Michigan Department of Health & Human Services

# Quarterly Update(Q2)

*State Innovation Model*

*Patient Centered Medical Home Initiative*

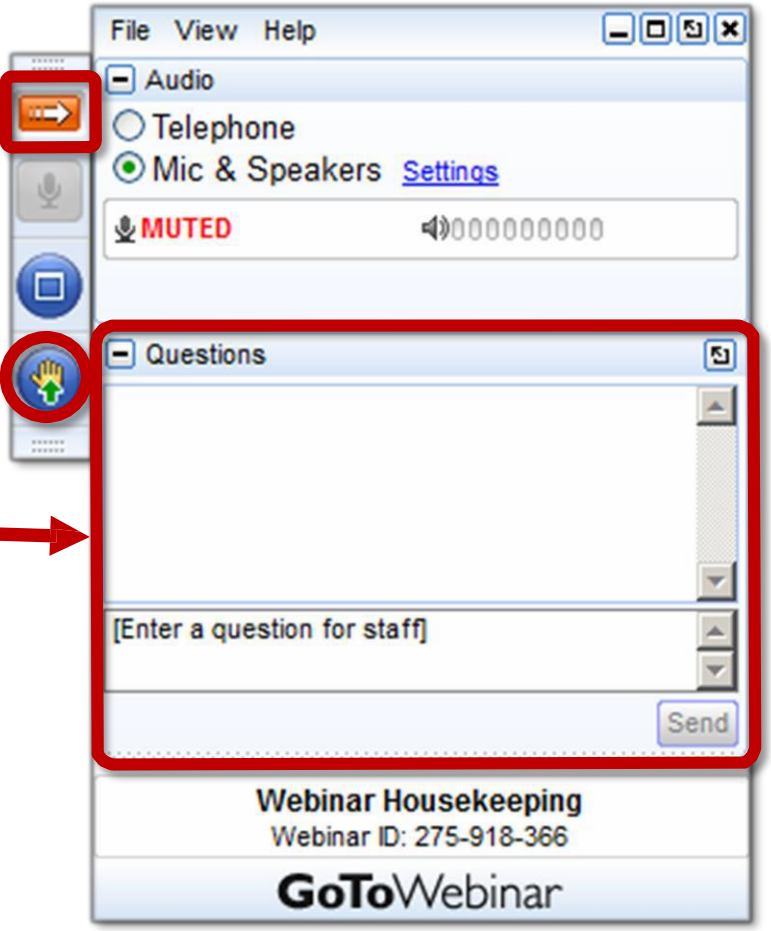
June 22, 2017

# Housekeeping: Webinar Toolbar Features

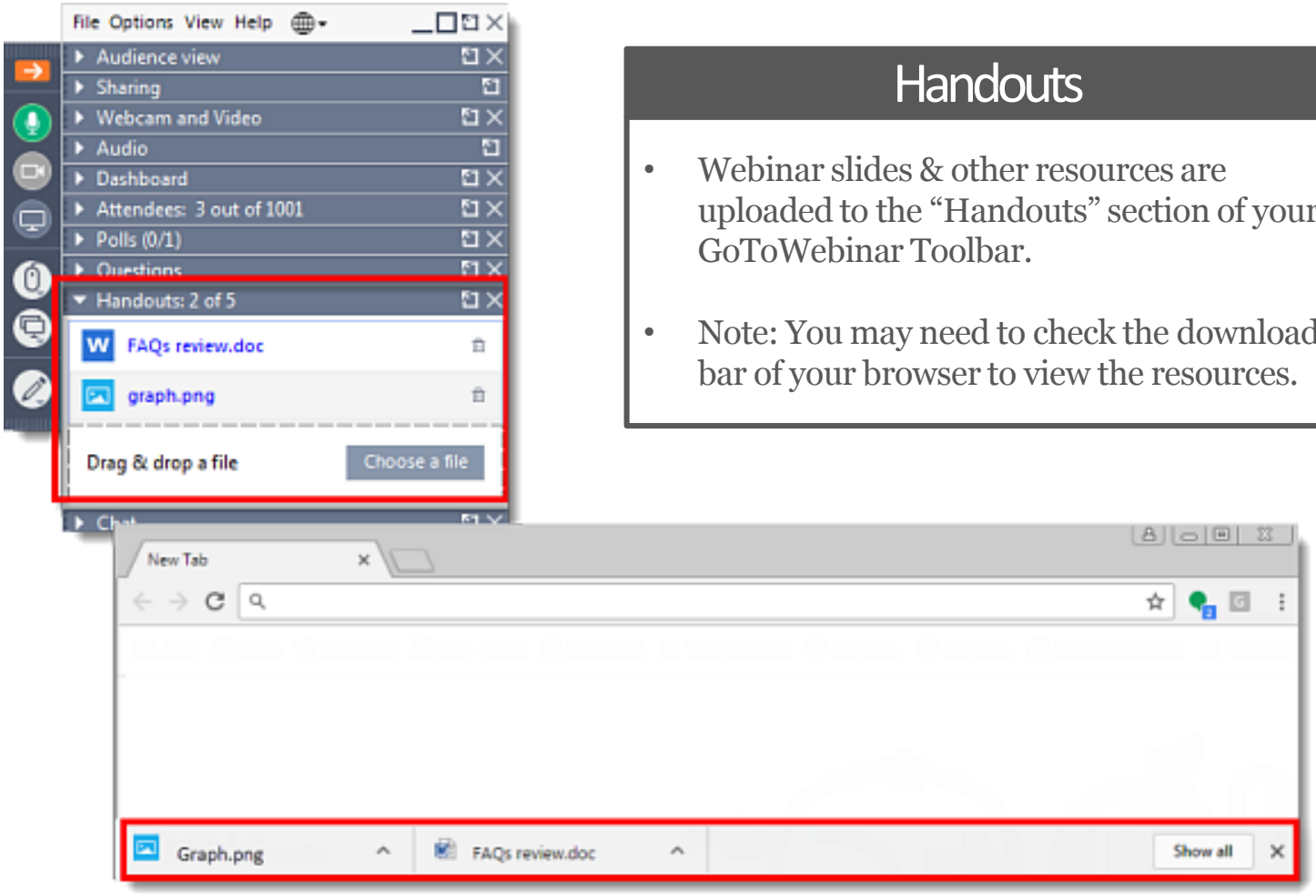
**Collapse Toolbar**

**Raise Your Hand**

**Ask a Question**



# Housekeeping: Webinar Resources/Handouts




## Handouts

- Webinar slides & other resources are uploaded to the "Handouts" section of your GoToWebinar Toolbar.
- Note: You may need to check the download bar of your browser to view the resources.

