2019 PCMH Initiative Participation Guide

September 13, 2019

Special Note: This guide is an iterative document which will be added to and amended as the PCMH Initiative continues implementation. The Department strongly encourages users to access this guide and associated materials through the SIM PCMH Care Delivery website rather than downloading and/or printing local copies to ensure that the most up-to-date information is always used.

State of Michigan
Department of Health and Human Services

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Introduction

This guide was written to support Physician Organizations (POs) and Practices who are participating in the 2019 State Innovation Model (SIM) Patient Centered Medical Home (PCMH) Initiative. State Innovation Models are Centers for Medicare and Medicaid Services (CMS) initiatives awarded to states to provide financial and technical support to states for the development and testing of state-led, multi-payer health care payment and service delivery models that will improve health system performance, increase quality of care, and decrease costs for Medicare, Medicaid and Children's Health Insurance Program (CHIP) beneficiaries—and for all residents of participating states.

Reinventing Michigan's health care system is one of the State's top priorities. The ambitious vision is shared by individuals and organizations across the State who desire to both improve the health of all Michiganders and have a health care system that provides better quality and experience at lower cost.

The Patient Centered Medical Home (PCMH) Initiative is the core component of the SIM strategy for coordinated care delivery, focusing on the development and testing service delivery models in order to achieve better care coordination, lower costs, and improved health outcomes for Michiganders. This focus is aligned with the overall SIM Care Delivery goals of:

1. Create a Sustainable PCMH Model – Implement payment models that provide meaningful incentives to Primary Care Providers for advancing health outcomes and delivery system transformation through public/private Payer and Practice collaborations to improve health care value and transform primary care in ways that are sustainable and can be replicated statewide.

2. Improve Quality and Outcomes – Maintain and expand measurable improvements in quality of care, total cost of care, and patient satisfaction through continuous quality improvement of participating PCMH Practices.

3. Lower Overall Health Care Costs – Reduce unnecessary or avoidable costs through the timely and effective transformation of care delivery by the PCMH Practice and stronger coordination of care in other settings.

Initiative Operations

To ensure continuity in the 2019 PCMH Initiative, a set of operational requirements were defined in the 2019 Participation Agreement. These requirements support daily functions across the initiative and facilitate regular data maintenance, participant monitoring and compliance, and information sharing.

Participation Agreements

The PCMH Initiative legal parameters, program requirements, attribution model, and payment model details have been outlined within the 2019 PCMH Initiative Participation Agreement. The PCMH Initiative has developed two versions of the Participation Agreement, designed to support the various ways participants are engaging in this program. While the Initiative is designed for individual practice transformation, each participating practice has the ability to choose if they will engage in the Initiative independently or via a Physician Organization/Physician Hospital Organization (PO/PHO). Therefore, there is both a PO Participation Agreement which is signed by the PO/PHO on behalf of all participating practices in their membership, and a Practice Agreement for individual practices participating without a PO/PHO. Throughout this guide the 2019 agreement is referenced, for continuity it is linked to the PO version of the agreement, although the practice agreement is also available on the MDHHS SIM Care Delivery website.

Amendments to Participation Agreement

Amendments to the Participation Agreement may take place if a participating practice or PO/PHO undergoes any legal name changes, chooses to leave the PCMH Initiative, or is terminated from the Initiative in accordance to the circumstances outlined within the executed agreement.

To amend an agreement for practice or PO/PHO legal name changes or if a practice is choosing to leave the Initiative, the participant should communicate with the Initiative team by completing the online change form. Michigan Department of Health and Human Services may also choose to amend the Participation Agreement at its sole discretion.

Initiative Payment Model

Participating payers in the 2019 PCMH Initiative include 11 Michigan Medicaid Health Plans (managed care organizations). Payment for SIM PCMH Initiative beneficiaries attributed to practices will be provided to the participant (the entity that signed the Participation Agreement; PO or practice) via the Michigan Data Collaborative SIM PCMH portal, which is limited to currently participating payers.

Participants will receive payments for attributed eligible Medicaid beneficiaries; these payments will be made directly by each applicable MHP on a quarterly basis. Please note: if an individual has a birthdate of 1/28/1999, they will be considered an adult on the January 2019 PCMH Patient List, and for the purposes of Initiative payment.

PCMH Initiative participants will receive two types of payments:

1. The Care Management and Coordination: PCMH Initiative

Participants will receive a care management and coordination payment to support embedded care coordination services as a PMPM rate according to their performance during the 4Q17-2Q18 performance period:

a. Participants that met the required 2.5% benchmark for the defined performance period will receive PMPM rates of:
    1. Adult Beneficiaries (19 years and above)
        a. $3.00 for Adult General Low Income Beneficiaries (TANF)
        b. $5.00 for Healthy Michigan Plan Beneficiaries (HMP)
        c. $7.00 for Aged, Blind and Disabled Beneficiaries (ABD)
    2. Pediatric Beneficiaries (18 years and under)
        a. $2.75 for Pediatric General Low Income Beneficiaries (TANF)
        b. $7.00 for Aged, Blind and Disabled Beneficiaries (ABD)
b. Participants that fell below the required 2.5% benchmark for the defined performance period will be subject to a Care Management Improvement Reserve that will adjust their 2019 PMPM rates as outlined below:
    1. Adult Beneficiaries (19 years and above)
        a. $2.85 for Adult General Low Income Beneficiaries (TANF)
        b. $4.85 for Healthy Michigan Plan Beneficiaries (HMP)
        c. $6.85 for Aged, Blind and Disabled Beneficiaries (ABD)
    2. Pediatric Beneficiaries (18 years and under)
        a. $2.60 for Pediatric General Low Income Beneficiaries (TANF)
        b. $6.85 for Aged, Blind and Disabled Beneficiaries (ABD)

Participants are required to fulfill requirements in order to maintain their payment and will have the opportunity to have their withheld amount returned. See Care Management and Coordination Benchmark for more details.

2. Performance Incentive Plan (PIP) PCMH Initiative Participants may receive a year end performance incentive payment relative to their performance on Initiative defined benchmarks for a specified set of quality and utilization measures outlined.
    a. Base Incentive Payment: Participants will receive a base incentive payment when their performance is at or above the initiative defined benchmarks for the measures for which they are eligible.
        i. The maximum base incentive payment to any organization

would be calculated at a rate of $21.00 per member across the average membership for the 2019 participation year.

ii. The base incentive earned by a participating organization would be adjusted based on the number of measures for which they meet the minimum volume criteria (denominator), and the portion of these for which they exceed the measure benchmark (numerator).

b. Bonus Incentive Payment: Participants will receive a bonus incentive payment when their performance meets or exceeds the defined benchmark on 75% or more of the measures for which they are eligible.

i. Funds remaining in the incentive pool following the calculation of the base incentive payments will be used to generate the bonus incentive payments.

ii. Total funds left in the incentive pool will be divided among all organizations that reached the 75% or above on their performance score based on the number of attributed SIM PCMH Initiative beneficiaries in each organization over the participation year.

Even though Medicaid funding is structured as a PMPM, practices are required to submit care management and coordination G and CPT tracking codes to provide insight into the type and intensity of Medicaid member services. Additionally, participating practices are required to maintain specific benchmarks for the two Care Management and Coordination benchmarks within the 2019 Participation Agreement in order to maintain consistent payment of the PMPM without potential for payment sanctions.

PCMH Practice and Provider Participation Updates

An accurate list of participating practices and providers is essential to the PCMH Initiative attribution and payment process. Attribution is run monthly and incorporates updates submitted by POs and practices in the previous month. Updates can be made to the following fields:

a. Practice participation status, name, TIN, practice address, billing address, phone number
b. Provider participation status, name and NPI
c. PO name, TIN, billing address

Changes can be made using the online Provider and Practice Change Form.

Multiple changes can be submitted at once by submitting a form at the above link and uploading an excel document with changes highlighted.

The Initiative requires participating organizations to update changes on a rolling basis. In general, changes submitted by the 25th of the month will be incorporated in the patient attribution the following month. For example, if updates are submitted via the online change form on January 23rd, changes will go into effect on February 1st. To verify that changes have been incorporated, a snapshot of the practice and provider data will be sent every quarter. In the future, this step may be replaced with a similar snapshot uploaded monthly to the SIM Initiative dashboards. As a reminder participants must inform the PCMH Initiative of any changes in accordance with the 2019 Participation Agreement.

Questions regarding PO, practice, or provider changes can be sent to the PCMH Initiative mailbox at MDHHS-SIMPCMH@michigan.gov.

Please note that changes sent to SIM PCMH Initiative are for Initiative purposes only and cannot be used to communicate changes directly to the Medicaid Health Plans.

Core Primary Care (PCMH)

The 2019 PCMH Initiative Participation Agreement outlines six (6) Core Primary Care Requirements for all participating practices. Please reference the 2019 Agreement to understand more about these requirements, which have been selected to align with many Patient Centered Medical Home accreditation/designation requirements, and compliment other current initiatives, demonstrations, or programs participants may be a part of. One of the requirements does allow the submission of an Alternative Consideration with the return of the signed 2019 PCMH Initiative Participation Agreement.

Clinical Practice Improvement Activities

Practice Transformation Objectives

All SIM PCMH Initiative practices must fulfill the **Clinical-Community Linkages** and **Population Health Management** practice transformation requirements. While both practice transformation elements are required for all participants, the Clinical-Community Linkage requirement particularly will support the continued development of synergies with Community Health Innovation Regions (CHIR) for those practices in SIM regions, which will foster relationships between primary care practices and the community.

Clinical-Community Linkages

The Clinical-Community Linkages requirement can be satisfied by maintaining documented partnerships between a Practice (or PO on behalf of multiple Practices) and community-based organizations (such as a CHIR hub, or community case management organizations) which provide services and resources that address

significant socioeconomic needs of the practice's population. Refer to the 2019 SIM PCMH Initiative Participation Agreement for the Clinical-Community Linkage required elements of the for all participants, however the general elements are described in the process below:

Assess Patients' Social Need:

Assess patients' social needs to better understand socioeconomic barriers using a brief screening tool with all attributed patients (all patients within the practice).

The purpose of screening is to determine whether an individual needs further assessment. The purpose of assessment is to gather the detailed information needed for a treatment plan that meets the individual needs of the patient/client. Many standardized instruments and interview protocols are available to help perform appropriate screening and assessment of patients/clients.

Screening involves asking questions carefully designed to determine whether a more thorough evaluation for a particular problem or disorder is warranted. Many screening instruments require little or no special training to administer. Screening differs from assessment in the following ways:

- *Screening* is a process for evaluating the possible presence of a particular problem. The outcome is normally a simple yes or no.

- *Assessment* is a process for defining the nature of that problem, determining a diagnosis, and developing specific treatment recommendations for addressing the problem or diagnosis.

The intent of the brief Social Determinants of Health (SDoH) screening is to identify barriers that impact a person's ability to achieve optimal health and wellness. The purpose of brief Social Determinants of Health screening is to establish a routinized process through which providers identify (in an actionable manner) social barriers their attributed patient population is facing. Accordingly, the brief screening should not take the place of deeper, more comprehensive assessment processes utilized as part of care management or mandated by other programs, but it should inform those processes.

To support Participants, MDHHS has developed a brief screening tool template and is providing this template that can be used as is, or adapted to meet the needs of the practice environment and the community being served. Questions (or other inputs) utilized in the screening tool must elicit patient assessment responses consistent with the purpose and intent of each topic as defined by the Initiative. However, question (or other input) phrasing, order and the format for administering screening (e.g. choosing different formats to administer the screening such as an EHR template or incorporating into existing patient questionnaires etc.) is flexible. Please note:

- PCMHs should not completely remove one or more of the topics/domains contained in the template, although combining and/or rearranging domains is

permitted, as long as the intent of each individual domain is maintained (please reference Appendix B: for more details on each required domain and intent).

- PCMHs located in SIM/CHIR regions should work with their CHIRs (typically through a PO) to use the brief screening tool the CHIR in your area has/is developing.
- The practice must also maintain a screening plan and screening procedure which document brief screening processes.
- The outcome/result of the brief screening tool utilized must be captured in an actionable format to inform required quality improvement activities.

Please see Appendix F "Screening Best Practices" for examples that PCMH Initiative Participants have provided in how they have developed their internal screening plans.

Provide Linkages to Community-Based Organizations:

Provide linkages to community-based organizations that support patient needs identified through brief screening, including tracking and monitoring the initiation, follow-up, and outcomes of linkages made.

As participants continue to enhance their systems to support the implementation of Clinical-Community Linkages, it is important to consider the data elements that will streamline not only the activities related to linking patients to needed resources, but also those data elements that will support internal quality improvement processes. In doing so, the PMCH Initiative encourages participants to consider capturing information regarding the type of linkage made by both SDoH domain (such as Housing), and entity name (such as Michigan State Housing Development Authority). The PCMH Initiative allows participants flexibility in how to document and follow-up on linkages, which should be reflected in an up to date methodology that describes the preparation, initiative and follow-up processes of a linkage.

Please see Appendix G "Linkage Best Practices" for examples from PCMH Initiative Participants in how they have developed their internal linkage processes.

Quality Improvement Activities:

As part of the Practice's ongoing population health and quality improvement activities, periodically review the most common linkages made and the outcome of those linkages to determine the effectiveness of the community partnership and opportunities for process improvement and partnership expansion.

Please see Appendix F "Quality Improvement Activities Best Practices" for examples that PCMH Initiative Participants have provided in how they have developed their internal plans to support continued quality improvement around Clinical-Community Linkage design.

Population Health Management

All Participating practices must engage in the Clinical Practice Improvement Activities to support Population Health Management as outlined below.

Ensure Engagement of Leadership

Ensure engagement of clinical and administrative leadership in practice improvement by ensuring responsibility for guidance of practice change (i.e. a Champion) is a component of clinical and administrative leadership roles.

Some sample activities include:

- Appoint clinical and administrative leadership to establish a population health vision for the PO/practice
- Update job descriptions for clinical and administrative leadership to specifically reflect their responsibility for guidance of practice change
- Provide training for clinical and administrative leadership in leading practice change

Empanel Patients

Empanel (assign responsibility for) at least 95% of the Practice's patient population, linking each patient to a clinician or care team. Use the resultant patient panels as a foundation for individual patient and population health management.

Some sample activities include:

- Form a committee to establish a robust attribution and empanelment process that includes ongoing review
- Explore the use of practice registry, EHR or outside product to assist in empanelment
- Hire panel managers to aid in managing patient panels
- Determine the best panel size for each physician considering patient needs and preferences, as well as practitioner/care team preferences, availability, and skills
- Once patients are empaneled, determine a standard risk-adjusted panel size, and actively review and adjust as needs change.

