State Innovation Model
Patient Centered Medical Home Initiative

Newsletter

Monthly Initiative announcements, news, and upcoming events

JANUARY | 2017

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ABOUT THE INITIATIVE

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

CONTACT US

General questions can be sent to:
SIMPCMH@mail.mihealth.org

Visit the SIM website at:
www.michigan.gov/sim

Questions regarding PCMH Initiative dashboards and portal access can be sent to:
MichiganDataCollaborative@med.umich.edu

Questions regarding Care Manager and Care Coordinator training can be sent to:
micmrc-requests@med.umich.edu

Initiative Announcements

Welcome

Welcome to the 2017 Patient Centered Medical Home Initiative, and the first release of our monthly newsletter. Each month we will bring together all the updates, news and upcoming events relevant to PCMH Initiative Participants. Additionally, we will provide updates on other happenings across the State Innovation Model.

You will continue to receive other regular communications and event reminders from the PCMH Initiative. This newsletter has been developed as a method to share information in one common location.

Ensuring Accurate PO, Practice and Provider Information

The PCMH Initiative actively monitors physician organization (PO), practice and provider information (TINs, NPIs, addresses, etc.) in partnership with Medicaid Health Plans (MHPs) for attribution, identification and payment purposes. As a reminder, any changes to this type of information must be submitted to the PCMH Initiative within 7 days of the change. To further ensure accuracy of the information, lead participating organization contacts will receive a quarterly spreadsheet of current information that should be reviewed for accuracy. While all of the data should be reviewed, there are a few key elements that are especially important:

- **An accurate list of providers.** The Initiative will process patient population attribution monthly, so any provider change need to be reported as soon as possible to ensure patient attribution is correct**.**
- **PO and Practice TIN and payment address.** This information is used for identification and payment by the MHPs.

A reminder that participants must give a 60-day notice to terminate participation from the Initiative. The practice must continue to serve patients during that 60-day period. In order to make changes or note plans for participation termination, **complete the change form**, or highlight the information on the quarterly spreadsheet you receive and send it to **SIMPCMH@mail.mihealth.org**

Michigan Care Management Resource Center Approved Self-Management Support Training Programs

The PCMH Initiative requires both Care Managers and Care Coordinators to complete Self-Management Support Training, for information about MiCMRC approved self-management training programs please review **this document.** This document includes details for each MiCMRC approved self-management program: location, objectives, modality, resources, course date/criteria to schedule, trainer qualifications, certification/CEs, and cost.

Important Information from Michigan Data Collaborative

Michigan Data Collaborative (MDC) is the data analysis and visualization partner for the PCMH Initiative. As the Initiative moves forward, we want to make sure you are aware of the following key participant information:

PCMH Patient Lists

Each month, MDC will create a PCMH Patient List (PPL) for each Practice as well as an aggregated list for each Managing Entity (Provider Organization). The PCMH Patient List provides a current list of patients who are attributed to a practice and considered participating in the PCMH Initiative. We plan to release the first PPL during the first full week of February and will send out notification and access instructions when it is available.

User Access

A communication was sent to Participant primary contacts in order to identify users for the MDC portal, and is in the process of securing user IDs and access information for those users that have been identified to date. Those individuals that have had user IDs and access information established, will begin receiving instructions on portal access and how to access their SIM PCMH Patient lists starting February 1. If you have yet to establish your organizations user access for the MDC portal, please contact MDC at the email address noted to the left.

New Website

MDC recently launched an updated website, which you can access here (**http://michigandatacollaborative.org**). Updates and support documentation will be added as applicable.

Practice Self-Assessments

The PCMH Initiative Self-Assessment Tool is intended to assess Participating Practices on their current Patient Centered Medical Home capabilities and identify opportunities for the Initiative to support participants in the future. The PCMH Initiative Self-Assessment Tool will also help sites track progress toward practice transformation when completed at regular intervals. The Self-Assessment tool will be released no later than Monday February 6th, and should be completed by February 28th. The completed information will be used to inform baseline capability and assess the areas of additional support and resources that would be most helpful to participants.

News

MiCMRC Complex Care Management Course Registration – 2017 Updates

The MiCMRC Complex Care Management (CCM) course, a required course for all PCMH Initiative Care Managers, has been updated to include new content covering social determinants of health, and expanded content on team based care. There is no fee for this course, and it provides both Social Work CE and Nursing CE!