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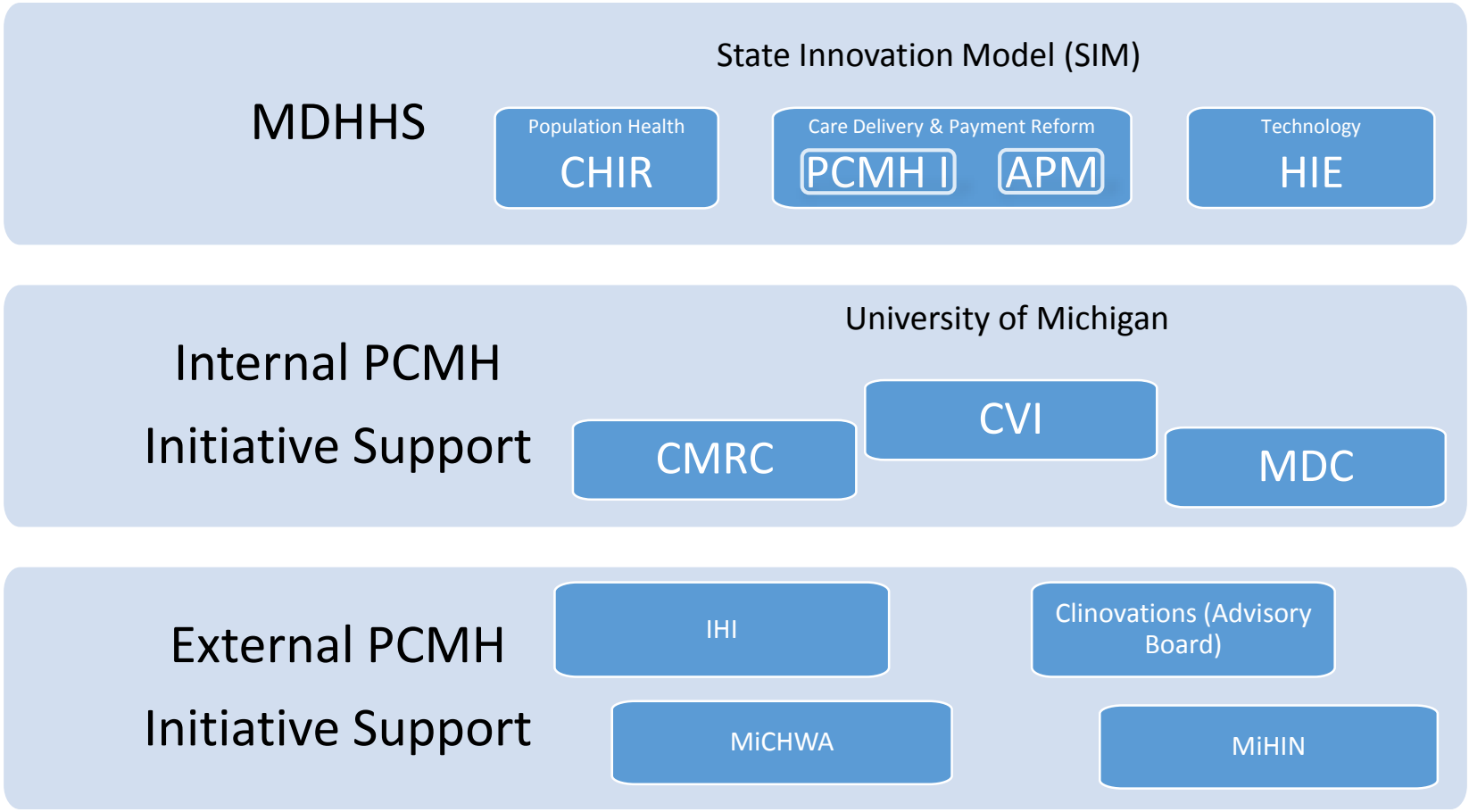
# Quarterly Update(Q2)

*State Innovation Model*

*Patient Centered Medical Home Initiative*

# SIM PCMH Initiative Team Structure




*Putting people first, with the goal of helping all Michiganders lead healthier and more productive lives, no matter their stage in life.*

# The MDHHS PCMH Initiative Team

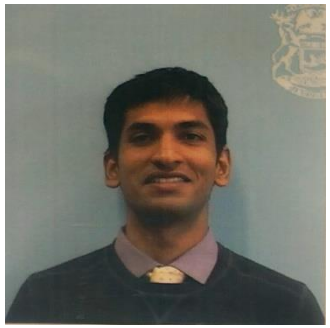
**Kathy Stiffler**
MSA, Deputy Director

**Katie Commey**
PCMH Initiative Coordinator

**Phillip Bergquist**
Policy & Strategic Initiatives Manager

**Justin Meese**
Sr. Business Analyst

**Linda Pappas**
Project Assistant



**Yagna Talakola**
Project Manager

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# The PCMH Initiative Internal Support Team