Once patients have been empaneled, practices can monitor patient empanelment using the following measures:

- Percentage of patient visits to their designated clinician
- Percentage of patient visits to clinicians other than their designated clinician
- Percentage of total active patients unassigned to a panel

Use of Feedback Reports

Use feedback reports provided by MDHHS, other payers and/or practice systems at least quarterly to implement strategies to improve population health on at least 2 utilization measures and 3 clinical process/quality/satisfaction measures at both practice and panel levels.

In the semi-annual report, the practice will specify which measures they are targeting for improvement, how they will assess the measures and the current baseline for at least one utilization measure and one process/quality/satisfaction measure. Metrics without baseline data cannot be used.

Some sample activities include:

- Develop reports using aggregated data. Describe which measures the practice is targeting for improvement with these reports. Reporting examples include:
    - Develop a quality report for practices using aggregated data information received from all payers to enable quality improvement on individual panel and population health management.
    - Create a portal wherein utilization, quality and patient satisfaction measures can be accessed at any time.
    - Create a utilization report that can identify high utilizers as well as patients who are using the ED for PCP-treatable conditions.
- Implement telehealth as a strategy to improve two utilization measures and three clinical process/quality/satisfaction measures (for example, ED utilization, all cause readmissions, diabetes HbA1c poor control, controlling high blood pressure and patient satisfaction). Review progress quarterly to ensure intervention is making an impact.
- Establish criteria for high-priority patients. Care managers and others involved in patient care review the list, discuss patients with providers, and engage patients in complex care management services. By proactively identifying patients who can benefit from care management interventions, the PO plans to decrease avoidable ED visits and inpatient admissions and improve diabetes HbA1c poor control, controlling high blood pressure and patient satisfaction.

Practice Transformation Reporting

Practice Transformation Reporting is a requirement that happens semi-annually. This reporting exercise provides insight to the SIM PCMH Initiative team on how each participant is approaching this important task, and also allows for the practice to reach out and request support in achieving their required objectives. Practice Transformation reporting requirements will be released 4 to 6 weeks in advance of the report submission date. Further detail on these dates can be found in the PCMH Initiative Progress Reporting Section in this guide. To get answers to questions, or to provide

feedback on any Practice Transformation Reporting related topics, please send an email to MDHHS-SIMPCMH@michigan.gov.

Care Management and Coordination

The PCMH Initiative is built upon the joint principles of a Patient Centered Medical Home, agnostic across designating bodies. Particular value is placed in core functions of a medical home such as enhanced access, whole person care, and expanded care teams that focus on comprehensive coordinated care. The 2019 Participation Agreement outlines requirements around enhanced access, and care team composition, while this section provides an overview of Care Management and Coordination staffing and services. The definitions for Care Management and Coordination Services, Care Manager, Care Coordinator, Care Team, etc. as provided within the 2019 PCMH Initiative Participation Agreement, will be referenced and provides additional context.

Goals of Care Management and Coordination

Improve patient's functional health status
Enhance coordination of care
Eliminate duplication of services
Reduce the need for unnecessary, costly medical services

Attributes of Successful Care Models

Successful care management and coordination programs to date have some common key elements: 1) The care manager(s) and coordinators are located in close proximity to the PCP and 2) The care manager(s) and coordinators are considered an integral part of the health care team. Care managers and coordinators working remotely, in isolation of the team; have not been shown to be as effective. For additional details see the archived 2018 Participant Guide.

Models of Care Management and Coordination

Care Management and Care Coordination means the application of systems, science, incentives, and information to improve clinical practice and assist patients and their support system to become engaged in a collaborative process designed to manage medical, social, and/or behavioral health needs more effectively. The level of intensity of care management will vary based on the needs of the patients, as to achieve an optimal level of wellness and improve coordination of care while providing cost effective, non-duplicative services.

Care management and coordination provides individualized services to patients at the highest risk, based on defined risk stratification process, and who are likely to benefit from care management interventions. Prioritizing patients who will benefit from care management is a key step. Building care management capability for your practice team includes addressing the needs of patients who may benefit from longer term care

management (longitudinal) and those at increased risk due to emergency department (ED) visit or hospital admission/discharge/transfer (short term or episodic care management).

Longitudinal care management and coordination focuses on patients identified as high risk or rising risk by your practices stratification approach, who are likely to benefit from ongoing proactive care management. This includes the use of an individualized care plan, centered on the patient's actions and support needs in the management of chronic conditions for care management and care coordination interventions. Building a relationship over time with the patient and their support system and delivery of intensive care management services, are elements of longitudinal care management and coordination.

Episodic care management and coordination focuses on provision of short-term care management services, related to acute events such as ED visits, hospitalizations, and new diagnoses. Episodic care management and care coordination services help to address cost savings and patient engagement. Examples of episodic care management and coordination interventions include medication reconciliation, ensuring patients have timely follow up visits with PCP or Specialist as indicated following hospital admission, discharge, and/or transfer.

Collaboration and Coordination

Both internal team collaboration and coordination with various partners is imperative to support improved patient outcomes. There are various examples in how the Care Management and Coordination staff team can support both internal collaboration between all members of the Patient Centered Medical Home Team, and external coordination with other clinical providers and community partners.

PCMH and Team Based Care

The practice team's aim is to meet the majority of the patient population's medical, behavioral, and health-related social needs to support each patient's health goals. Some examples could include:

Team Communication: The practice providers have frequent contact with the practice's Care Managers and Care Coordinators regarding patients receiving active care management and care coordination services. This contact occurs weekly or more frequently as needed to address patient needs. Regular communication supports the providers, care managers and care coordinators efforts to optimally deliver care management services for patients and their support systems. Examples include team huddles at the start of the day when possible or the use of technology to allow for frequent communication between team members.

Closing gaps in care: A patient registry or registry function within the EHR can be used to generate routine, systematic communication to patients regarding gaps in care. Practice team members have clearly defined responsibilities to operationalize outreach to patients who are either due or overdue for preventive services and/or tests for their chronic condition.

Longitudinal care management: A patient-specific action plan and patient's individual goals are documented in the EHR or electronic care management documentation tool, enabling providers and the practice team members to monitor and follow-up with the patient during subsequent visits. The individualized care plan includes patient specific goals and interventions and is updated at regularly defined intervals. Updates to the care plan occur when there are changes in the patient's health status, preferences, goals, and/or values. The care plan is accessible by members of the primary care team and the patient receives a copy of his or her care plan.

PCMH Practice Collaboration with Specialists, Behavioral Health Providers, Community Resource agencies (external to the practice).

Collaborative relationships are established and maintained with entities external to the PCMH such as, specialists, behavioral health providers, community-based agencies, and Medicaid Health Plan care managers to ensure patient linkages to needed resources are effective and appropriate with the exchange of information both initially and ongoing. The expected outcome of these linkages should be the resolution of the patient's identified needs. The PCMH practice, specialist, behavioral health specialists, community-based agencies, and Medicaid Health Plan care managers work together to deliver coordinated care and address identified barriers and social needs for patients and their support systems. This can be accomplished through documentation and implementation of care agreements with specialists or other partners to foster interactions which promote effective and efficient delivery of patient care and coordination.

The PCMH practice should establish collaborative relationships with appropriate community-based organizations relevant to their patient population needs. The relationship(s) involve ongoing telephonic, face-to-face or other modalities for direct dialogue. An area of focus may be to improve the process of linking patients with the community resource and subsequent follow up to assess the patient's outcome and experience.

Shared Care Plan Development

A shared care plan is a patient-centered health record designed to facilitate communication among members of the care team, including the patient and providers. Rather than relying on separate care or treatment plans from each provider, or

organization supporting the patient, a shared plan of care combines all aspects to encourage a team approach to care.

Engaging patients to participate in developing their shared care plan and gaining an understanding of their preferences leads to an increase in shared decision making between patients and providers. Engaging patients in the development of their plan requires participation of multiple members of the care team both internal to the PCMH and with external partners. Depending on the concerns, goals, and needs of the patient, many team members may work with the patient and family member(s) or support system, to identify the health and overall wellness goals. Development of a shared care plan occurs over time and requires multiple interactions with the patient, support system, and extended team. (reference: J. van Dongen, et al. 2016)

Four elements of a shared care plan include:

Current State: Current state includes the patient's background, demographics, functioning, use of medication and usual treatment. The current state element may be continuously adjusted by the health care team.

Goals and Concerns: This involves the patient's goals and concerns and includes information related to the care requirements and goals identified by the patient and the professionals within the extended care team. These goals are in line with the individual's preferences, values, needs and expectations, which is the central focus of the plan.

Actions and Interventions: Actions and interventions are based on the established goals and concerns and are individualized and tailored per the patient's perspective. Additionally, the plan needs to be kept up to date, ideally is documented using lay terms, and includes aspects to support the patient's emotional, social, and physical needs. Redundancy can be minimized if the interventions are specific, time based, and correspond to the extended care team members involved in supporting the patient.

Evaluation: Evaluation includes the care team members documenting a patient's progress to include successes and struggles and level of participation in goal setting. This also involves revising the plan of care based on the patient's response and current status. The plan should be up to date and address the patient's emotional, physical, and social needs.

The shared care plan is a living document utilized by members of the care team and includes updates which reflect the patient's current goals and preferences. For additional details regarding development of shared care plans using an electronic health record, engaging patients in their care plan, and to view examples of shared care plans click here.

Optimizing Care Management and Coordination Staff Teams

Orienting and onboarding CMs/CCs who are new to their role provides an important foundation and prepares the CM/CC to work collaboratively with team members. An understanding of the practice's quality metrics, goals, workflows and patient centered care delivery builds the CMs/CCs ability to partner with team members.

The MiCMRC website offers CM/CC orientation resources and tools that may be used to enhance an existing CM/CC orientation program, assist with building an effective CM/CC orientation, and address onboarding for new CMs and CCs. Information on this page can also assist the CC/CM embedded in a practice to identify additional training needs. Examples of tools on the website include:

- New Care Manager Checklist
- Daily Tasks Workflow
- Cornerstones for Developing a Care Manager Orientation

Finding and retaining qualified personnel to fill the unique role of the CM/CC can be challenging for a practice. The SIM PCMH Initiative offers an educational webinar on Attracting and Retaining Care Managers which may be useful.

In order to optimize team role-based functioning, evaluate current duties and responsibilities of each practice team member and consider potential to utilize team members' time/resources differently in order to best meet the needs of the practice's patient population. As part of this review, assess if every team member works to the highest level of their scope of practice, licensure, training, and capabilities. This requires support from the practice leaders and champions. The outcome of this review may include increased awareness of work which provides minimal value, insight about work which may allow a shift in responsibilities for a team member to optimize patient care. An example may be to decrease the administrative non-clinical work of the CM or CC, so they have more time to focus on clinical work.

Efforts to optimize the Care Management and Coordination team and how they function within the broader care team is a continuous effort, which can result in greater team efficiencies, potential for cost reduction, and overall increased patient satisfaction.

Embedded Care Management and Coordination Staff

The PCMH Initiative requires Care Management and Coordination staff to be embedded within the participating practice in which they are serving. While POs or multi-site practices can hire care management and coordination staff across participating practice locations, the requirement for care management and coordination staff to be embedded remains. The use of the term "embedded" means the care management and coordination staff spends some portion of their time in the physical participating practice

location. Face to face time with patients and the practice team is known to contribute to increased success for positive care management outcomes. The care manager should be physically located in the practice and have a work station for the allotted FTE identified for that practice. Due to the variation of population needs for each participating practice, there is no set minimum amount of time for the care management and coordination staff to be physically located in the participating practice.

Participants may allocate the care manager and care coordinator staff FTE for each participating practice based on the need of the patient population. It is expected that needs of the patient will guide the staffing model and allocation of FTE for the care manager and care coordinator staff.

PCMH Initiative Care Management and Coordination Learning Requirements

The 2019 Participation Agreement indicates that Care Managers and Care Coordinators supporting the PCMH Initiative patient population must receive initial care management and self-management training provided or approved by the Initiative in addition to obtaining an additional 8 hours[1] of care management/coordination training (longitudinal training) annually. The initial and longitudinal training requirements are described below.

Initial Training Requirements

Both Care Coordinators and Care Managers are required to complete a MiCMRC approved Self-Management Training course within the first six months of hire. The MiCMRC has identified a number of approved Self-Management training programs: Michigan Center for Clinical Systems Improvement (MICCSI), Practice Transformation Institute (PTI), or Integrated Health Partners (IHP). Care Managers are additionally required to complete the MiCMRC led Complex Care Management Training course within the first six months of hire. The table below provides an illustration of the training requirements for Care Managers and Coordinators.

Care Coordinators who are Community Health Workers (CHWs), must complete a CHW training certificate program. The PCMH Initiative does not specify the CHW certificate program. As an example, a CHW certificate training program available in Michigan is the Michigan Community Health Worker Alliance.

[1] 4/17/2019

Initial Learning Requirements for Care Managers and Care Coordinators

Initial Required Training	Care Coordinator	Care Manager	Time
MiCMRC Approved Self-Management Support Course	X	X*	Click here for details (details of each course)
MiCMRC CCM Course		X	Click here for details
SIM Overview Recorded Webinar	X	X	30 minutes
PCMH, Chronic Care Model, and ACOs Recorded Webinar	X	X**	20 minutes
Team Based Care Recorded Webinar	X	X**	45 minutes
Introduction to Social Determinants of Health Recorded eLearning Module	X	X***	25 minutes
The Role of Care Managers & Care Coordinators in Developing and Maintaining Community Linkages eLearning Module	X	X***	30 minutes
Social Determinants of Health and the Implications for Care Management eLearning Module	X	X***	20 minutes
Social Determinants of Health Case Study eLearning Module	X	X***	20 minutes

*Care managers are strongly encouraged to complete this course prior to registering in the MiCMRC CCM Course.
**Recorded webinar content is included in the CCM course. If a care manager attends the CCM course after January 2017, they do not need to complete the PCMH, Chronic Care Model, and ACO or the Team Based Care recorded webinars. However, Care Coordinators do need to complete.
***SDOH eLearning modules are included in the CCM course content. If the care manager attends the CCM course after July 2017, they do not need to complete the eLearning Modules. However, Care Coordinators do need to complete.

Existing Care Coordinators and Care Managers that have completed the Initial Training requirements as outlined above will not be required to attend the courses again. Example: If the CM has completed the MiCMRC Complex Care Management in the past, there is no need to repeat this course.

Longitudinal Learning Requirements

The PCMH Initiative maintains the expectation that all Care Managers and Coordinators will maintain their current licensure/certification, including the requirements to seek continuing education approved by the appropriate professional organization/association.

