Landefeld, C. Martin, F. Opelka, L. Sandy, L. Sato, and C. Sinsky. 2018. Implementing optimal team based care to reduce clinician burnout. *NAM Perspectives*. Discussion Paper, National Academy of Medicine, Washington DC.
2. Naylor, M.D. K.D. Coburn, E.T. Kurtzman, J.P. Bettger, H.G. Buck, J.V. Cleave, and C.A. Cott. 2010. *Inter-professional tean-based care for chronically ill adults: State of the science*. Unpublished white papter presented at the ABIM Foundation Meeting to Advance Team-Based Care for the Chronically Ill in Ambulatory Setting, Philadelphia, PA.
3. Gordon, S., D.L. Feldman, and M. Leonard. 2014. *Collaborative caring: Stories and reflections on teamwork in health care*. Ithaca, NY: Cornell University Press.
4. Mitchell, P., M. Wynia, R. Golden, B. McNellis, S. Okun, C.E. Webb, V. Rohrbach, and I.V. Kohorn. 2012. Core principles and values of effective team-based health care. Discussion Paper, Institute of Medicine, Washington DC.

5. Cromp, D., C. Hsu, K. Coleman, P.A. Fishman, D.T. Liss, K. Ehrlich, E. Johnson, T.R. Ross, C. Trescott, B. Trehearne, and R.J. Reid. 2015. Barriers and facilitators to team-based care in the context of primary care transformation. *Journal of Ambulatory Care Management* 38(2):125-133.
6. Njie, G. J., K. K. Proia, A. B. Thota, R. K. C. Thota, D. P.Hopkins, S. M. Banks, D. B. Callahan, N. P. Pronk, K.J. Rask, D. T. Lackland, T. E. Kottke, and Community Preventive Services Task Force. 2015. Clinical decision support systems and prevention: A community guide cardiovascular disease systematic review. American Journal of Preventive Medicine 49(5):784-795.

Michigan Data Collaborative Updates

Updated Reporting Schedule for Care Coordination & Detail Reports

Starting in January 2019, the *Care Coordination* and *Claims Detail* reports will be posted each month with a rolling quarter timeframe. These reports will replace the previous single month and quarter reports. Each month's report will include the most recent three months of available data to better capture a bigger picture of care coordination services for your population. The January 2019 report's rolling quarter matches up with 3rd Quarter 2018 (includes data from July, August, and September 2018). For more information about these reports see the Care Coordination Reports Reference document on the MDC Website.

SIM PCMH Dashboard Release 7.0

Michigan Data Collaborative 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 December 15, 2018)
- A 12-month reporting period of October 2017 – September 2018
- September 2018 filtered SIM Participant File (SPF) and Provider Hierarchy data
- Trend lines
- All measures will be re-run to account for multiple HEDIS versions, updated measure definitions, and to include measure results for all measures in each release

We will provide more information at the time of the release.

Upcoming MDC Deliverables

- January 2019 PCMH Patient Lists and Provider Reports – late January 2019
- Aug – Oct 2018 Care Coordination and Claims Detail Reports – late January 2019
- SIM PCMH Dashboard Release 7.0 – late February 2019

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

Upcoming Events and Initiative Resources

Michigan Care Management Resource Center 2018 Care Management Educational Webinars

Title: 5 Steps to Help Patients Prevent Type 2 Diabetes
Date and Time: Wednesday, February 27, 2019 from 2-3 p.m.
Presenter: Tamah Gustafson, MPH, CHES
Public Health Consultant
Diabetes and Kidney Disease Unit
Michigan Department of Health and Human Services
REGISTER HERE

Title: Identifying and Addressing Anxiety in Primary Care
Date and Time: Wednesday, March 27, 2019 at 2 p.m.
Presenter: Teague Simoncic, LMSW
Behavioral Health Care Manager Preceptor, IHA
REGISTER HERE

Michigan Care Management Resource Center Approved Self-Management Course Registration

To access the list of the Michigan Care Management Resource Center (Michigan Care Management Resource Center) approved Self-Management Support courses. The list provides a detailed summary of each course, with associated objectives, location, cost and more.

Additionally, Michigan Care Management Resource Center has collected resources for Self-Management Support including: websites of interest, publications, tools, videos, and even patient materials. Michigan Care Management Resource Center'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 Michigan Care Management Resource Center website.

Upcoming Complex Care Management Course Dates and Registration

The Michigan Care Management Resource Center 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.

February 25-28, 2019 | Lansing | REGISTER HERE | Registration deadline: February 21, 2019

March 11-14, 2019 | Dimondale | REGISTER HERE | Registration deadline: March 7, 2019

NOTES: If you have 15 or more Care Managers in your area and would like the Michigan Care Management Resource Center 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