**Amanda First**
Analyst - CVI

**Diane Marriott**
Director - CVI

**Veralyn Klink**
Administrator - CVI

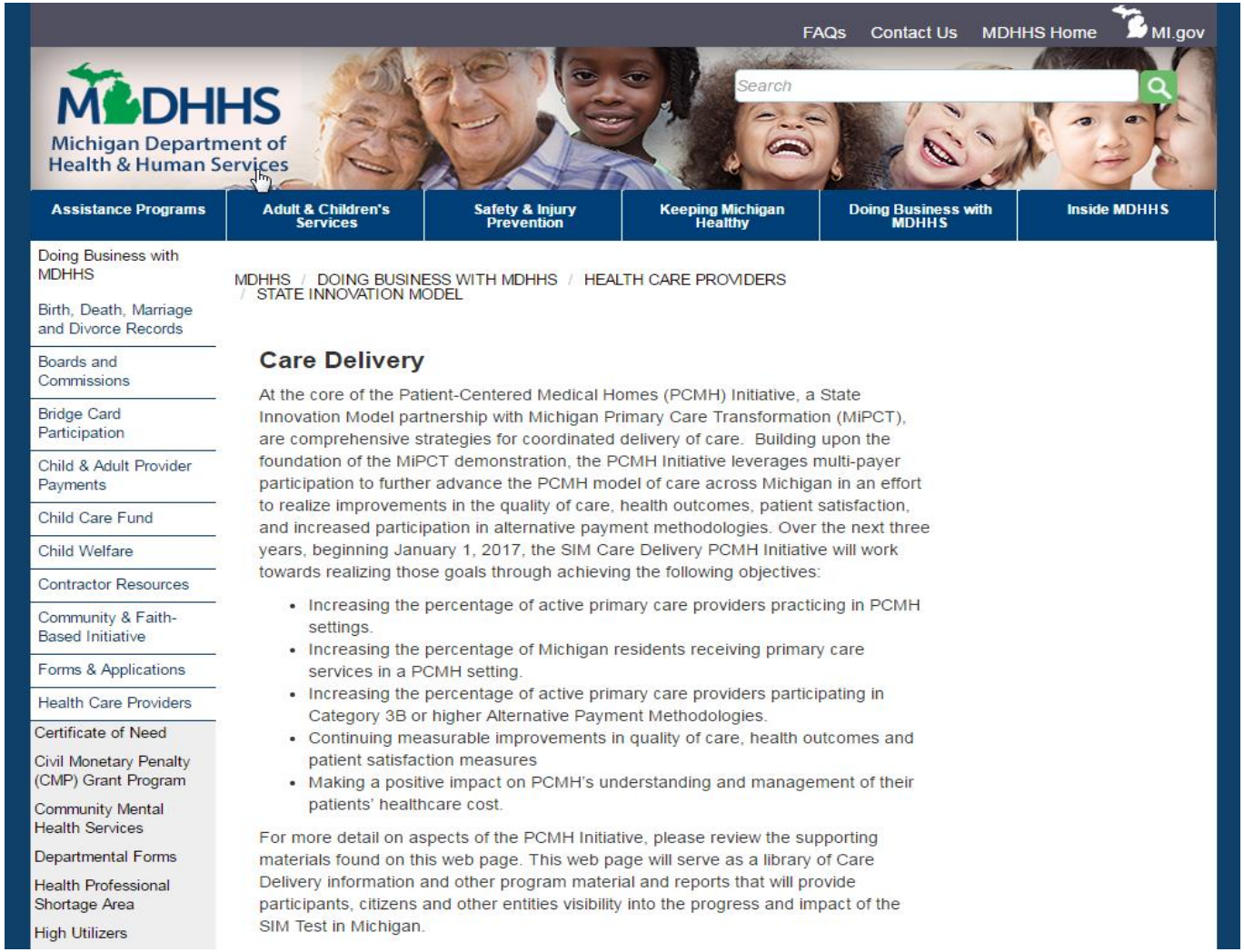
**Yi Mao**
Analyst - CVI

**Marie Beisel, MSN, RN, CPHQ**
Sr. Project Manager - CMRC

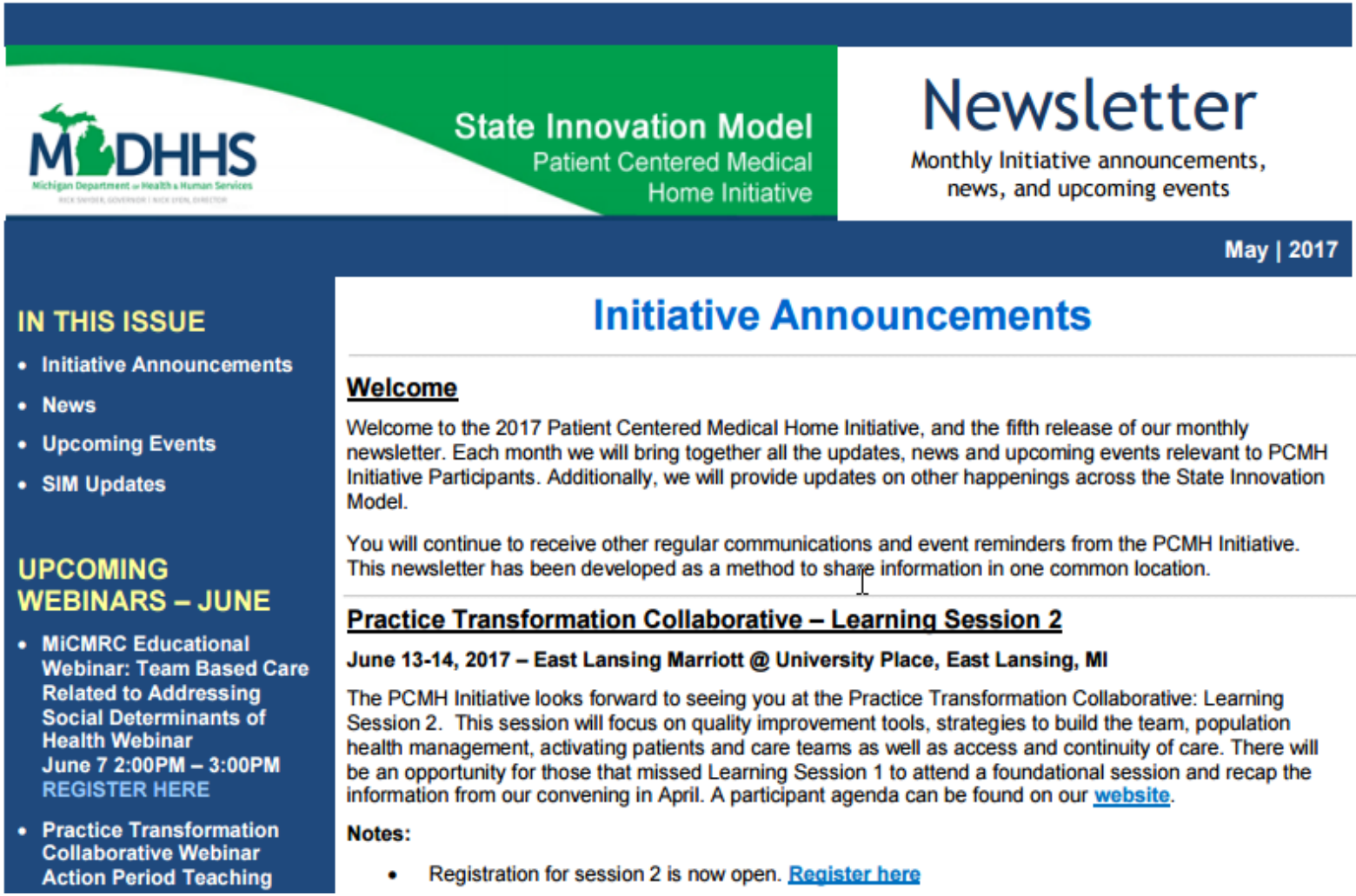
**Lauren Yaroch, RN**
Project Manager - CMRC