To support this expectation, the Initiative requires each Care Manager and Care Coordinator must complete a total of eight (8)[1] hours of education per year. The requirement of training throughout the year is termed "longitudinal learning activity." This can be satisfied by either:

Eight (8)[1] hours of MiCMRC webinars/sessions (e.g., topic based live webinars and recorded webinars, web based interactive self-study eLearning modules – Basic Care Management, in person Summit attendance, etc. that offer CE certificates or certificates of completion), OR four (4) hours of MiCMRC webinars/sessions PLUS four (4) hours of PO-led, or other related learning activity events. No preapproval is necessary for PO-led or other CE granting care manager, care coordinator training sessions. However, a certificate of completion should be maintained for audit purposes.

MiCMRC hosts live webinars and trainings on topics pertinent to the CM/CC role throughout the year, many of which provide continuing education credits. In 2019, MiCMRC will host webinars addressing topics relevant to delivery of care management and coordination for the adult and pediatric population. Additionally, MiCMRC maintains a library of recorded trainings, many offering continuing educations credits, that may be accessed on demand. The live and recorded webinars and eLearning modules can be accessed via the MiCMRC website. The website offers a variety of topic pages with various resources ranging from sample tools, articles, and toolkits.

Please note, the completion of the initial required training, as stated above, is not included as part of the hours for the required longitudinal training per year. For example, the Complex Care Management course is not counted as part of the eight (8)[1] hours of longitudinal training. If a Care Coordinator and/or Care Manager is hired during the calendar year, the eight (8)[1] hours of longitudinal training requirement is prorated based on the date of hire. A general guide for prorating the longitudinal learning requirements will be completion of one hour of longitudinal training per month, using hire date within the calendar year.

Care Management and Coordination Service Tracking

The PCMH Initiative utilizes a set of Healthcare Common Procedure Coding System (HCPCS) and the American Medical Association's Current Procedural Terminology (CPT) codes to facilitate tracking the provision of Care Management and Coordination Services within the Patient Centered Medical Home. These codes were selected to represent common Care Management and Coordination services relevant to the SIM PCMH Initiative population. A draft code set was shared with providers across Michigan in the fall of 2016 during an open comment period, and the set was finalized

[1] 4/17/2019

based on feedback. In 2018 four additional codes were introduced to meet additional feedback from providers and support learnings from the 2017 PCMH Initiative, and alignment with the expectations of the 2018 Initiative. To review the set of codes used within the 2019 PCMH Initiative, please reference Appendix C: Care Management and Coordination Tracking Quick Reference.

The Care Management and Coordination services outlined by the HCPCS and CPT codes must be provided under the general supervision of a primary care provider. However, many of the services themselves or activities to support the service can be accomplished through coordinated team efforts, maximizing Care Manager and Coordinator skills to engage patients efficiently. While many team members may be involved in the provision of a single service (such as a care transition), the service may only be billed using the National Provider Identifier (NPI) of the primary care provider. Additionally, the date of service reported should be the date the care management and coordination service took place. In some cases, a service may take place over the course of more than one day, in such an event the date of service reported should be the date the service was completed.

Care Management and Coordination Service Documentation

Appropriate documentation of Care Management and Coordination services is imperative, not only to support continuity of care between care team members and external partners, but to ensure accuracy in claims submission. PCMH Initiative participants must have a care management and coordination documentation tool, either as a component of an EHR or able to communicate with an EHR to ensure pertinent care management and coordination information is visible to care team members at the point of care. At a minimum, documentation in the care management and coordination documentation tool should include:

- Date of Contact
- Duration of Contact
- Method of Contact
- Name(s) of Care Team Member(s) Involved in Service
- Nature of Discussion and Pertinent Details
- For G9001- Comprehensive assessment results and detailed, individualized care plan
- For G9007- Update(s) and/or additions made to individualized care plan

Care Management and Coordination Claim Submission

All Care Management and Coordination services provided to eligible SIM PCMH Initiative patients (as identified within the PCMH Patient Lists produced by the Michigan Data Collaborative), must be submitted to the appropriate participating payers

(Michigan's Medicaid Health Plans), to be recognized for Initiative tracking purposes. When submitting these claims, all diagnoses relevant to the care management and coordination encounter should be reported, with diagnosis codes reported in the appropriate order to indicate primary diagnosis.

While the HCPCS and CPT codes are being utilized for tracking purposes, supporting participant compliance and monitoring and as a part of the Initiative payment model, some participating payers may reimburse specific services, and all payers must reimburse for the provision of transition of care (99495 and 99496) services. Therefore, when participants are submitting claims, they should attach their customary charge to the service in the event the payer will reimburse (according to contractual agreements, and specified fee schedule). If the service is not a reimbursable service (used for tracking purposes only) the participating payer may adjudicate the claim and pay at $0.00, providing a reason code or explanation indicating that the claim is being accepted for informational purposes only. If a participant should experience any claims rejections, they should contact the PCMH Initiative with specific examples of the rejections including any reason codes provided by the payer.

Health Information Technology

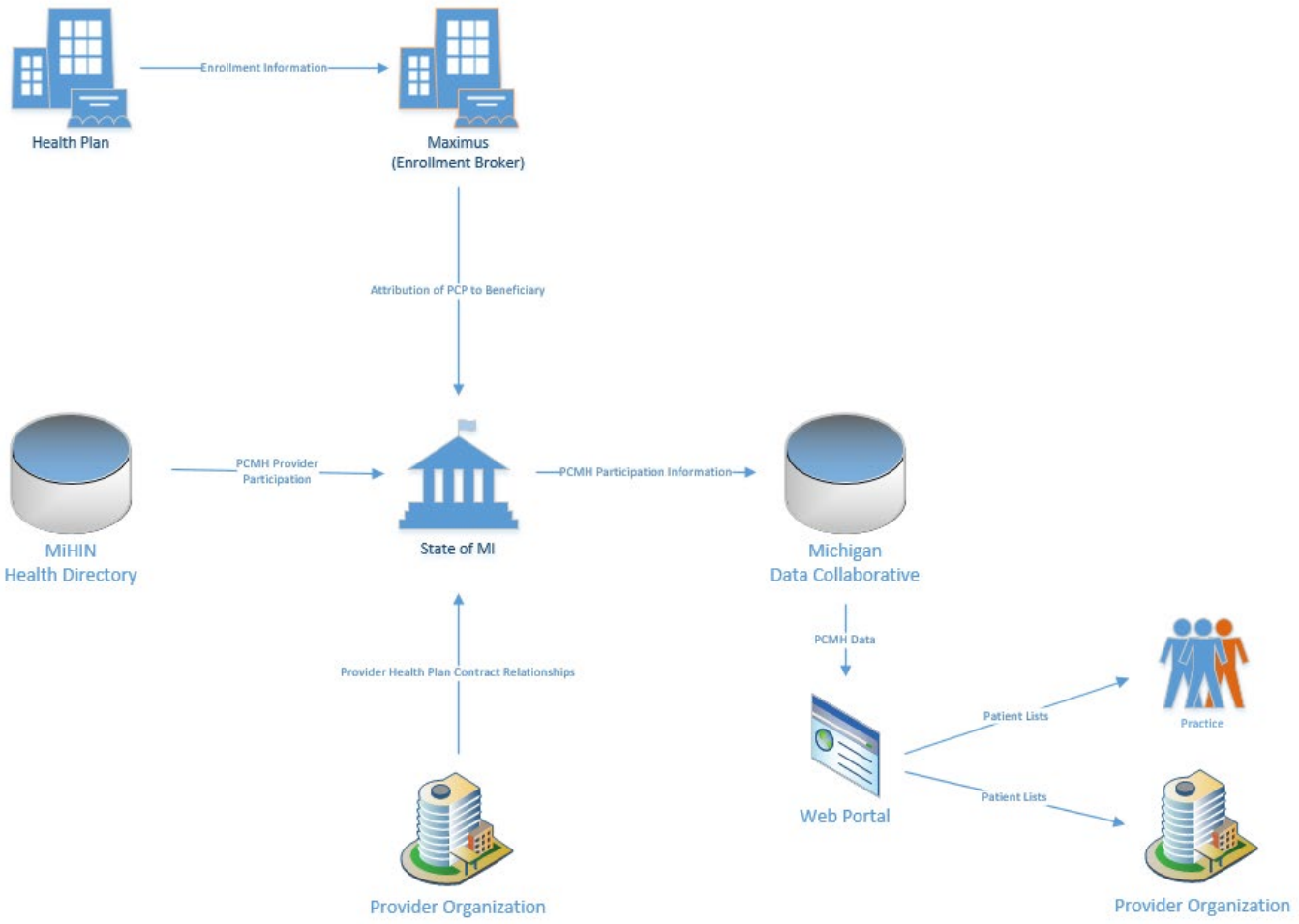
The PCMH Initiative has focused efforts on leveraging existing infrastructure to facilitate continued transformation and the testing of promising practices within primary care and more specifically Patient Centered Medical Home settings. As a foundation, the Initiative has required all participants to possess and utilize a 2014 or 2015 Office of the National Coordination (ONC) Certified Electronic Health Record Technology (CEHRT), to support the testing of the Relationship and Attribution Management Platform (RAMP).

Relationship and Attribution Management Platform (RAMP)

The Relationship and Attribution Management Platform has been created to support the identification and capture of relationships between patients/consumers and their healthcare delivery team members, to facilitate the active exchange of necessary information between these identified individuals and organizations, and to provide an infrastructure that is necessary for the PCMH Initiative to be effective.

The Michigan Health Information Network Shared Services (MiHIN), the state-designated entity for health information exchange in Michigan, has been engaged in the RAMP project to leverage the widespread interoperability network MiHIN has established in the State of Michigan, along with multiple tools and services to support the goals of this large undertaking.

The State Innovation Model utilizes RAMP as the foundation for the PCMH Initiative monthly attribution process. Technical details on the attribution process are included in Appendix B: PCMH Initiative Medicaid Attribution Model, of the 2019 Participation Agreement. A diagram of the attribution process has been included below to support participant understanding and review of the process. The information transmitted through RAMP for the purposes of attribution supports the development of monthly patient lists as described in the SIM PCMH Dashboards section of this guide.



Summary of Use Cases

The work described above includes several “Use Cases” created by MiHIN to facilitate statewide exchange of health information. These uses cases supporting the State Innovation Model, and the PCMH Initiative are described below.

Active Care Relationship Service

The Active Care Relationship Service tracks patient-provider attributions by identifying which healthcare providers have “active care relationships” with patients/consumers. This service acts as the basis of RAMP by allowing RAMP to match patients/consumers with their attributed care team members. This Use Case enables organizations to submit data files which record the care team relationships attributing a patient with health professionals at that organization. These attributions are then utilized to accurately route information for a patient to all members of their care team. The Active Care Relationship Service also captures key physician organization, practice unit, and additional provider information to support the hierarchical relationships within the Health Directory (discussed below).

The ACRS Use Case is the foundation for several other use cases, including HD, ADT and QMI. Therefore, participation is crucial, as the ACRS file is used for routing of information for ADT messages and QMI files.

Health Directory

While multiple organizations track physicians and information on how to contact them (name, address, specialty, national provider identifier, or specific credentialing information), the MiHIN Health Directory also includes the electronic service information required to know how and where health information is to be delivered electronically for each healthcare provider.

Quality Measure Information

The Quality Measure Information Use Case enables providers and payers to consolidate and standardize the electronic exchange of quality-related data and performance results. With this Use Case, providers gain the ability to send one supplemental clinical quality data file in one format and have it distributed to multiple locations, if and as needed.

Admission-Discharge-Transfer Notifications

Admission-Discharge-Transfer (ADT) notifications can be leveraged to improve patient care coordination through exchange of health information. ADT messages are sent when a patient is admitted to a hospital, transferred to another facility, or discharged from the hospital. These alerts are sent to update physicians, care management teams, and payers on a patient’s status; to improve post-discharge transitions; to prompt follow-up; to improve communication among providers; and to support patients with multiple or chronic conditions. The use of the ADT feeds and alerts are crucial in supporting active care coordination processes.

Active Participation in RAMP

PCMH Initiative Participants are required to actively participate in RAMP and the corresponding use cases (described above). To be considered actively participating in RAMP the following must occur:

- All legal onboarding (execution of all requisite legal documents) must be completed and maintained.
- All technical onboarding must be complete and maintained
- Consistent submission of valid files (as appropriate to each use case – ACRS, QMI), or continuous connect and receipt of notifications (ADT use case).

Should a PCMH Initiative Participant experience a change (such as merger/legal name change, change in EMR, etc.), then it is the responsibility of the participant to maintain active participation in RAMP. This includes maintenance of all appropriate legal documents and ensuring smooth transition to the new system to limit the potential for disrupted submission (or receipt) of necessary information for any of the required Use Cases (HD, ACRS, ADT, QMI) within the PCMH Initiative.

MiHIN Additional Resources

For all support issues: via https://mihin.org/requesthelp/
Legal onboarding: legal@mihin.org
For more information: www.mihin.org
Technical onboarding contact information:

Lindsey Weeks	Katherine Olds	Hannah Burseth
Production Manager	Onboarding Coordinator	Onboarding Coordinator
517-588-8373	517-980-0038	513-503-0118
lindsey.weeks@mihin.org	katherine.olds@mihin.org	hannah.burseth@mihin.org

MiHIN Use Case Implementation Guides

The published MiHIN use case implementation guides for the identified SIM use cases may be accessed via following web pages on www.MiHIN.org:

Active Care Relationships
Health Directory
ADT Notifications
Quality Measures Information

Performance Monitoring and Initiative Feedback

The PCMH Initiative utilizes several mechanisms to monitor participants and to provide feedback across the Initiative performance. Each mechanism serves a purpose to facilitate Initiative operations, in addition to providing participants with a mechanism to access important quality and utilization data, or provide the Initiative with valuable feedback. The following section of this guide outlines the mechanisms used to support participant monitoring and feedback, these mechanisms have been broken into two focus areas:

Performance Monitoring: Supports the monitoring of quality of care, health outcome, utilization, and cost performance metrics to report progress/success and enable quality and process improvement for Initiative participants.
Compliance: Ensures PCMH Initiative participants operate in accordance with the requirements of the Initiative upon selection and on a continuous basis during their participation.

Participant Monitoring

The PCMH Initiative utilizes aggregated data from the participating payers across medical claims, pharmacy claims, and eligibility files to monitor participant performance and compliance. The PCMH Initiative has leveraged the efforts of existing infrastructure and collaborative partnerships as experienced within the Physician Payer Quality Collaborative (PPQC). The PPQC has identified a set of 27 quality measures that had overlap between national and local quality reporting programs.

In order to support participant monitoring, and participants' internal quality efforts, a subset of the PPQC measures were selected for use within quality reporting through the Michigan Data Collaborative SIM PCMH dashboards. Metrics were selected based on multiple considerations, including:

The population being served within the PCMH Initiative.
Whether a particular metric is a CMMI priority metric for SIM.
The ease with which a data aggregator could collect, store, and disseminate the data.