The MiCMRC Complex Care Management course is designed to prepare healthcare team members for taking on the role of Complex Care Manager. Course content is applicable to all Care Managers in the ambulatory care setting, working with complex patients. The MiCMRC Complex Care Management Course (CCM) curriculum provides the framework for the complex care management role, foundational elements of integration into the ambulatory care setting, and development of complex care management skills.

The training format for MiCMRC CCM course consists of: a one-hour introductory live webinar, recorded webinar self-study (consisting of approximately 6 hours of course content) and two days of in-person classroom instruction.

Due to the growing number of care management programs in 2017, CMRC is now requiring the PO leader, practice manager or attendee's direct manager to register care managers for the Complex Care Management Course. This will facilitate accurate completion of the course registration materials and access to longitudinal resources.

NOTES: If you have 15 or more Care Managers in your area and would like the MiCMRC team to provide a regional training at your location please submit your request to: **micmrc-ccm-course@med.umich.edu**

*Upcoming course dates are noted in the **Upcoming Events section below**.*

Care Management Resource Center Announces New eLearning—Online "Basic Care Management Program"

The Michigan Care Management Resource Center is proud to announce a new interactive online program focused on building care management skills and quick tools for daily work. The online eLearning series is open to all care managers and other care team members at no cost. Learn at your pace and at a time convenient for you!

This online learning opportunity is designed for busy care managers and other care team members. The "Basic Care Management Program" consists of a series of online, interactive modules. Each module has brief 15-30 minute lessons which are ideal for a busy schedule.

When you participate in the eLearning modules you are joining care managers and office practice team members across the state from many practices and physician organizations, building core skills and improving the care delivered to their patients.

Each module will offer continuing education contact hours for both nursing and social work. Modules available beginning February 2017 include:

- *Medication Management*
- *Introduction to Advance Care Planning and Palliative Care*
- *Transition of Care (coming soon!)*

Modules are due to be released in February. Stay tuned to our website for more information @ **www.micmrc.org**

Upcoming Events

MiCMRC Complex Care Management Courses

- **February 20-23, 2017 - Lansing** Registration deadline: February 16th, 2017.
- **February 27- March 2, 2017 - Grand Rapids** Registration deadline: February 23rd, 2017.
- **March 20-23, 2017 - Lansing** Registration deadline: March 16th, 2017.

Register Here: **http://micmrc.org/training/micmrc-complex-care-management-course/registration**

Care Manager/Coordinator CE Opportunity

Title: Introduction to COPD

Date: Wednesday February 22, 2017 2:00pm to 3:00pm

Presenters: Catherine Meldrum, PhD, MS, RN, CCRC, & Carlos Martinez, MD, MPH

Register Here: **http://micmrc.org/webinars**

SIM Updates

Community Health Innovation Regions

The Community Health Innovation Region (CHIR) is a commitment to the upstream factors that can prevent utilization of some types of health care and social services, and ensure that required care for chronic conditions have complementary community-based services in addition to clinical care. The CHIR concept requires a community-based organizing and governance model that improves partnership among community partners, and between health care providers and community organizations, to meet the whole health needs of individuals. CHIRs are intended to be regional governing bodies facilitated by a backbone organization and are a core component of the SIM test.

Starting in August 2016, CHIRs started meeting individually and as a cohort with MDHHS to help develop regionally governance structures and to frame the CHIR participation guide which was released in November 2016. Since that time, the regions have been working very hard to develop operational plans that will guide their implementation efforts starting August 2017.

The major components of the CHIR include:

- A coalition governance model sufficient to produce Collective Impact across the social determinants of health
- Clinical-Community Linkage activities that bridge healthcare and social services
- Infrastructure and processes for data sharing and analytics across clinical and community-based organizations

The three year vision for the Clinical-Community Linkage component of CHIRs, an element directly relevant to participating PCMH Initiative practices, is a process that:

- Becomes integrated into clinical and community-based service providers' workflow in a manner that is sustainable beyond the SIM period for SIM priority populations
- Assess the system-level capacities of community-based service providers, and consistently fulfills the referrals generated during the intake and screening processes
- Explores multiple reimbursement structures among payers and providers to support Post-SIM payment reform options that enhance investments into population health improvement endeavors

Participating Patient-Centered Medical Homes located within a CHIR region will all have the opportunity to participate with CHIRs, especially in designing and implementing Clinical-Community Linkages. PCMHs will also coordinate their participation in a CHIR with the Accountable Systems of Care within their regions.