**Susan Stephan**
Sr. System Analyst - MDC

# Participant Resources: MDHHS SIM Care Delivery Website



# Participant Resources: Monthly Newsletter



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State Innovation Model
Patient Centered Medical Home Initiative

Newsletter
Monthly Initiative announcements, news, and upcoming events

May | 2017

**IN THIS ISSUE**

- Initiative Announcements
- News
- Upcoming Events
- SIM Updates

**UPCOMING WEBINARS – JUNE**

- MiCMRC Educational Webinar: Team Based Care Related to Addressing Social Determinants of Health Webinar
  June 7 2:00PM – 3:00PM
  REGISTER HERE
- Practice Transformation Collaborative Webinar Action Period Teaching

## Initiative Announcements

### Welcome

Welcome to the 2017 Patient Centered Medical Home Initiative, and the fifth 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.

### Practice Transformation Collaborative – Learning Session 2

**June 13-14, 2017 – East Lansing Marriott @ University Place, East Lansing, MI**

The PCMH Initiative looks forward to seeing you at the Practice Transformation Collaborative: Learning Session 2. This session will focus on quality improvement tools, strategies to build the team, population health management, activating patients and care teams as well as access and continuity of care. There will be an opportunity for those that missed Learning Session 1 to attend a foundational session and recap the information from our convening in April. A participant agenda can be found on our website.

**Notes:**

- Registration for session 2 is now open. Register here

# Quarter 1 (January – March 2017) Payments

Payments for Quarter 1 were disbursed by each participating payer (the 11 Michigan Managed Care Organizations) to the PCMH Initiative Participants.

- Payments require an established payment arrangement

The PCMH Initiative worked with partners at the Michigan Data Collaborative to develop an aggregate Q1 PCMH Initiative Patient list to assist in the payment reconciliation process.

- This will become a standard deliverable for each quarter, in line with payment cycles

# Background: Care Management and Coordination Metrics

To receive the PMPM care management and coordination payment, Practices must:

- Maintain care management and coordination expectations as defined in Appendix C (of the 2017 Participation Agreement). **Reported during Quarterly Reports**
- Maintain care management and coordination performance above benchmarks established by the Initiative no later than June 30, 2017, on the following two metrics:
  - The percentage of a Practice's attributed patients receiving care management and coordination services; and
  - The percentage of a Practice's attributed patients receiving a timely (within 14 days) follow-up visit with a Provider following a hospital inpatient or emergency discharge or transfer from one care setting to another.

# Care Management and Coordination Metric Benchmarks

**2017 BENCHMARK**

Any patient who has had a claim with one of the applicable codes during the reporting period

---

Eligible Population

→ **2.0%**

Any patient who sees a PCP, within 14 days of the last discharge date on a room and board claim in the measurement period.

---

Eligible Population with an inpatient claim*

→ **XX%**

This metric will be revisited at Q3 update

*Exclude any member who had an inpatient stay in a psychiatric facility.

# Technical Setback

A technical setback was uncovered during the Quarter 1 payment process, MDHHS has been investigating. This setback has impacted deliverables related to patient attribution, including the following items:

- PCMH Initiative Patient Lists
- The Quality Measure Dashboards
- Quarter 2 Payment

# Quarter 2 (April – June 2017) Payments

Quarterly payments rely on monthly patient lists. With technical setbacks impacting the generation/delivery of patient lists, it is anticipated that Q2 payments will be delayed. MDHHS is actively working to minimize any potential delay.

The PCMH Initiative will continue to work with MDC to generate monthly patient lists, and a Q2 aggregate patient list.

The PCMH Initiative will work with Medicaid Health Plans to process payments in a timely manner, once anticipated payment dates are known, participants will be notified.