Performance Monitoring

To facilitate participant performance monitoring, the PCMH Initiative partners with Michigan Data Collaborative (MDC), a non-profit healthcare data organization at the University of Michigan. MDC supports care delivery transformation initiatives across the state of Michigan by providing solutions for data collection, aggregation and visualization, measure calculation, and reporting.

Database

MDC developed a database to collect the following types of data for the PCMH Initiative:

- Claims, eligibility, immunization, and lead screening data
- Clinical/EHR received through the Quality Measure Information Use Case
- Patient population
- Provider hierarchy (Provider NPI and associated practice and Managing Organization relationship)

The SIM PCMH Dashboard

MDC uses the information collected in their database to calculate quality, utilization and cost measures, as well as chronic condition prevalence, which are displayed on the SIM PCMH Dashboard in both tables and visualizations.

The Dashboard includes pages for each data analysis area: overview (executive summary), tile, quality of care, utilization, ACSC, comparisons, care coordination, and reports. From these pages, participants can view demographic information, view chronic condition prevalence, compare measure performance against other entities and published benchmarks, and download reports.

Using the Dashboard, Initiative participants can analyze the data and access reports for their organization.

You can find descriptions for the Dashboard components, instructions for using the Dashboard features, and detailed information about the data in the SIM PCMH Dashboard User Guide.

Dashboard Releases

Throughout the duration of the SIM PCMH Initiative, MDC will provide regular data updates (releases) to the SIM PCMH Dashboard.

The following releases are targeted for 2019.

Release	Reporting Period	Target Date
7	October 2017 – September 2018 (May include iterative releases of new pages--incentive, trends, etc.)	End of February 2019
8	January 2018 – December 2018	End of April 2019
9	April 2018 – March 2019	End of July 2019

10	July 2018 – June 2019	End of October 2019

Measures Included in the SIM PCMH Dashboard

The following tables list measures for performance monitoring. Changes that occurred across releases:

- Quality measures
  - Updated from HEDIS 2015 to 2018 in Release 3.
  - Began supplementing with QMI data available in Release 4.
- Utilization measures were updated in Release 4.01:
  - Hospital Admissions are no longer generated, instead Acute Admissions will be calculated which are a subset of overall Hospital Admissions.
  - Readmissions were updated to HEDIS 2018 and also sourced from Acute Admissions.
  - Emergency Department Visits were updated to the HEDIS 2018 definition.

All measures will be reprocessed in Release 7 to report results in the same definitions across time.

QUALITY OF CARE

Measure Name	Dashboard Release
Adolescent Immunization	2
Adolescent Well-Care	2
Breast Cancer Screening	1
Cervical Cancer Screening	1
Childhood Immunization Status	2
Chlamydia Screening	2
Diabetes Eye Exam	1
Diabetes HbA1c Testing	1
Diabetes Nephropathy	1
Lead Screening	2

Well Child Visit: 3-6 Years	2
Well Child Visit First 15 Months	2

QUALITY OF CARE – OUTCOME MEASURES

Requires EMR/QMI data.

Measure Name	Dashboard Release
Adult BMI	6
Depression Screen and Follow Up	6
Diabetes Blood Pressure Control	6
Diabetes HbA1c Poor Control	6
Controlling High Blood Pressure	6
Tobacco Use Screening and Cessation	6
Weight Assessment and Counseling	6

UTILIZATION AND COST

Measure Name	Dashboard Release
Acute Hospital Admissions	4.01
All-Cause Readmission (HEDIS 2018)	4.01
Ambulatory Care Sensitive Condition Hospitalizations	6.01
Emergency Department Visits (revised to HEDIS 2018)	4.01
Preventable ED Visits	5
Total PMPM (Per Member Per Month) Cost	6

CHRONIC CONDITION PREVALENCE

Measure Name	Dashboard Release

Asthma	1
Diabetes	4
Hypertension	1
Obesity Overall	1
Obesity – Overweight	1
Obesity – Moderate	1
Obesity – Severe	1

Detailed definitions for the measures are available in the SIM PCMH Dashboard Technical Guide

Measures Removed	Reason
Appropriate Testing for Children with Pharyngitis	Low volume of patients that fit the requirements, so the results are not statistically significant.
Appropriate Treatment for Children with URI	Low volume of patients that fit the requirements, so the results are not statistically significant.
All-Cause Readmission (HEDIS 2015)	This measure was no longer calculated as of Release 4.01 and was replaced with All Cause Readmissions using the HEDIS 2018 definition.
Hospital Admissions	This measure was no longer calculated as of Release 4.01 and was replaced with Acute Admissions
Low Back Pain Imaging	This measure was removed with the Release 3 to align with measures reported to CMS.

MDC Dashboard Reports

To further support Initiative participants, MDC provides practice-level and managing organization-level reports on the Dashboard. The following reports are included (along with their target delivery timeframes):

Report Name	Description	Target Delivery Timeframe
PCMH Patient Lists (PPLs)	Each month, MDC creates a current list of patients who are attributed to a practice participating in the SIM PCMH project. Both Practice-level and MO-level reports are available as applicable. The patient list includes additional helpful information such as the number of hospitalizations and emergency department visits a patient has had for the last dashboard release reporting period. For more information, see the PCMH Patient List Reference Document.	End of the month
Aggregated Patient Reports	MDC generates quarterly aggregate patient reports to assist organizations in reconciling their Medicaid Health Plan payments. The reports contain counts of patients attributed to a provider for each practice for the quarter. For more information, see the PCMH Aggregated Patient Report Reference Document.	Beginning of the month following the close of the quarter
Care Coordination Reports	These reports provide a view of both the frequency of care management services and appropriate follow-up care for members with inpatient encounters. The following reports are included with each monthly and quarterly release: *Percentage of Patients Receiving Care Management Service Report* 1) This report shows the unique number of patients who received a care management service in the measurement month or quarter based on medical claims data. 2) Claims detail reports associated with the totals provided in the *Percentage of Patients Receiving Care Management* *PCP Follow-Up after Inpatient Discharge Report* This report includes the percentage of patients with an inpatient stay who had a follow-up visit with a SIM primary care physician within 14 days of the last discharge date in the measurement month or quarter. For more information, see the PCMH Care Coordination Reports Reference Document.	Rolling quarterly report released each month

Report Name	Description	Target Delivery Timeframe
Provider Reports	MDC began generating monthly provider reports in February 2018 following the same cadence as patient reports. These reports were requested so that participating managing organizations and independent practices can easily evaluate the provider, practice and managing organization relationship that applies to each month.	End of the Month

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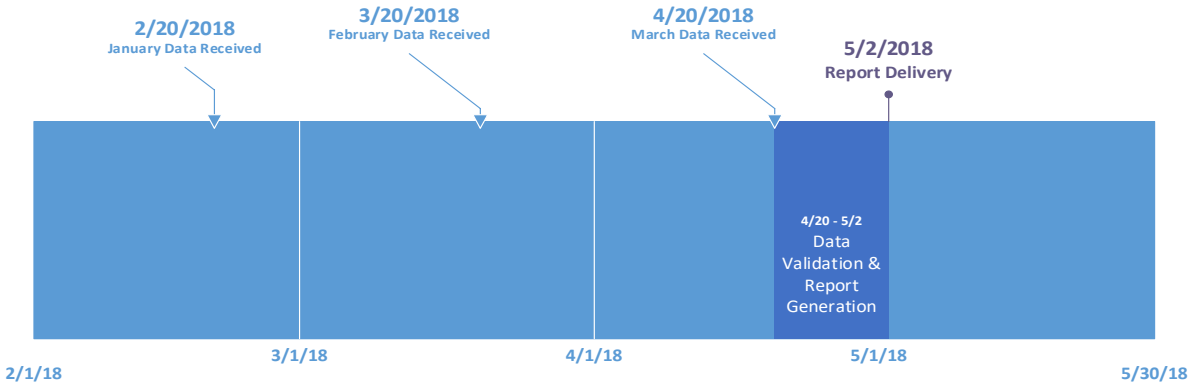
The Care Coordination reports have a four-month lag because of timing of data receipt, data quality and report validation testing:

- Two months of run-out data are included in each report to capture a more complete data set.
    - MDC analyzed data for the Inpatient Follow-Up report, and only about 10% of claims were paid in the month incurred. The month following the incurred service had about 48% of the claims records and the second month had about 41%.
    - Without the two months lag most claims would be missed and PCMH Initiative participants would not get credit for work completed.
- Monthly claims data is received in the month following the close of the incurred month. For example, December claims are received towards the end of January.
- MDC completes quality testing to confirm validity within 5 business days of data receipt, prior to including them into reports.
- MDC generates and test the reports.

The following graphic shows a sample timeline:



Starting in 2019, Care Coordination reports are generated each month and represent a rolling quarter. Previously a single monthly report and calendar year quarterly reports were generated. This change provides additional data in each monthly report to better capture data as it flows into the MDC database. Four times a year, they represent the calendar quarter. The table below details the content of each report that is generated on a monthly frequency:

Target Report Release Date	**Months in Report**
Early January '19	Calendar 3Q18: July, August and September
Late January '19	August, September, and October '18
Early March '19	September, October and November '18
Early April '19	Calendar 4Q18: October, November and December
Late April '19	November '18, December '18 and January '19
Late May '19	December '18, January '19 and February '19
Early July '19	Calendar 1Q19: January, February and March
Late July '19	February, March and April '19
Late August	March, April and May '19
Early October '19	Calendar 2Q19: April, May and June '19
Late October '19	May, June and July '19
Early December '19	June, July and August '19
Early January '20	Calendar 3Q19: July, August and September '19

True-Up Processing for Care Management Reports

To include additional claims received by MDC after the original quarterly reports were generated, the 4Q17, 1Q18 and 2Q18 **Percent of Patients with Care Management**

reports were re-run. There are several reasons that MDC receives claims after the original reporting period:

- Some Medicaid Health Plans made improvements in processing the Care Management Codes and these claims were received after the reports were generated.
- Some SIM PCMH Initiative participating organizations needed to make changes to their billing groups to include zero-dollar claims.
- The regular adjudication process results in a lag between when claims are serviced and paid. This process allows for additional months of run-out claims to be included.

MDC is also modifying the **Follow-Up with a PCP after Inpatient Discharge** to align with recent changes to the Acute Admissions measures. Those reports will also be re-processed in the revised logic.

MDC provided these reports in December 2018. These reports were utilized to determine the whether the Care Management Improvement Reserve (CMIR) is applied to 2019 payments.

Official Deliverables Calendar

MDC maintains the target dates for upcoming deliverables on the SIM PCMH page of the MDC website. Adjustments due to holidays, etc. will be communicated in the target dates provided here.

MDC Deliverables Notification

When MDC posts a deliverable that is ready to be viewed/downloaded, an email notification is sent directly to participants who have an active MDC account. Additionally, an announcement is posted on the SIM PCMH News page of the MDC website.

Care Management and Coordination Metric Benchmarks

The PCMH Initiative is committed to ensuring patients receive quality care management services. One of the mechanisms to evaluate whether participants are providing this is the use of Care Management and Care Coordination tracking codes.

As outlined in the most recent 2019 PCMH Initiative Participation Agreement amendment, all participants are required to maintain care management and coordination performance above the benchmark established by the Initiative on the following metric:

The percentage of a Practice's attributed patients receiving care management and coordination services.

With support from the Michigan Data Collaborative, the PCMH Initiative has created monthly reports to support participants in monitoring their progress in achieving this benchmark. MDHHS will continue to work with the Michigan Data Collaborative to produce monthly and quarterly reports for "The percentage of a Practice's attributed patients receiving a timely (within 14 days) follow-up visit with a Provider following a hospital inpatient stay", but this metric will no longer be included in the 2019 compliance and potential payment sanction plans. Participant performance related to the care management and coordination benchmark will be measured quarterly and at a participant level.

Quarterly Reports will be aggregated to produce a Performance Rate for each PCMH Initiative participant. We define participant as the organization that submitted a signed agreement (i.e. a Physician Organization or Independent Practice). The report from each of three quarters in the 2018 Measurement Period will be aggregated to generate the Performance Rate for each participant. While individual practice performance varies across a Physician Organization, the overall performance for the participant will need to achieve the 2.5% benchmark.

Below is an example of one PCMH Initiative participant's performance calculation for the month of April:

April 2018 Report Results

PCMH Initiative Participant Organization	# Claims	SIM Population	Percent
Practice A	13	391	3.32%
Practice B	0	2323	0.00%
Practice C	17	933	1.82%
Practice D	7	91	7.69%
Practice E	6	1319	0.45%
Practice F	33	775	4.26%
Practice G	78	987	7.90%
Practice H	15	999	1.50%
Practice I	6	655	0.92%
Practice J	13	304	4.28%
Practice K	33	906	3.64%
Practice L	1	269	0.37%
Practice M	152	4213	3.61%
Practice N	32	560	5.71%
Practice O	70	1170	5.98%
Practice P	3	2880	0.10%
Practice Q	4	243	1.65%
Practice R	124	7441	1.67%
Practice S	4	484	0.83%
Practice T	77	3222	2.39%
Practice U	24	404	5.94%
Practice V	57	917	6.22%
Practice W	23	328	7.01%
Total	**790**	**31587**	**2.50%**

Calculating Participant Performance

$$\frac{\text{Sum of claims from each Participating Practice}}{\text{Sum of SIM Population from each Participating Practice}}$$

The last quarter of 2017 dates of service will be included in the 2018 measurement period; along with the first two quarters of 2018 dates. The claims reported during these periods, along with the average attributed population will be used to determine the 2018 performance rate, as outlined below.

Dates of Service	Quarterly Report Delivered on MDC PCMH Portal
Oct. – Dec. 2017	April 2018
Jan. – Mar. 2018	July 2018
Apr. –Jun. 2018	Oct. 2018
Jul. – Sept. 2018	Jan. 2019
Oct. – Dec. 2018	April 2019
Jan. – Mar. 2019	July 2019
Apr. – Jun. 2019	Oct. 2019
Jul. – Sept. 2019	Jan. 2020
Oct. – Dec. 2019	Apr. 2020

2018 Measurement Period

Performance Impacts

The Initiative is reserving a portion of the SIM PMCH Initiative Care Management and Care Coordination Per Member Per Month (PMPM) payment based on poor performance on this established metric. This will be referred to as the Care Management Improvement Reserve (CMIR) and will reduce all Care Management Care Coordination PMPMs by $0.15 for those participants that fall below the benchmark defined as 2.49% or below. PCMH participants will have an opportunity to "earn back" the Care Management Improvement Reserve based on subsequent performance in 2019. The Initiative has included plans for a true-up (historical pull) of all CMCC claims prior to final determination of 2018 Performance Benchmark. The 2019 Benchmark has yet to be defined, but 2019 performance will be assessed independently. Please see the 2019 Participation Agreement for further details.