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# Participant Engagement Opportunities

# Billing and Coding Collaborative

- Key Partners: Clinovations/The Advisory Board (for Medicare Care Mgt G/CPT Codes) and Medicaid (for Medicaid Tracking Codes)

- Key Dates:

| All Sessions Take Place From: 11:30 AM -1:00 PM ET | | | | |
|---|---|---|---|---|
| Date | Engagement Opportunity Type | | Topic | Other Information |
| | Topic-Focused Webinar | Q&A Hour | | |
| June 27, 2017 | | X | Q/A Re: Complex Chronic Care Management (CCCM) and Chronic Care Management (CCM) Codes | Submit your questions in advance on the registration link |
| July 25, 2017 | X | | Strategies to Overcome Patient Engagement Challenges Related to CMS' Incorporation of Patient Financial Liability | |
| August 1, 2017 | | X | Q/A Re: Strategies to Overcome Patient Engagement Challenges Related to CMS' Incorporation of Patient Financial Liability | Submit your questions in advance on the registration link |

For more information, see the Billing and Coding Collaborative informational flyer

# Practice Transformation Collaborative

**TRANSFORMATION OBJECTIVES DEVELOPED**

**COLLABORATIVE ORIENTATION CALL**
**March 9, 2017**
**Pre-Work:**
- Draft Aim for Clinical Community Linkages
- Vulnerable patient story

| Learning Session 1<br>April 3-4, 2017 | Learning Session 2<br>June 13-14, 2017 | Future Learning Sessions<br>TBD |
|---|---|---|
| **Clinical-Community Linkages** | **Population Health Management & Clinical-Community Linkages** | **TBD** |

Learning Sessions are face-to-face sessions that include the following:
- Plenary and breakout sessions focused on the PCMH Transformation Objectives combined with Quality Improvement tools and methods to advance the work.
- Dedicated team meeting time.
- Poster sessions.
- Opportunities to meeting informally with peers and communities of practice from around the State.

Learning Session Guiding Principles:
- Incorporate interaction and mixture of formats for participants—honor adult learning principles.
- Minimize didactic (talking head) sessions.
- Engage participants as the teachers/faculty as soon as possible.
- Provide sufficient time for teams to plan together.
- Set a pace—urgency and excitement.

*All teach, all learn*


**Action Period (AP) Supports**

***Monthly AP Teaching Webinars (April 13, May 11, June 8, July 13) :***
The aim of these webinars are to accelerate testing of changes between face-to-face sessions. Teams come together for continued learning around the Transformation Objectives, the Model for Improvement, changes teams are making and helpful quality improvement tools & methods.

***Bi-Monthly Peer Coaching Webinars (May 16-19; July 18-21—Select One Bi-Monthly):***
Also aimed at accelerating change and improvement, these bi-monthly webinars offer dedicated space for teams to engage in facilitated conversations and coaching with one another. Participants will create their own agenda of things that they need to talk about to advance the work.

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# Practice Transformation Collaborative: July Bi-Monthly Peer Coaching Webinars

| ALL SESSIONS TAKE PLACE FROM 12:00 – 1:00PM ET | | |
|---|---|---|
| **Date** | **Focus** | **Details** |
| **Tuesday, July 18** | Implementing SDoH Screening | Screening tool, mapping to current screenings/processes, testing the workflow design |
| **Wednesday, July 19** | Establishing Linkage Process | Going beyond the referral, examples from developing and testing the linkage process and documentation |
| **Thursday, July 20** | Designing CCL QI Activities | Identifying activities to test CCL design, how will success be measured? Driving continuous improvement |
| **Friday, July 21** | Practice/PO Leaders | Supporting a larger team, or multiple practices in CCL design, testing and implementation |

To register for these sessions follow this link

# Affinity Groups – Care Managers and Care Coordinators

| **Benefits of Participation:** |
|---|
| **The Participants of the Affinity Groups identify the focus/topics for each Affinity Group meeting.** |
| **Meetings are interactive with participants sharing experiences, challenges, lessons learned and successes.** |
| **Networking opportunities.** |
| **Affinity Groups are offered quarterly via one hour virtual meetings.** |
| **Care Managers and Care Coordinators who participate in an Affinity Group will receive a maximum of *four longitudinal learning activity hours* each calendar year.*** |
| **Care Manager & Care Coordinator Participant Commitment:** |
| **Attendees will participate in a variety of ways during the interactive virtual meeting; posting questions, sharing experiences and lessons learned, and responding to polls.** |
| **Completion of post meeting evaluation.** |
| **Post meeting information sharing. Attendee contact information will be shared with the group to promote networking. Example: in addition to the contact information, sharing information such as area of expertise.** |
| **Completion of a brief survey to identify future high priority Affinity Group meeting topics.** |

# Affinity Groups – CMs/CCs Upcoming Connections

| Date | Patient Population | Topic | Registration | Other Information |
|---|---|---|---|---|
| **August 2, 2017** | Adult | Care Manager and Care Coordinator Visit Documentation: What and How? | **Register Here** | Submit your questions in advance on the registration link |
| **August 3, 2017** | Adult | Shared Care Planning: What and How? | **Register Here** | Submit your questions in advance on the registration link |
| **August 10, 2017** | Pediatric | 1. Care Manager and Care Coordinator Visit Documentation: What and How?2. Shared Care Planning: What and How? | **Register Here** | Please identify your topic of interest (1 or 2) in advance on the registration link.<br><br>Submit your questions in advance on the registration link |

# Potential Participant Opportunity: Patient Experience of Care

- Patient Experience of Care is a valuable PCMH capability that the PCMH Initiative supports and is exploring opportunities to support participants in engaging in a structured/standardized manner to gather data on Patient Experience of Care with key partner Greater Detroit Area Health Council (GDAHC) through the Michigan Patient Experience of Care Initiative. The potential opportunity could provide:
  - Voluntary opportunity for low-cost all-panel patient experience of care surveying with CG-CAHPS nationally-recognized survey instrument
  - Transparency—publicly available performance information
  - Access to evidence-based, actionable data (incl. benchmarking uniquely available through MiPEC) that physicians can use to improve patient experience
  - Capacity to meet BCBSM PCMH capability 4.4 and Priority Health PIP PEC measurement requirement, generating incentive $
  - Support toward NCQA Distinction in Patient Experience Reporting recognition

Note:

- There would be an associated cost to participating POs/practices
- Would require MOU and submission of data before the end of July

*** The PCMH Initiative is soliciting participant feedback on this opportunity via a live poll, will communicate further availability once opportunity is finalized*

# 2017 Annual Summit(s)

These regionally located events are designed to provide an opportunity for team members within participating organizations to gather, connect with other participants, engage in knowledge and skills building, and learn about vision and strategy for future of the Initiative.