2018 Performance Rate	Initiative Action	Impact on Payments
2.50% or above	None	None
2.49% or below	Impose Care Management Improvement Reserve	Reduce all CMCC PMPMs by $0.15

Access to the Dashboard and Reports

MDC maintains access control for participants to view the SIM PCMH Dashboard and to download appropriate reports and lists for their Managing Organization (MO) or practice.

If an organization leaves the SIM PCMH Initiative, the provider hierarchy drives the continued access rights. For example, if the organization is part of the project during a report timeframe, they will still have access to that report. Additionally, the organization will continue to be included in the data and have Dashboard access as long as the provider hierarchy indicates that they are part of the project during the reporting period.

The process for requesting and maintaining access is documented in the SIM PCMH Dashboard Account Maintenance Guide.

Support Documentation

All support documents can be found on the SIM PCMH Support page of the MDC Website. The following list provides a short description of each support document:

Accessing the SIM PCMH Dashboard

Accessing the SIM PCMH Dashboard – Provides information and detailed instructions for accessing the Dashboard.
Accessing the SIM PCMH Dashboard Video Demonstrations:
Dashboard Access Step 1: Setting Up Duo
Dashboard Access Step 2: Setting Your Level-2 Password
Dashboard Access Step 3: Setting Up Citrix Receiver to Access the Dashboard
SIM PCMH Dashboard Account Maintenance Guide – Information about the account process for Dashboard Users and Acknowledgers.

SIM PCMH Dashboard Support

Release Notes – Provides details about each dashboard release.

User Guide – Includes descriptions of the Dashboard components, instructions for using the features, and detailed information about the data.

Timeline – Visual graphic that displays date-specific information about the data included in the Dashboard.

Technical Guide – Provides detailed information about each measure included in the Dashboard.

SIM PCMH Report Support

PCMH Care Coordination Reports - Reference Document
PCMH Care Coordination Claims Detail Reports - Reference Document
PCMH Patient List - Reference Document
PCMH Patient Lists - Report Notes
PCMH Provider Report - Reference Document
PCMH Aggregated Patient Report - Reference Document
PCMH Aggregated Patient Report - Quarterly Report Notes

Additional Information

Use the following MDC resources to find out additional information or make inquiries.

Website: https://michigandatacollaborative.org/

General Inquiries: MichiganDataCollaborative@med.umich.edu

Account Inquiries: MDC-Accounts@med.umich.edu

Participant Compliance

To support continued progress within the PCMH Initiative and ensure participant compliance with requirements as outlined in the participation agreement, a series of reports, audits and other compliance mechanisms have been developed to facilitate Initiative understanding of how participants are meeting program expectations. Each report has been focused to capture information that will allow for attestation of participant requirements, as well as provision of information imperative to program implementation and evaluation. The following section outlines the various mechanisms used to gain information about participants and how they continue to execute participation requirements.

PCMH Initiative Progress Reporting

The PCMH Initiative will track participant progress towards achieving relevant milestones in healthcare delivery transformation and to ensure fidelity to the Initiative model. The Initiative will use several types of PCMH Initiative participant reporting (described below) to accomplish these tasks.

PCMH Initiative participant reporting will be collected through the Qualtrics system using a combination of survey response style questions and spreadsheet uploads. Reports will be due at different intervals depending on the report type:

Report Title:	Frequency:	Release:	Due Date (s):	Contents
Practice Self-Assessment	Annually	4-6 weeks prior to due date	2/8/19	Standardized scale and multi-select survey questions for the purposes of assessing overall PCMH practice capability/maturity and how PCMH capability changes over time
Progress Report	Semi-Annually	4-6 weeks prior to due date	4/30/19 and 10/31/19	Participating Organization Contacts Participation Requirements Information, Updates and Attestation Participation Experience, Strengths and Challenges

Report Title:	Frequency:	Release:	Due Date (s):	Contents
Practice Transformation	Every Six Months	6-8 weeks prior to due date	7/31/19 and TBD (Dec 2019 or Jan 2020)	Includes some survey response style transformation progress questions for response on behalf of multiple practices (if applicable) and a small amount of progress narrative specific to each participating practice's transformation activity to track completion of the Population Health objective.

Progress Report:

The progress report is intended to be a brief report utilized to assess the progress participants are making across multiple areas of the Initiative. The progress report will feature spreadsheet-based templates for participating organizations to use in uploading participating organization contacts. Once completed, the spreadsheets can be saved between due dates to expedite subsequent reporting cycles (the spreadsheets will only need to be updated with changes that occurred during the quarter). The participation requirements section of the progress report is attestation-based, providing survey style questions which confirm a participating organization is following all Initiative requirements for compliance purposes. The participation experience section of the progress report will feature a small number of short narrative response and survey questions geared toward understanding how elements of the Initiative are impacting participating practices as well as ascertain participant challenges and opportunities for improvement.

Semi-Annual Practice Transformation Report (SAPTR):

The semi-annual practice transformation report is intended to assess the progress participants are making in implementing the required practice transformation objectives: Clinical-Community Linkages and Population Health Management. The semi-annual report will feature survey style questions with either multiple choice response options or request detailed narrative on progress. POs may be required to upload appropriate documentation to substantiate their reports. The semi-annual report will also feature spreadsheet-based templates for participating organizations to use in uploading participating organization contacts (the same spreadsheets required in the progress report).

Annual Self-Assessment:

Self-assessment reporting will capture details on existing practice capabilities across a number of domains related to care management and coordination, team-based care,

quality improvement, patient engagement, leadership, etc. This annual assessment will provide the Initiative the ability to assess what the technical assistance and practice support needs are for participants, while also allowing a standardized system for capturing participant growth. The assessment tool must be completed at the practice level, therefore in the case of Physician Organizations, or multi-site organizations (such as a Federally Qualified Health Center) each site should complete a separate PCMH Initiative Self-Assessment Tool. Practice transformation, even when directed and supported by consistent organizational leaders, happens differently at the site level. Organizational leaders can compare PCMH Initiative Self-Assessment Tool scores and use this information to share knowledge and cross-pollinate improvement ideas.

It is strongly recommended that the PCMH Initiative Self-Assessment Tool be completed by a multidisciplinary group (e.g., providers, nurses, medical assistants, care managers, other operations and administrative staff) in order to capture the perspectives of individuals with different roles within the practice and to portray the most representative viewpoint of current capabilities. It is additionally recommended that staff members complete the assessment individually, and then meet together to discuss the results and produce a consensus version for final submission via Qualtrics. This discussion is a great opportunity to identify opportunities and priorities for PCMH transformation

Participant Input Opportunities

The PCMH Initiative will provide participants with input opportunities via surveys and committees, along with feedback mechanisms after webinars and in person events. Surveys will be specifically designed to be as concise and simple as possible, while providing targeted feedback to shape technical assistance, reporting or other aspects of the Initiative. The PCMH Initiative is also engages volunteers to serve on committees (for example the Care Coordination Collaborative Planning Committee and the Summit Planning Committee) to help to make these events as beneficial as possible for all involved. Evaluations will be included in all events within the year, and participants are encouraged to complete post webinar and event evaluations to provide the Initiative with real time feedback on areas of improvement. Finally, the PCMH Initiative email MDHHS-SIMPCMH@michigan.gov is available to all participants for questions and other input.

Practice Support and Learning Activities

The PCMH Initiative will facilitate a number of opportunities for participants to engage in collaborative learning, technical assistance, and peer to peer learning. Many of these opportunities/activities are optional; however, participation in the Initiative Quarterly Updates detailed below is required of all participants. To view a calendar of all of the

learning opportunities currently being offered, please review the calendar on the Care Delivery Website.

Quarterly Update Meetings:

The PCMH Initiative will conduct virtual update meetings each calendar quarter. While many opportunities/activities available through the PCMH Initiative are optional; participation in the Initiative Quarterly Updates is mandatory for Physician Organization representatives and key practice staff for practices participating independently. These meetings will provide participants with important Initiative updates and resources for successful participation.

Annual Summit

The PCMH Initiative will support one Annual Summit in 2019 to engage participants across the state of Michigan. The annual summit will be geared towards engaging in networking and opportunities to build on the foundation of regular learning opportunities. This event will be open to participant staff including, but not limited to, administrative staff, care managers and coordinators, quality improvement staff, and other leaders within participating organizations. The Summit Committee will help select the location for our 2019 annual summit, which will be in the fall of 2019.

Care Coordination Collaborative

The State Innovation Model will host Care Coordination Collaborative events in 2019 to support participants in the PCMH Initiative, Medicaid Health Plans, and community partners that are involved in Care Management and Coordination processes (such as Community Health Innovation Regions). These events will serve as opportunities to support networking and facilitate exercises to align efforts, reduce duplication, and identify methods of collaboration on shared patients. The Initiative anticipates hosting a series of regional, half-day events to accommodate participants across the state. The Care Coordination Collaborative Committee will guide decisions around timing and location of these events.

Office Hour Sessions

The PCMH Initiative will offer monthly office hour sessions to provide operational, technical, topic based and current health care policy information in a timely and concise manner. Using a webinar format, PCMH Initiative participants will be able to access sessions that will both inform and allow for peer learning. Topics will be determined based on Initiative current happenings, trends and through feedback from PCMH Initiative participants. Sessions will be about 1 hour in length.

Pediatric Office Hour Sessions

In response to requests for care management curriculum with a focus on pediatric topics, the State Innovation Model PCMH Initiative is providing a series of Pediatric

Office Hours in 2019. The PCMH Initiative will offer the three Pediatric Office Hour Sessions every 2 to 3 months that will be 1 hour in length and a recording will be available. These sessions will be informed by a pediatric office hours workgroup, which will began convening in early 2019.

PCMH Initiative Communications

The PCMH Initiative currently maintains a general public facing web presence on the SIM PCMH Care Delivery website. The website includes resources for implementing/operating the PCMH Initiative, including information on upcoming events and learning opportunities, Summit, archives of newsletters and webinars, guides to billing, coding and payment and contact information should project participants have questions.

Official PCMH Initiative communications will be facilitated via the MDHHS "Gov Delivery" system. The "Gov Delivery" system is designed as a "send only" system. This system is utilized to send PCMH Initiative monthly newsletters and other communications pertinent to participants. Additionally, the PCMH Initiative utilizes the MDHHS-SIMPCMH@michigan.gov mailbox to receive participant questions and other communications.

PCMH Initiative Monthly Newsletters

The PCMH Initiative will send monthly newsletters to all participants to ensure up to date and timely communication of events, technical assistance opportunities, reporting requirements, data distributions, resource ideas and other current happenings. The monthly newsletter will also include a calendar of events for easy reference of upcoming events and report due dates. Initiative participants are encouraged to provide newsletter ideas via MDHHS-SIMPCMH@michigan.gov.

PCMH Initiative Contacts

The PCMH Initiative is possible through a number of partnerships between the Michigan Department of Health and Human Services and various stakeholders, therefore participants may receive communications from these partners in order to support the overall goals and efforts of the Initiative. These partners include:

The Michigan Health Information Network: for information regarding use cases
The Michigan Data Collaborative: for information regarding the impact of clinical data on measure results, dashboard access and member list questions
The University of Michigan: for information regarding project operations
The Michigan Care Management Resource Center: for information regarding Care Manager and Care Coordinator training and education opportunities

The PCMH Initiative is grateful for your continued work on behalf of patients and families. We recognize that this work is incredibly difficult and a team is available to assist you. Below are the best contacts for the various questions you may have throughout the Initiative.

General Questions:
SIM PCMH Initiative Mailbox (MDHHS-SIMPCMH@michigan.gov)

Program Requirements:
Katie Commey (CommeyK@michigan.gov)

Care Management and Coordination:
CMRC mailbox (micmrc-requests@med.umich.edu)
Marie Beisel (mbeisel@med.umich.edu)

Participant Reporting, Compliance and Updates:
Amanda First Kallus (afirst@med.umich.edu)
Yi Mao (yimao@med.umich.edu)

Technology Requirements (Specific to HIE Use Cases):
MiHIN (help@mihin.org)

Performance Dashboards and Downloadable Performance Reports:
MDC MichiganDataCollaborative@med.umich.edu)

Appendix A: SIM PCMH Initiative Glossary

	Acronym	
•	ABD	Aged, Blind and Disabled Medicaid
•	ACRS	Active Care Relationship Service
•	ADT	Admission, Discharge, Transfer Notifications
•	CAP	Corrective Action Plan
•	CCC	Care Coordination Collaborative
•	CCL	Clinical-Community Linkage
•	CCSI	Center for Clinical Systems Improvement
•	CCM	Complex Care Management
•	CHAP	Community Health Accreditation Partner
•	CHIR	Community Health Innovative Region
•	CHW	Community Health Worker
•	CM/CC	Care Management and Care Coordination
•	CMIR	Care Management Improvement Reserve
•	CKS	Common Key Service
•	CPC+	Comprehensive Primary Care Plus
•	FFS	Fee-For-Service
•	FQHC	Federal Qualified Health Center
•	HIE	Health Information Exchange
•	HMP	Healthy Michigan Plan
•	HPD	Health Provider Directory
•	IHI	Institute for Healthcare Improvement
•	MHP	Medicaid Health Plan
•	MiCHWA	Michigan Community Health Worker Alliance
•	MiCMRC	Michigan Care Management Resource Center
•	MiHIN	Michigan Health Information Network Shared Services
•	MPI	Master Patient Index
•	MSA	Medical Services Administration
•	MU	Meaningful Use
•	PMPM	Per Member Per Month
•	PPL	PCMH Patient List
•	PIP	Performance Incentive Program
•	PPQC	Physician Payer Quality Collaboration
•	PT	Practice Transformation
•	PTO	Practice Transformation Objectives
•	QMI	Quality Measure Information
•	RAMP	Relationship and Attribution Management Plan
•	RHC	Rural Health Clinics
•	SDoH	Social Determinants of Health
•	SIM-PCMH	State Innovation Model-Patient Centered Medical Home
•	SNF	Skilled Nursing Facility
•	TANF	Temporary Assistance for Needy Families
•	TCM	Transitional Care Management

Legend • Personnel/Population • Organizations • Reform and Innovation • Sites of Care • Payment and Insurance

A

ABD •
Aged, Blind and Disabled Medicaid
ABD Medicaid is for adults 65 and older or anyone who is disabled according to Social Security.