Tentative dates/locations:

| Summit West | Summit Southeast | Summit North |
|---|---|---|
| Grand Rapids | Ann Arbor | Thompsonville |
| Tuesday, October 10 | Tuesday, October 17 | Tuesday, October 24 |

*** The PCMH Initiative is soliciting participant feedback on these locations via a live poll, will communicate finalized dates/locations as soon as available*

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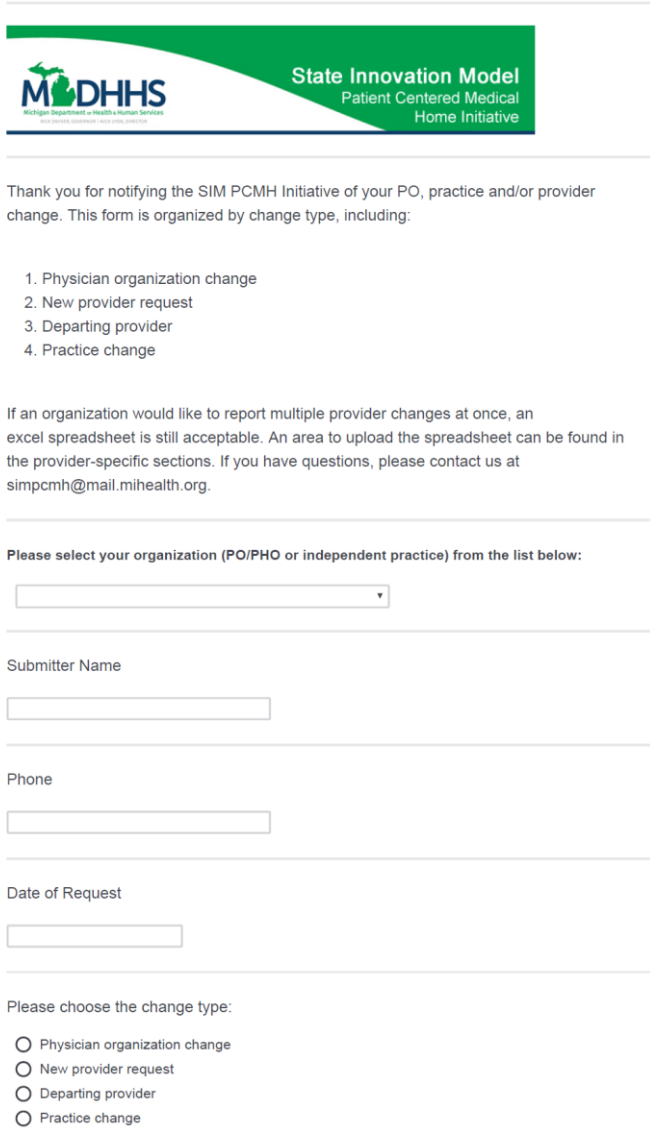
# Participant Requirements and Compliance

# Change Form to become Electronic

- Participants can begin submitting PO, practice and provider changes online
- https://umich.qualtrics.com/jfe/form/SV_d5015qVCFHixFwV
- If an organization would like to report multiple provider changes at once, an excel spreadsheet is still acceptable. An area to upload the spreadsheet can be found in the provider-specific sections.
- Forms emailed to the SIM mailbox will also be accepted for several months



MDHHS State Innovation Model Patient Centered Medical Home Initiative

Thank you for notifying the SIM PCMH Initiative of your PO, practice and/or provider change. This form is organized by change type, including:

1. Physician organization change
2. New provider request
3. Departing provider
4. Practice change

If an organization would like to report multiple provider changes at once, an excel spreadsheet is still acceptable. An area to upload the spreadsheet can be found in the provider-specific sections. If you have questions, please contact us at simpcmh@mail.mihealth.org.

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

Submitter Name

Phone

Date of Request

Please choose the change type:

- Physician organization change
- New provider request
- Departing provider
- Practice change

# Compliance

- Comprehensive guide released today

- Requirements can be grouped into 6 categories:
  - Care Management
  - Learning Requirements
  - PCMH Status and Infrastructure
  - Practice Transformation
  - Technology
  - Participation and Reporting

- Audits to be conducted for the following requirements:
  - Care Management Workspace
  - Utilize EHR
  - 24/7 Access to a Clinical Decision-Maker
  - 30% Open Access
  - 6 non-traditional hours
  - Medicaid enrollment
  - Monthly care team meeting

# Sample Entry – Care Management Ratio

**Tracking mechanism:** All quarterly reports. A care manager ratio will be calculated based on the FTE counts from the quarterly reports over the attribution received from MDC.
**Report dates:** 4/30/17, 7/31/17, 10/31/17, 1/31/18
**Participation Agreement Language:** Maintain a ratio of at least 2 Care Management and Coordination staff members per 5,000 patients attributed (see Appendix B) to the Practice as part of the PCMH Initiative.
**Outcomes Leading to Corrective Action:** Less than 2 FTE care managers or coordinators per 5000 attributed members
**Corrective Action Process:** Approximately 3 weeks after the quarterly report deadline, an MDHHS designee will send a warning letter giving POs/independent practices 3 weeks to submit a corrective action plan. Corrective action plans must resolve the issue by the end of the current quarter (i.e. deficiencies from Q1 must be resolved by the end of Q2).
**The issue will be considered resolved when:** PO submits email verification that the ratio has been met and submits the care manager/coordinator name, email, FTE and primary practice.
**Consequences if not resolved:** Care management funding suspended
**Additional documentation/notes:** The care management ratio will be calculated by PO/independent practice and will be a ratio of total care management/coordination FTE over attributed members as of the last month of the previous quarter (data supplied by MDC).

# Quarterly Report II

- Released today, June 22, 2017
- **Due Monday, July 31, 2017**
- Content:
  - PO and practice contacts and champions
  - Care Manager and Care Coordinator staffing information
  - Medicaid Health Plan contracting information (new)
  - Clinical decision support (new)
  - Infrastructure, practice, and provider changes
  - Participation experience, strengths and challenges

# Semi-Annual Practice Transformation Report

- Released today, June 22, 2017
- **Due Monday, July 31, 2017**
- Content:
  - Clinical-Community Linkages (CCL)
    - Assessing social determinants of health
    - Linkage methodology
    - Quality improvement activities
  - Practice Transformation Objective(PTO) identified by POs
    - PTO will have a subsection for each PTO selected.

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# PCMH Patient List and Participant Dashboard

# MDC Upcoming Deliverables

- Targets are dependent on receipt of revised SIM Participation Files
- May PCMH Patient List (PPL) targeted for mid-July
  - Target Dates forthcoming
    - Ongoing monthly PPLs
    - January through April PPLs
- Release 1 Dashboard targeted for July
  - Visualizations and charts
  - Reporting Period: 1/2016 - 12/2016 (Baseline)
  - January 2017 Attribution
  - Medicaid eligibility, medical and drug claims as well as January attribution utilized to calculate measure results

# Dashboard Measures

- Quality Measures
  - Breast Cancer Screening
  - Diabetes Eye Exam Performed
  - Diabetes Hemoglobin A1c Testing Performed
  - Diabetes Medical Attention for Nephropathy
  - Use of Imaging for Low Back Pain
- Utilization Measures
  - All-Cause Readmission
  - Emergency Department Visits
  - Hospital Admissions
- Chronic Conditions (Identify prevalence in the population)
  - Asthma
  - Hypertension
  - Obesity (Any, Moderate, Overweight and Severe)

# MDC Connection Options

- Revised streamlined connection to the MDC portal
  - Single sign-on requires Level 2 credentials and DUO (not Level 1)
  - 10 beta users successfully accessed the site and downloaded files
  - Addressed issues that users had encountered in the original site:
    - Browser incompatibility
    - Previous VPN
    - Firewall issues
  - Utilizes Citrix Receiver
  - With the next deliverable, this new option will be available to everyone
  - Eventually, this will be the only method to access the portal
- Secure FTP
  - Some users have requested that MDC provide the patient lists (PPLs) using sFTP
  - If you have interest using this option, please contact Susan Stephan at susanmst@med.umich.edu
- MiShare is still an option as needed

# MDC Documentation

- Patient Lists:  PCMH Patient List Information Guide
- Dashboard
  - User Guide
  - Technical Guide describing measures and chronic condition calculation
  - Timeline visual showing the historical data included for each measure and chronic condition
  - Release Notes
- Connection to the MDC portal documentation
  - Accessing SIM PCMH Project Site (original connection)
  - Accessing the SIM PCMH Project Site Using Virtual Places (revised connection to the portal)
  - Installing Duo to Use Two Factor Authentication
- Aggregated Patient Report:  Quick Reference

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# Use Case Onboarding

# SIM PCMH Participants

**Managing Organizations:**

- 29 Physician Organizations
- 5 Multi-Site Practices

**Practices:**

- 338 Total Practices
  - Includes 9 Independent Practices

**Providers:**

- 2150 Physicians

# SIM PCMH Initiative Legal Agreement Status

| SIM PCMH Initiative Participants | MUCA/SDOA/QDSOA | ADT | ACRS | HD | QMI | CKS |
|---|---|---|---|---|---|---|
| Medicaid Health Plans | 100% | 100% | 100% | 100% | 100% | 100% |
| Managing Organizations | 100% | 100% | 100% | 100% | 100% | 100% |
| Multi-site Practices | 100% | 100% | 100% | 100% | 100% | 100% |
| Independent Practice Units | 100% | 100% | 100% | 100% | 100% | 100% |

# SIM PCMH Initiative Onboarding Status: Overall Participation

| SIM PCMH Initiative Participants | TOTAL (OF 43) | PERCENTAGE |
|---|---|---|
| In ACRS Service | 38 | 88% |
| In Health Directory | 38 | 88% |
| Receiving ADTs | 29 | 67% |

# SIM PCMH Initiative Onboarding Status

| SIM PCMH Initiative Participants | ACRS | ADT | HD |
|---|---|---|---|
| 29 Managing Organizations | 26 of 29<br>90%<br>In Production | 22 of 29<br>79%<br>In Production | 26 of 29<br>90%<br>In Production |
| 5 Multi-Site Practices | 100%<br>In Production | 2 of 5<br>40%<br>In Process | 100%<br>In Production |
| 9 Independent Practice Units | 7 of 9<br>78%<br>In Production | 4 of 9<br>44%<br>In Production | 7 of 9<br>78%<br>In Production |

**MiHIN and the PCMH Initiative Team are working with participants that need assistance with technical onboarding**

# Medicaid Health Plan Use Case Onboarding

| Medicaid Health Plan | ACRS | ADT | HD |
|---|---|---|---|
| Aetna | In Production | In Production | In Production |
| Blue Cross Complete | In Production | In Production | In Production |
| HAP Midwest Health Plan | In Production | In Production | In Production |
| Harbor Health Plan | In Production | In Production | In Production |
| McLaren Health Plan | In Production | In Production | In Production |
| Meridian Health Plan | In Production | In Production | In Production |
| Molina Healthcare | In Production | In Process | In Production |
| Priority Health | In Production | In Process | In Production |
| Total Health Care | In Production | In Process | In Production |
| United Healthcare Community Plan | In Production | In Process | In Production |
| Upper Peninsula Health Plan | In Production | In Production | In Production |

# PCMH Initiative Quality Measure Use Case

| SIM PCMH Initiative Participants | TOTAL (OF 43) | PERCENTAGE |
|---|---|---|
| Kick Off Call Complete | 42 | 98% |
| SFTP Accounts Created | 18 | 42% |
| PPQC Files Received | 4 | 9% |

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# Care Manager and Coordinator Training and Learning Opportunities

# CM/CC Initial Required Training

| Initial Required Training | Care Coordinator | Care Manager |
|---|---|---|
| MiCMRC Approved Self-Management Support Course | X | X*** |
| MiCMRC CCM Course | | X |
| SIM Overview Module (Self-Study) | X | X |
| PCMH, Chronic Care model, ACOs Module (Self-Study)* | X | X |
| Team Based Care Module (Self-Study)* | X | X |
| Social Determinants of Health Module (Self-Study)** – *coming soon!* | X | X |

*Self-Study modules are included in the CCM Course content. If Care Manager attends the CCM course *after January 2017*, they do not need to retake the modules.