ACRS •
Active Care Relationship Service
ACRS provides the ability to link patients with their care team members (providers who have declared an active care relationship with that patient).
Learn more

ADT •
Admission, Discharge, Transfer Notifications
Patients transition from one provider or healthcare setting to another as the patients' health care needs require. These transitions trigger Electronic Health Records to generate ADT notifications that identify the patient along with important details that provide insight to an extremely complex set of care decisions being made by care teams, families and the patient.
Learn more

Assessment
A process for defining the nature of that problem, determining a diagnosis, and developing specific treatment recommendations for addressing the problem or diagnosis.

C

CAP •
Corrective Action Plan
A response to a compliance warning notification from MDHHS. CAP describes exactly how a SIM PCMH participant will resolve the issue in order to meet the PCMH-SIM compliance.

CCC •
Care Coordination Collaborative
Supportive networking events designed to facilitate efforts to align, reduce duplication, and identify methods of collaboration on shared patients across SIM participants.

CCLs •
Clinical-Community Linkages
CCLs support referral processes and coordination between clinical care and community-based social services to improve population health.

CCSI •

Center for Clinical Systems Improvement
Also known as Mi-CCSI. MCCSI is an organization supports its stakeholders and their communities to deploy models that deliver better care for individuals, improved population health and lower cost, promote initiatives supporting clinical integration, and develop and provide care management training.
Learn more

CCM •
Complex Care Management
CCM is a set of activities designed to more effectively assist patients and their caregivers in managing medical conditions and co-occurring psychosocial factors.
Learn more

Champion
A Champion has both the vision and authority to drive forward a project within the organization. The champion supports specific change efforts for ongoing practice improvement/organization learning.

CHAP •
Community Health Accreditation Partner
CHAP is an independent, nonprofit accrediting body for home and community-based health care organizations.
Learn more

CHIR •
Community Health Innovative Region
CHIRs are small number of regional governing bodies launched by the SIM program to define regional health priorities, support regional planning, increase awareness of community-based services, and increase linkages between community and health entities in Michigan.

CHW •
Community Health Worker
CHW is a front-line public health worker that has a close understanding of the community served, serves as a liaison between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery, and builds individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support and advocacy.
Learn more

CM/CC •
Care Management and Care Coordination
CM/CC are activities that care manager and care coordinator partner with the practice care team to; effectively empower patients and their families, engage patients in self-management and health behavior change, positively affect patient self-care practices and

decision-making, provide comprehensive assessment and care planning using shared decision making, implement evidence-based interventions and advocate for the right care, at the right time and in the right place.

CKS •
Common Key Service
The Common Key Service use case provides a consistent and reliable way to match patients across multiple organizations, applications and services, ensuring patient safety and high data integrity when data is shared.
Learn more

CMIR•
Care Management Improvement Reserve
A reserved portion of the SIM PCMH Initiative Care Management and Coordination Per Member Per Month (PMPM) Payment, due to Participant poor performance on established Initiative metric.

CPC+ •
Comprehensive Primary Care Plus
CPC+ is a national advanced primary care medical home model that aims to strengthen primary care through regionally-based multi-payer payment reform and care delivery transformation. CPC+ includes two primary care practice tracks with incrementally advanced care delivery requirements and payment options to meet the diverse needs of primary care practices in the US.
Learn more

F

FFS •
Fee-For-Service
System of payment in which providers receive reimbursement for each service they perform.

FQHC •
Federal Qualified Health Center
Clinics offering comprehensive health care to an underserved population and receive Medicare and Medicaid payment.

H

HIE •
Health Information Exchange
Electronic infrastructure that allows health care professionals and patients to appropriately access and securely transmit a patient's vital medical information across sites of cares in many geographic regions of the country.
Learn more

HMP •

Healthy Michigan Plan
The HMP is a category of eligibility authorized under the Affordable Care Act. The benefit design of the Healthy Michigan Plan ensures beneficiary access to quality health care, encourages utilization of high-value services, and promotes adoption of healthy behaviors.

HD•
Health Directory
HD is a foundational service within MiHIN's road map to standardize electronic communications among providers and anyone empowered to access protected health information.
Learn more

I
IHI •
Institute for Healthcare Improvement
IHI is an independent not-for-profit organization which promotes care improvement worldwide.
Learn more

M
MHP •
Medicaid Health Plans

MiCHWA •
Michigan Community Health Worker Alliance
MiCHWA is the CHW information hub for the State of Michigan.
Learn more

MiCMRC •
Michigan Care Management Resource Center
MiCMRC provides training and support for the statewide Care Management initiatives.
Learn more

MiHIN •
Michigan Health Information Network Shared Services
MiHIN is Michigan's initiative to continuously improve health care quality, efficiency, and patient safety by promoting secure, electronic exchange of health information.
Learn more

MPI •
Master Patient Index
MPI is an electronic medical database that holds information on every patient registered at a healthcare organization. It may also include data on physicians, other medical staff and facility employees.

MSA •
Medical Services Administration
MSA oversees the operation of Medicaid plans in Michigan.

MU •
Meaningful Use
A CMS Medicare and Medicaid program that awards incentives for using certified electronic health records to improve patient care.

P

PMPM •
Per Member Per Month
PMPM is a capitation payment that payers provide to providers.

PIP•
Performance Incentive Program
The opportunity for Participants to earn an incentive payment relative to Participant performance on a set of Initiative quality and utilization metrics as presented on the SIM PCMH Initiative dashboard developed by the Michigan Data Collaborative

PPL •
PCMH Patient List
PPL provides a current list of patients who are attributed to a practice and participating in the SIM PCMH project.

PPQC •
Physician Payer Quality Collaboration
The PPQC is a physician-led activity that engages government and commercial payers in an effort to focus quality improvement efforts around a core set of measures and standardize performance report and feedback with health plans.

PT •
Practice Transformation
PT in the SIM-PCMH Initiative context refers to building capability and developing structures which make the work of a PCMH participating practice more effective in the required and selected objective focus areas.

PTO •
Practice Transformation Objectives
PTO refers to the Clinical-Community Linkage and Population Health Management requirement in the SIM-PCMH Initiative context.

Q

QMI •
Quality Measure Information

QMI Use Case contains multiple scenarios for sending, receiving, finding and using quality measure information for different quality reporting programs.
Learn more

R

RAMP •
Relationship and Attribution Management Plan
RAMP has been created to support the identification and capture of relationships between patients/consumers and their healthcare delivery team members, to facilitate the active exchange of necessary information between these identified individuals and organizations.

Referral
Directing a patient for further consultation, review or further action. For example, directing a patient to a medical specialist by a primary care physician.

RHC •
Rural Health Clinics
RHCs are clinics located in rural areas that provide outpatient primary care services and basic laboratory services for Medicaid and Medicare patients.

S

Screening
A process for evaluating the possible presence of a particular problem. The outcome is normally a simple yes or no.

SDoH •
Social Determinants of Health
SDoH are conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels.

SIM-PCMH Initiative •
State Innovation Model-Patient Centered Medical Home Initiative
SIM focuses on the development and testing of multi-payer health care payment and service delivery models in order to achieve better care coordination, lower costs, and improved health outcomes for Michiganders. The SIM-PCMH Initiative is the core component of the SIM strategy for coordinated care delivery, focusing on the development and testing of multi-payer health care payment and service delivery models in order to achieve better care coordination, lower costs, and improved health outcomes for Michiganders.

SNF •
Skilled Nursing Facility

SNF is a type of nursing home recognized by the Medicare and Medicaid systems as meeting long term health care needs for individuals who have the potential to function independently after a limited period of care.

T

TANF •

Temporary Assistance for Needy Families

TANF provides temporary financial assistance for pregnant women and families with one or more dependent children. TANF provides financial assistance to help pay for food, shelter, utilities, and expenses other than medical.

TCM •

Transitional Care Management

TCM includes services provided to a patient whose medical and/or psychosocial problems require moderate or high-complexity medical decision making during transitions in care from an inpatient hospital setting, partial hospital, observation status in a hospital, or skilled nursing facility/nursing facility, to the patient's community setting

Appendix B: Social Determinants of Health Brief Screening Tool

The intent of brief social determinants of health screening is to establish a routinized process through which providers identify (in an actionable manner) social barriers their attributed patient population is facing. Accordingly, the brief screening will not take the place of deeper, more comprehensive assessment processes utilized as part of care management or mandated by other programs, but it should inform those processes

The State Innovation Model is providing this template screening tool to participants; however this tool can be altered to match local needs (e.g. changing how questions are phrased, varying how questions are categorized in domains, choosing different formats to administer the screening such as an EHR template or incorporating into existing patient questionnaires etc.) Participants cannot completely remove one or more of the topics/domains contained in the template, although combining and/or rearranging domains is permitted. PCMHs located in SIM/CHIR regions should work with their CHIRs (typically through a PO) to use the brief screening tool the CHIR in your area has/is developing.

Note: *the tool provided below is representative of the tool provided during the 2017 calendar year to promote participant development of their own tool (or adaptation of the template). The requirements for the PCMH Initiative were updated in 2018, expanding the childcare domain to family care (inclusive of child and elder care), removing the clothing and household domain, and adding the personal and environmental safety domain. Participants, while allowed to alter the questions used within the screening tool, must ensure that the questions used remain consistent with the intent of the domain as defined by MDHHS. To support participants in ensuring consistency MDHHS developed both an updated screening tool template and guidance on the intent of each required domain. As of 2019 all required domains must be implemented.*

Suggested 2018 Social Determinants of Health Screening Tool

Domain	Question	Response	
Healthcare	In the past month, did poor health keep you from doing your usual activities, like work, school or a hobby?	**Yes**	**No**
	In the past year, was there a time when you needed to see a doctor but could not because it cost too much?	**Yes**	**No**
Food	In the past year, did you ever eat less than you needed to because there was not enough food?	**Yes**	**No**
Employment & Income	Is it hard to find work or another source of income to meet your basic needs?	**Yes**	**No**
Housing & Shelter	Are you worried that in the next few months, you may not have housing?	**Yes**	**No**
Utilities	In the past year, have you had a hard time paying your utility company bills?	**Yes**	**No**
Family Care	Do you need help finding or paying for care for loved ones? For example, child care or day care for an older adult.	**Yes**	**No**
Education	Do you want help with school or job training, like finishing a GED, going to college, or learning a trade?	**Yes**	**No**
Transportation	Do you ever have trouble getting to school, work, or the store because you don't have a way to get there?	**Yes**	**No**
Personal and Environmental Safety	Do you ever feel unsafe in your home or neighborhood?	**Yes**	**No**
General	If you answered yes, would you like to receive assistance with any of these needs?	**Yes**	**No**
	Are any of your needs urgent?	**Yes**	**No**

State Innovation Model

Question Intent by Domain

Domain	Intent
Healthcare	Assess patient/client perception of their physical and/or mental health and potential impact on overall wellbeing and independence.
	Assess healthcare access related to cost, or more broadly, economic stability.
Food	Assess food insecurity, access and affordability.
Employment & Income	Assess potential joblessness, and income instability.
Housing & Shelter	Assess potential risk of homelessness, and housing instability.
Utilities	Assess risk, not whether there has been a shut off notice or had services shut off, but as a proxy of economic stability. This question intentionally focuses more broadly than service shut off (i.e. includes notices).
Family Care	Assess whether dependent care may be a barrier to (patient, client, beneficiary) taking care of themselves; assess the potential need for respite care and/or any patient concerns around current family care arrangements.
Education	Assess patient/client education level, ability for economic independence/stability and potential activation.
Transportation	Assess if transportation, or lack of transportation, is a limiting factor in daily life (i.e. goes beyond medical transportation).
Personal and Environmental Safety	Assess potential concerns of personal safety in a broad enough sense to capture potential for subsequent domestic violence screening.
General	Identify if any of the needs the patient, client, beneficiary indicated above are already being addressed or not, and whether the patient, client, beneficiary is open to assistance activation.
	Assess severity of identified needs.

Appendix C: Care Management and Coordination Tracking Quick Reference

2018 PCMH Initiative Care Management and Coordination Tracking Codes Quick Guide

Code	Quick Description	Formal Description	Code Purpose	Provider	Method	Max Frequency (/Beneficiary)	Length (minutes, quantity)	PCP Signature Required	Associated Fee Schedule*	Note
G9001	Comprehensive Assessment	Coordinated Care Fee Initial Rate	Document a comprehensive assessment and development of a care plan with a beneficiary	CM	In-person	Once/year	> 30 minutes	Yes	No	Date of service should be the date the assessment is completed for patients entering into care management. If patient does not agree to enter into care management, the date of service should be the date of the face-to-face component. All active dx should be reported on the claim.
G9002	In-person Encounter	Coordinated Care Fee Maintenance Rate	Document any care management or coordination service provided	CM/CC	In-person	Once/day	1-45 minutes, quantity of one; 46-75 minutes, quantity of two; 76-105 minutes, quantity of three; 106-135 minutes, quantity of four.	No	No	Can be reported on the same date of service as G9001 if care management and coordination service(s) in addition to the comprehensive assessment are provided.
98966	Telephone Services	Telephone assessment and management service to an established patient, parent or guardian	Document any care management or coordination service provided over the telephone or by other real-time interactive electronic communication.	CM/CC	Phone OR Real-time interactive electronic communication	Once/day	5-10 minutes	No	No	Can be reported on the same date of service as G9001 if care management and coordination service(s) in addition to the comprehensive assessment are provided. Should not be used to report routine provider communication such as appointment reminders or test results.
98967	Telephone Services	Same as above	Same as above	CM/CC	Same as above	Once/day	11-20 minutes	No	No	Same as above
98968	Telephone Services	Same as above	Same as above	CM/CC	Same as above	Once/day	21-30 minutes	No	No	Same as above
99495	Care Transition	Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge; AND Medical decision making of at least moderate complexity during the service period; AND Face to face visit within 14 calendar days of discharge	Document supportive services for patients experiencing discharge from an inpatient, long term care, skilled nursing, rehabilitation or emergency department environment to a home or community setting.	CM/CC	Direct contact, telephone, or electronic communication within 2 business days of discharge; AND Face to face visit within 14 calendar days of discharge	Once/ transitional care management period	N/A	No	Yes	Can be reported on the same date of service as G9001 if care management and coordination service(s) in addition to the comprehensive assessment are provided. Reasonable and necessary evaluation and management services (other than the required face-to-face visit) to manage the beneficiary may be reported separately. Other care management and coordination service(s) may be reported during the transitional care management period.
99496	Care Transition	Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge; AND Medical decision making of high complexity during the service period; AND Face to face visit within 7 calendar days of discharge	Same as above	CM/CC	Direct contact, telephone, or electronic communication within 2 business days of discharge; AND Face to face visit within 7 calendar days of discharge	Once/ transitional care management period	N/A	No	Yes	Same as above
G9007	Team Conference	Coordinated Care Fee Scheduled Team Conference	Document meetings between, at minimum, a beneficiary's primary care provider and care manager or coordinator during which formal discussion of a patient's care plan occurs.	1.PCP+CM/CC; OR 2.Primary CM/CC+Specialty CM/CC; OR 3.PCP+SCP+CM/CC	Face-to-face, via secure live video conference OR telephone	Once/day	N/A	No	No	Communication should include substantive, focused conversation pertinent to each patient's individualized care plan and goal achievement.
G9008	Physician Coordinated Care Oversight Services	Coordinated care fee Physician coordinated care oversight services	Document physician engagement at the initiation of care management	Physician	In-person	N/a	N/A	No	No	E&M visit performed by the physician must be simultaneously or previously billed for the patient (for Priority Health: in close proximity to the visit date) Patient/care giver understanding and agreement to care plan 3.Service must include completion of patient assessment. 4. Bill code after the patient enrolls in a care management program.
98961	Group Education and Training	Formalized educational sessions led by qualified non-physician personnel for patient self-management for 2–4 patients	Document educational sessions for patient self-management in a group setting	CM+Other Care Team Members	In-person	None	30 minutes; May be quantity billed.	No	No	There must be some level of individualized interaction included in the session. Must use a standardized curriculum
98962	Group Education and Training	Formalized educational sessions led by qualified non-physician personnel for patient self-management for 5-8 patients	Document educational sessions for patient self-management in a group setting	CM+Other Care Team Members	In-person	None	30 minutes; May be quantity billed.	No	No	Same as above
S0257	End-of-life Counseling	Face to face or telephonic counseling and discussion regarding advance directives or end of life care planning and decisions	Document counseling and discussion regarding advance directives or end of life care planning and decisions	CM+PCP+Other care team members	In-person OR telephone	None	N/A	No	No	

*Associated Fee Schedule is determined individually by each Medicaid Health Plan, additionally, MHPs may choose to include codes beyond 99495 and 99496 on their fee schedule CM: Care Manager PCP: Primary Care Provider

CC: Care Coordinator SCP: Specialty Care Provider

Appendix D: Medicaid Beneficiary Inclusion-Exclusion

A Medicaid beneficiary must have full Medicaid coverage and be served through a Medicaid managed care organization (Medicaid health plan) to be attributed to a participating Practice. For purposes of the PCMH Initiative, the benefit plans listed under "included" below are full Medicaid coverage.

Included Benefit Plans		**Excluded Benefit Plans**		
BMP	Benefits Monitoring Program	APS	Ambulatory Prenatal Services	Not Full Coverage
MA-HMP-MC	Healthy Michigan Plan – Managed Care	CSHCS	Children's Special Health Care Services (FFS)	Not Medicaid Health Plan
MA-MC	Medicaid – Managed Care	CSHCS-MC	Children's Special Health Care Services – Managed Care	Existing and/or Potentially Duplicative Payment Structure
TCMF	Targeted Case Management Flint	HHMICARE	Primary Care Health Homes	Existing and/or Potentially Duplicative Payment Structure
		HHBH	Health Home Behavioral Health	Existing and/or Potentially Duplicative Payment Structure
		Hospice	Hospice	Not Medicaid Health Plan
		ICF-IID	Intermediate Care Facility for Individuals with Intellectual Disabilities	Not Medicaid Health Plan
		ICO-MC	Integrated Care - MI Health Link	Existing and/or Potentially Duplicative Payment Structure
		INCAR-ESO	Incarceration – Emergency Services Only	Not Full Coverage
		INCAR-MA	Incarceration - MA	Not Medicaid Health Plan
		INCAR-MA-E	Incarceration – MA Emergency Services Only	Not Full Coverage

		MA	Full Fee-for-Service Medicaid	Not Medicaid Health Plan
		MA-ESO	Medical Assistance Emergency Services Only	Not Full Coverage
		MA-HMP-ESO	Healthy Michigan Plan Emergency Services Only	Not Full Coverage
		MA-HMP	Healthy Michigan Plan (FFS)	Not Medicaid Health Plan
		MA-HMP-ESO	Healthy Michigan Plan Emergency Services Only	Not Full Coverage
		MA-HMP-INC	Healthy Michigan Plan Incarceration	Not Medicaid Health Plan
		MME-MC	Medicaid – Medicare Dually Eligible – Managed Care	Existing and/or Potentially Duplicative Payment Structure (Medicare)
		MIChild - ESO	MIChild Program – Emergency Services Only	Not Full Coverage
		MI Choice-MC	Home and Community Based Services – Managed Care	Existing and/or Potentially Duplicative Payment Structure
		MOMS	Maternity Outpatient Medical Services	Not Full Coverage
		NH	Nursing Home	Not Medicaid Health Plan
		PACE	Program of All-Inclusive Care for Elderly	Not Medicaid Health Plan
		Plan First!	Family Planning Waiver	Not Full Coverage
		QMB	Qualified Medicare Beneficiary – All Inclusive	Not Medicaid Health Plan
		Spend-down	Medical Spend-down	Not Full Coverage
		SPF	State Psychiatric Hospital	Not Medicaid Health Plan
		QDWI	Qualified Disabled Working Individual	Not Full Coverage / Not Medicaid Health Plan

		SLMB	Specified Low Income Medicare Beneficiary	Not Full Coverage / Not Medicaid Health Plan
		ALMB	Additional Low Income Medicare Beneficiary	Not Full Coverage / Not Medicaid Health Plan
		MKPL-MC	Marketplace Managed Care	Not Full Coverage / Not Medicaid Health Plan
		MA-MKPL	Fee For Service Marketplace	Not Full Coverage / Not Medicaid Health Plan

Not Applicable for Inclusion/Exclusion Decisions

The following benefit plans are either not directly relevant to deciding whether or not a beneficiary can be included in the population (dental, mental health etc.) or represent services that are additions/enhancements to the standard Medicaid state plan benefit (waivers etc.).

HK-Dental Healthy Kids Dental
HK-EXP Full Fee-for-Service Healthy Kids Expansion
HK-EXP-ESO Healthy Kids Expansion Emergency Services Only
NEMT Non-Emergency Medical Transportation
PIHP Prepaid Inpatient Health Plan
PIHP-HMP PIHP Healthy Michigan Plan
DHIP Foster Care and CPS Incentive Payment
AUT Autism Related Services
CWP Children's Home and Community Based Services Waiver
HSW Habilitation Supports Waiver Program
SED Children's Serious Emotional Disturbance Waiver Program
SED-DHS Children's Serious Emotional Disturbance Waiver Program – DHS

For a full Medicaid Benefit Plan Listing:
https://www.michigan.gov/documents/mdch/Benefit_Plan_Table_293077_7.pdf

Appendix E: Screening Best Practices

Many of the PCMH Initiative practices have robust procedures for administering the Social Determinants of Health screening. Below are some best practices submitted by participants.

Screening approach

- Create an office-based process**:** the front desk provides the tool to the patient, the MA interprets the results, and the CM or provider provides referrals if necessary
- Collect responses either electronically or scan paper and enter results into registry for tracking
- Enter results in the EHR (sections such as visit navigator section, social history - social needs assessment). The information is accessible to the care team.
- A patient note/reminder is placed in the EHR. A screening date is noted with the data to help determine the appropriate next screening date.
- For some practices, information is linked to the community HUB or CHIR

Screening tool

- Translate tool for patient population if needed: Spanish, Arabic, visual survey (for patients with limited literacy)

Screening monitoring

- Use patient registry report to identify missed screening
- Use EHR system. For instance, one of the organizations has created an icon that will change color depending on if the screening has occurred during the annual exam. If screening was completed during annual exam, the button turns green or red (green meaning no positive screens identified, red meaning positive screens identified). If screening was not yet completed for patient, button will be purple. Care Team, Providers, and office staff are trained to monitor this icon status as part of daily workflows.
- Monitor each clinic's screening rate and social needs. Primary care leadership expects clinic leadership to be doing continuous quality improvement to increase screening rates and understand social needs at the clinic level.

Appendix F: Linkage Best Practices

Many of the PCMH Initiative practices have robust procedures for linking patients to appropriate community services. Below are some best practices submitted by participants.

Linkage process

- Linkages to community partners can be documented as a specialty referral. Referrals made in the system are tracked to identify which referrals were successfully completed and which referrals did not meet the needs of the patients and the reasons why.
- A clinical order for a linkage is created by the provider or care manager. Once resources are provided, the order status is changed to “completed” if no further follow-up is required. If further follow-up is required or requested by parent/guardian, the order can be changed to “scheduled” and further follow-up can be arranged (through appropriate tasking).

Linkage follow-up

- Standard follow-up: Once a referral for a linkage to a community partner has been provided to a patient, the office follows practice standard policy on referrals, which states that after 2 weeks the office will make contact with the patient to determine if their need was met. If after two attempts the patient is still unable to be reached for follow-up, a letter will be sent, and the order will be closed in the Orders Management documentation tool within the EHR.
- Urgency based follow-up: If an urgent SDOH need is identified, the provider or care manager follows up with the open SDOH linkage as soon as possible; If a non-urgent SDOH need is identified, they follow up with open SDOH referrals at the next scheduled appointment.
- The linkage is treated as any other healthcare referral. Each PCMH practice monitors the referral within the appropriate electronic system and runs a monthly report to see the status of the referral. If the feedback loop is not closed then the patient, caregiver, agency or organization is called to determine barriers.

Linkage outcome documentation

The best practice is to map the survey results to a patient registry and create reports. Reports are created to:

- Identify the percentage of patients flagged as having needs within the various domains. Information is then viewed by insurance plan and age groups to determine areas that patients encounter the largest needs.
- Track patients that have reported having a need to ensure patient needs have been addressed.

Appendix G: Quality Improvement Activities Best Practices

Many of the PCMH Initiative practices have implemented quality improvement activities to ensure all patients receive the Social Determinants of Health screening and are appropriately linked to community services. Below are some best practices submitted by participants.

Screening procedure quality improvement activities

- Close screening gaps: Map data into patient registry. A report is created to identify patients that may have been missed, which allows CMs/CCs to follow up. Track completion rates. Reviewing the information allows the PO to identify any variation in screening rates between offices and improve overall performance. Efficiency in the office is more difficult to monitor, but an inefficient office process can be identified by a smaller than expected number of completed screenings.
- Identify high frequency community needs and collaborate with available resources in the community. For those needs yielding no responses, the wording for questions will be reviewed to ensure it is clear to get the necessary patient feedback.
- Pilots performed to optimize the screening procedure and identify the circumstances under which screenings are most useful have found the following:
    - Try different approaches for completing the screening (paper/phone)
    - Screening is better received when there is a warm hand off between the MA and CHW when the screening is complete and a need is identified. If the CHW has to call the patients after the visit, the screening is less effective. Even with an up-to-date phone number, patients rarely call back or want to discuss needs over the phone.
    - One PO/practice re-engineered the survey tool to align responses for better patient understanding (yes = need/action needed or no = no need/no action), and developed a text based and visual survey instrument given the spectrum of literacy within the targeted survey population.
    - A PDSA cycle revealed that a brief two sentence introduction by the care manager or support staff of why the screening is being completed was more successful in obtaining a completed screen versus a paper copy of the screen only being handed to the patient.

Linkage documentation quality improvement activities

- Identify high volume needs within the community. For instance, one PO identified the need for behavioral health needs and pediatric behavior and development programs. The PO SIM leadership began reaching out to community agencies and establishing relationships. By building relationships, both sides will have the opportunity to identify and improve process gaps that hinder optimal patient care and provision of services.
- Review the community resources quarterly. Staff can report any positive and negative circumstances that they found during the linkage process with the community resources. These include but are not limited to: receiving documentation back to the office, any issues that the patient may have reported, any scheduling issues, patient view of resource, etc.

Build a community services document that identifies highly utilized community resources, providing such details as patient population served, waiting list duration (if any), accepted insurance, location, hours of operation, contact person, etc. staff can utilize this document to determine appropriate community partners to link a patient to.

Appendix H: 2018 Compliance Timeline

To enable further implementation of the core PCMH Initiative components, a wide range of compliance activities have been outlined. All of the requirements outlined in this guide originated in the 2019 Participation Agreement signed by the Participating Organizations, and language will be referenced where appropriate. The guide is organized by month. A short overview of compliance activities for the month are given, followed by requirement details (tracking mechanism, key dates and notes on audits if applicable). For reoccurring requirements, details only appear in the first month in which they are relevant.

The PCMH Initiative is built upon core competencies essential to the operation of the State Innovation Model to ensure the long-term goals of the model are both feasible and effective. Due to this, all practices must maintain PCMH status to participate in the Initiative. The PCMH Initiative will seek to support participants with all other PCMH requirements outlined in the corresponding PCMH Compliance Guide Monthly Checklist and further detail (where appropriate) here:

- Quarterly Report—Initiative participants will be required to submit quarterly reports where they will attest to basic requirements of the Initiative. These reports will be used as the foundation to understand the extent of implementation of PCMH Initiative policies and ensure compliance. However, the PCMH Initiative will also conduct random Administrative Audits.
- Administrative Audits—A random sample will be created in excel using the RAND function. Practices that have been chosen for one area of audit will be excluded from further audits in that calendar year. Selected practices will be contacted and asked to provide the documentation listed in the PCMH Compliance Guide Monthly Checklist.
- MiHIN Use Cases—PCMH Initiative participants will not be required to submit specific documentation regarding their participation in the Use Cases but the Initiative will obtain information from MiHIN regarding this. However, the Initiative may randomly choose practices and request documentation displaying their utilization of these Use Cases. For example: documentation of the ADT Use Case would be a screen shot of the practice's EMR showing a clinical note outlining the corresponding action taken.

The PCMH Initiative has also developed a scoring methodology to determine adherence to compliance requirements. This methodology is determined by weighting performance on 18 areas of compliance, including: timely reporting and contracting, care manager at every practice, performance, infrastructure, practice transformation-Clinical-Community Linkages and Population Health, technology, etc. When a PO or Practice is found to be out of compliance on a given component, a warning letter will be sent by an MDHHS designee. A template for the Corrective Action Plan (CAP) is located at the end of this document If compliance is not met by the dates outlined in

the issued CAP, then further consideration by Initiative leadership could result in payment sanctions or removal from the program.

We encourage participants to proactively identify areas of concern with regards to their compliance status and reach out to an MDHHS designee or MDHHS-SIMPCMH@michigan.gov for further technical assistance and support. While the SIM PCMH Initiative will seek to provide support, it's important that participants work to address their compliance concerns and keep themselves up to date on requirements of the Initiative. We appreciate the hard work involved in providing high quality, patient-centered primary care and hope this guide can facilitate PO and practice understanding and implementation of the program requirements, ensuring that the Initiative reaches its goals.

Activity	Responsibility	January	February	March
Launch/Quarterly Update Meetings	Attended by one representative from each PO or independent practice	**1/8/2019** ☐ Attendance by a representative from every PO/independent practice requirements		
Progress Report	Completed by one representative from each PO or independent practice	**1/31/2019** ☐ Care Manager at every practice ☐ PCMH Status ☐ 24/7 Clinical Access Mechanism with EHR Access ☐ 30% open access ☐ Alternative visit types ☐ Possess & utilize electronic care management documentation ☐ Possess & utilize EHR ☐ Possess & utilize registry ☐ Care Team Meetings		
Practice Self-Assessment	Completed by each participating practice unit		**2/8/2019** ☐ Final report due from each practice	
Administrative Audits	Completed by MDHHS staff		☐ Utilize Dashboards ☐ Utilize Patient Lists	

Ongoing Monitoring	Completed by MDHHS staff	☐ MiHIN Use Cases – maintain all legal documents and be actively participating in: ○ ACRS ○ HPD ○ ADT ○ QMI ☐ Medicaid enrollment – ensure enrollment in CHAMPs	☐ MiHIN Use Cases – maintain all legal documents and be actively participating in: ○ ACRS ○ HPD ○ ADT ○ QMI ☐ Medicaid enrollment – ensure enrollment in CHAMPs	☐ MiHIN Use Cases– maintain all legal documents and be actively participating in: ○ ACRS ○ HPD ○ ADT ○ QMI ☐ Medicaid enrollment – ensure enrollment in CHAMPs

Activity	**Responsibility**	**April**	**May**	**June**
Launch/Quarterly Update Meetings	Attended by one representative from each PO or independent practice	**4/17/2019** ☐ Attendance by a representative from every PO/independent practice requirements		
Progress Report	Completed by one representative from each PO or independent practice	**4/30/2019** ☐ Care Manager at every practice ☐ PCMH Status ☐ 24/7 Clinical Access Mechanism with EHR Access ☐ 30% open access ☐ 6 non-traditional hours ☐ Utilize electronic care management documentation ☐ Possess & utilize EHR ☐ Planned care team meetings		

Activity	Responsibility	April	May	June
		☐ Organize care by teams and empanel patients		
Administrative Audits	Completed by MDHHS staff		☐ Utilize Dashboards ☐ Utilize Patient Lists ☐ Practice consent to participate – provide documentation of PO/Practice PCMH Initiative collaboration ☐ Monthly Planned Care Team Meetings – provide documentation of agendas and meeting minutes	☐ Utilize EHR ☐ 24/7 Clinical Access Mechanism with EHR Access ☐ 30% open access ☐ Alternative visit types
Ongoing Monitoring	Completed by MDHHS staff	☐ MiHIN Use Cases– maintain all legal documents and be actively participating in: ○ ACRS ○ HPD ○ ADT ○ QMI ☐ Medicaid enrollment – ensure enrollment in CHAMPs	☐ MiHIN Use Cases– maintain all legal documents and be actively participating in: ○ ACRS ○ HPD ○ ADT ○ QMI ☐ Medicaid enrollment – ensure enrollment in CHAMPs	☐ MiHIN Use Cases– maintain all legal documents and be actively participating in: ○ ACRS ○ HPD ○ ADT ○ QMI ☐ Medicaid enrollment – ensure enrollment in CHAMPs

Activity	Responsibility	July	August	September
Launch/Quarterly Update Meetings	Attended by one representative from each PO or	**7/17/2019** ☐ Attendance by a representative from every		

Activity	Responsibility	July	August	September
	independent practice	PO/independent practice requirements		
Semi-Annual Practice Transportation Report	Completed by one representative from a PO or independent practice	**7/31/2019** ☐ Clinical-community Linkages ☐ Population Health Management		
Administrative Audits	Completed by MDHHS staff		☐ Utilize Dashboards ☐ Utilize Patient Lists	
Ongoing Monitoring	Completed by MDHHS staff	☐ MiHIN Use Cases– maintain all legal documents and be actively participating in: ○ ACRS ○ HPD ○ ADT ○ QMI Medicaid enrollment – ensure enrollment in CHAMPs	☐ MiHIN Use Cases– maintain all legal documents and be actively participating in: ○ ACRS ○ HPD ○ ADT ○ QMI Medicaid enrollment – ensure enrollment in CHAMPs	☐ MiHIN Use Cases– maintain all legal documents and be actively participating in: ○ ACRS ○ HPD ○ ADT ○ QMI Medicaid enrollment – ensure enrollment in CHAMPs

Activity	Responsibility	October	November	December
Launch/Quarterly Update Meetings	Attended by one representative from each PO or independent practice	**10/16/2019** ☐ Attendance by a representative from every PO/independent practice requirements		
Progress Report	Completed by one representative from each PO or independent practice	**10/31/2019** ☐ Care Manager assigned to every practice ☐ PCMH Status ☐ 24/7 Clinical Access Mechanism with EHR Access ☐ 30% open access ☐ Non-traditional visit types ☐ Utilize electronic care management documentation ☐ Utilize EHR ☐ Utilize registry ☐ Planned care team meetings ☐ Organize care by teams and empanel patients		
Administrative Audits	Completed by MDHHS staff		☐ Utilize Dashboards ☐ Utilize Patient Lists ☐ Care Manager/Coordinator Initial and Longitudinal Training	☐

Activity	Responsibility	October	November	December
Ongoing Monitoring	Completed by MDHHS staff	☐ MiHIN Use Cases– maintain all legal documents and be actively participating in: ○ ACRS ○ HPD ○ ADT ○ QMI Medicaid enrollment – ensure enrollment in CHAMPs	☐ MiHIN Use Cases– maintain all legal documents and be actively participating in: ○ ACRS ○ HPD ○ ADT ○ QMI Medicaid enrollment – ensure enrollment in CHAMPs	☐ MiHIN Use Cases– maintain all legal documents and be actively participating in: ○ ACRS ○ HPD ○ ADT ○ QMI Medicaid enrollment – ensure enrollment in CHAMPs
		☐	☐	☐

Activity	Responsibility	January 2020
Semi-annual Practice Transportation Report	Completed by one representative from a PO or independent practice	**TBD** ☐ Clinical-community Linkages ☐ Population Health

Appendix I: Community Health Innovation Region (CHIR) Framework

The State Innovation Model working collaboratively with all components has developed the following framework to represent an ideal state of Clinical-community Linkages (CCLs). This framework is being used by the CHIR regions to promote cross-collaboration among the various patient services sectors.

Appendix J: Spanish Version of the SDoH Screening Tool

Modelo de innovación

Herramienta de evaluación de factores sociales determinantes para la salud sugeridos en 2018

Dominio	Pregunta	Respuesta	
Cuidados de la salud	En el último mes, ¿la mala salud evitó que usted realizara sus actividades normales, como trabajar, ir a la escuela o algún pasatiempo?	**Sí**	**No**
	En el último año, ¿hubo algún momento en el que necesitaba ver a un médico, pero no pudo hacerlo porque costaba demasiado?	**Sí**	**No**
Alimentación	En el último año, ¿alguna vez comió menos de lo que necesitaba debido a que no tenía suficiente comida?	**Sí**	**No**
Empleo e ingresos	¿Le es difícil encontrar trabajo u otra fuente de ingresos para cubrir sus necesidades básicas?	**Sí**	**No**
Vivienda y albergue	¿Le preocupa que en los próximos meses usted podría no tener una vivienda?	**Sí**	**No**
Servicios públicos	En el último año, ¿ha tenido dificultad para pagar sus cuentas de servicios públicos?	**Sí**	**No**
Cuidado de la familia	¿Necesita ayuda para encontrar o para pagar el cuidado de sus seres queridos? Por ejemplo, guardería o cuidados para un adulto mayor.	**Sí**	**No**
Educación	¿Desea ayuda con la escuela o con la capacitación laboral, como terminar su desarrollo educativo general (GED, por sus siglas en inglés), ir a la universidad o aprender un oficio?	**Sí**	**No**
Transporte	¿Alguna vez tiene problemas para llegar a la escuela, al trabajo o a la tienda porque no tiene cómo llegar?	**Sí**	**No**
Seguridad personal y medioambiental	¿Alguna vez se ha sentido inseguro(a) en su hogar o vecindario?	**Sí**	**No**
General	Si contestó que sí, ¿le gustaría recibir ayuda con cualquiera de estas necesidade	**Sí**	**No**
	¿Alguna de sus necesidades es urgente?	**Sí**	**No**

Appendix K: Arabic Version of SDoH Screening Tool

نموذج ابتكار الدولة

المحددات الاجتماعية المقترحة لعام 2018 لأداة الفحص الطبي

نطاق	السؤال	الإجابة	
الرعاية الصحية	في الشهر الماضي، هل منعتك سوء صحتك من القيام بأنشطتك المعتادة ، مثل الذهاب إلى العمل أو المدرسة أو ممارسة هوايتك؟	**نعم**	**لا**
	في العام الماضي، هل كان هناك وقت تحتاج فيه إلى زيارة الطبيب ولكنك لم تستطع لأن ذلك سيكلفك الكثير؟	**نعم**	**لا**
الغذاء	في العام الماضي، هل سبق لك أن أكلت أقل مما تحتاج إليه لأنه لم يكن هناك ما يكفي من الطعام؟	**نعم**	**لا**
التوظيف والدخل	هل من الصعب العثور على عمل أو مصدر دخل آخر لتلبية احتياجاتك الأساسية؟	**نعم**	**لا**
السكن والمأوى	هل أنت قلق من أنه قد لا يكون لديك سكن، في الأشهر القليلة المقبلة ؟	**نعم**	**لا**
الخدمات	في العام الماضي، هل واجهت صعوبة في دفع فواتير لشركة التي قدمت لك الخدمات؟	**نعم**	**لا**
الرعاية الأسرية	هل تحتاج إلى المساعدة في العثور على الرعاية لأحبائك أو دفع تكاليفها؟ على سبيل المثال ، رعاية الطفل أو الرعاية النهارية لشخص بالغ.	**نعم**	**لا**
التعليم	هل تريد المساعدة في المدرسة أو التدريب الوظيفي، مثل من أجل إنهاء مرحلة التعليم العام، أوالذهاب إلى الكلية ، أو تعلم التجارة؟	**نعم**	**لا**
المواصلات	هل لديك مشكلة في الذهاب إلى المدرسة أو العمل أو المتجر لأنك لا تملك الوسيلة للوصول إلى هناك؟	**نعم**	**لا**
السلامة الشخصية والبيئية	هل تشعر بعدم الأمان في منزلك أو حيك؟	**نعم**	**لا**
العام	إذا كانت إجابتك نعم، هل ترغب في تلقي المساعدة في أي من هذه الاحتياجات؟	**نعم**	**لا**
	هل أي من احتياجاتك هذه ملحة؟	**نعم**	**لا**

Appendix L: Social Determinants of Health Maturity Checklist

The intent of the Social Determinant of Health (SDoH) Maturity Checklist is to help organizations to continue to enhance their systems to support the implementation of SDoH screening and Clinical-Community Linkages (CCLs). As with any major workflow change, planning is imperative, and this checklist attempts to identify areas where an organization has room for growth and where they are already implementing best practices. It is important to consider all elements involved that help streamline not only the activities related to screening and linking patients to needed resources but will also support internal quality improvement processes. While there is a quality improvement domain called out, ongoing quality improvement efforts would include moving along the continuum to eventually achieve the highest level of maturity in each domain. It is likely that an organization would fall into more than one column of maturity depending on the domain and their existing capacities.

Please find the checklist on the following page.

SDoH Maturity Checklist	Beginner	Intermediate	Advanced
Screening Tool	☐ Questions meet the intent of the domains set forth by MDHHS ☐ Question responses consistently indicate need as a positive screen	☐ Questions include needs beyond domains set forth by MDHHS ☐ Question domains overlap with other affiliated practices and community organizations	☐ All questions aligned across all affiliated practices and community organizations
Tool Administration	☐ Survey tool handed to patient by administrative staff ☐ Documented procedure for handing out survey tool	☐ Administered by a staff member accompanied by a priming conversation (what, why, etc.) ☐ Dedicated topic and procedure in new employee training	☐ Survey is filled out by a patient who is accompanied by a Care Manager or Care Coordinator ☐ Standardized training which is implemented on an ongoing basis (i.e. yearly) for all staff
Timing for Screening	☐ Initiated at a new patient visit ☐ Initiated at annual wellness check	☐ Initiated every six months (or frequent, designated intervals)	☐ Incorporate into care plan, which is review every visit ☐ Provide screening option within a patient portal
Technology	☐ Paper tool provided and placed in patient file	☐ Paper or electronic tool provided, and digital image uploaded to the EHR	☐ Electronic tool built into the EHR and discrete data points collected ☐ EHR reminders/flags to prompt screening ☐ EHR alerts to positive screens
Partnerships	☐ Referral options such as Aunt Bertha, 211, or MI Bridges	☐ Identified community organizations in local area that accept referrals for each domain of needs	☐ Setting expectations with community partners for feedback loop of patient linkages

		☐ Engaged partner in community hub that both sends and receives referrals	☐ Formal agreement outlining expectations for partnership
Referrals & Linkages	☐ Referral out: paper copy of resources available with phone numbers to contact ☐ Outward referral data tracked disparately by practice staff	☐ Linkage out: practice contacts community organization on patient's behalf ☐ Follow up after two weeks to identify if need was met ☐ Linkage data tracked electronically from practice to community resource/hub in a systematic way	☐ Closed loop linkage: practice provides warm handoff to community organization. ☐ Community organization indicates if/when need was met and provides information back to the practice ☐ Linkage data tracked electronically both directions in a systematic way ☐ Regularly pull SDoH reports out of EHR to track open linkages
Practice Workforce Capacity	☐ Physicians and administrative staff cover most screening duties	☐ Care Manager/Care Coordinator partially or centrally available across more than one practice to cover screening and linkage duties as available	☐ Full time Care Manager/Care Coordinator directly embedded in practice dedicated to cover all screening and linkage duties
Quality Improvement	☐ Address needs as they arise ☐ Identified QI activities	☐ Assignment of QI activities and responsibilities ☐ Engagement of organizational leadership	☐ Ongoing progress tracking via available data sources ☐ Registry implementation

Revision History

Revision Date	Version	Section(s)	Page(s)	Summary
2.25.2019	V1	All	NA	Initial Draft
4.17.2019	V2	Longitudinal Learning Requirements	20-21	Lowering Care Management education requirement from 12 hours to 8 hours to match the BCBSM change in 2019.
9.13.2019	V3	Appendix L	77-79	Social Determinants of Health Maturity Checklist