**Self-study module is included in the CCM course content. If Care Manager attends the CCM course *after July 2017*, they do not need to re-take this module.

***Care Managers are *strongly encouraged* to complete this course prior to registering in the MiCMRC CCM Course.

# Social Determinants of Health (SDOH) Expanded Curriculum

MiCMRC Complex Care Management Course offered monthly

Blended learning activity: live webinar, self study recorded webinars and 2 in person course days

- Registration: http://micmrc.org/training/micmrc-complex-care-management-course/registration

NEW . . . Starting June 19 – 22, 2017 the CCM course will include expanded SDOH content:

- Self study recorded webinar
  - "SDOH Introduction"
- In Person
  - "SDOH Implications for Care Management"
  - "Role of the Care Manager and Care Coordinator in Developing and Maintaining Clinical Community Linkages"
  - Group activities – case study, community mapping, care mapping
- Resources
  - Sample SDOH screening tools
  - Community resource mapping tool

# CM/CC Initial Required Training: SDOH Self-Study Module

The SDOH online required training includes:

- Recorded Webinar
  - Introduction to SDOH
  - Role of the Care Manager and Care Coordinator in Developing and Maintaining Clinical Community Linkages
- Interactive web based module
  - Implications of SDOH for Care Management
  - Case study
- Resources
  - Sample SDOH screening tools, community mapping tool

***NOTE:*** The SDOH online initial required training is to be completed by:

- All Care Coordinators
- Care Managers who took the Complex Care Management course prior to July 2017
- Starting approx. end July 2017, access the SDOH online required training at http://micmrc.org/training/supported-programs/sim-pcmh
- Date for completion of the SDOH online required training: 6 months after go live date

# CM/CC Longitudinal Learning Activity Requirements

The PCMH Initiative requires Care Coordinators and Care Managers must complete twelve (12) hours of education per year.

- The requirement of training throughout the year is termed "longitudinal learning activity". This can be satisfied by:
  - Twelve (12) hours of PCMH Initiative -led Care Manager and Care Coordinator webinars/sessions (e.g., topic based live and recorded webinar trainings, web based interactive self-study eLearning modules, in person Summit, etc.), OR
  - Six (6) hours of PCMH Initiative - led Care Manager and Care Coordinator webinars/sessions PLUS six (6) hours of PO-led, or other related learning activity events. No preapproval is necessary for PO-led care manager, care coordinator training sessions

# CM/CC Longitudinal Learning Activity Opportunities

- Care Management Webinars offered monthly by MiCMRC http://micmrc.org/webinars
  - Live and recorded webinars
  - Several of the Live and recorded provide CE Contact Hours for Nursing and Social Work
    - *New* recorded SDOH webinars titled: "SDOH and Team Based Care", "SDOH Impact on Chronic Conditions"

- Basic Care Management Program – web based, interactive eLearning http://micmrc.org/e-learning
  - CE Contact Hours for Nursing and Social Work upon completion of each module
  - Module Topics
    - Medication Reconciliation
    - Transition of Care
    - Introduction to Palliative Care and Advance Care Planning
    - Role of the Care Manager
    - 5 Step Process
    - Care Planning
    - Patient engagement – coming soon!

# Michigan Care Management Resource Center

micmrc

Search...

Home | Training & Support | Care Management 101 | Topics | Resources | Webinars | Best Practices

New! Available Now

## MiCMRC CareManagement eLearningCourses

- Free online lessons
- Learn at your own pace
- Earn CE Credit

### Programs MiCMRC Supports

MiCMRC provides training and support for the following statewide Care Management initiatives:

BCBSM Provider-Delivered Care Management

BCBSM PDCM-Specialists

SIM - PCMH Initiative

Comprehensive Primary Care Plus (CPC+)

High Intensity Care Model

### Continuing Education

Select MiCMRC activities offer the opportunity to obtain free CE credits in Nursing or Social Work suitable for Michigan professional licensing requirements. Click here for more information regarding CE activities...

### MiCMRC Complex Care Management Course

The MiCMRC Complex Care Management course is designed to prepare the healthcare professional for the role of Complex Care Manager. **Read More**

### MiCMRC-Approved Self-Management Support Programs

MiCMRC approves Self-Management Support Programs. For a detailed summary listing program objectives, resources, tools, locations and more, click to view or download the PDF file

### Care Management Connection Newsletter

Keep up with the latest care management news from MiCMRC. Click for the latest or past issues ...

### Share Your Success Story

MiCMRC wants to hear about and share success stories in care management, team-based care and high intensity care management (HICM). Click here to share yours...

### Upcoming Webinars

**MiCMRC Educational Webinar**

Wednesday, May 24, 2017 - 2:00pm

PAIN MANAGEMENT

**Pain Assessment in Ambulatory Care - Time to Repeal and Replace the Pain Score**

Presented by
Terri Voepel-Lewis, PhD RN

***Application in progress for Nursing and Social Work CE contact hours***

Webinar Registration

**MiCMRC Educational Webinar**

Wednesday, June 7, 2017 - 2:00pm

WEBINAR

SOCIAL DETERMINANTS OF HEALTH

**Team Based Care Related to Addressing Social Determinants of Health**

Presented by
Cherry Health Care Team

Alcona Health Center Care Team

# Resources for CM/CC Training

- SIM PCMH Initiative Participation Guide describes required Initial learning activities and longitudinal education requirements
  - http://www.michigan.gov/documents/mdhhs/2017_PCMH_Initiative_Participant_Guide_Draft_v1_1-9-16_547757_7.pdf

- MiCMRC SIM web page to access the required Initial self study modules
  - http://micmrc.org/training/supported-programs/sim-pcmh

- MiCMRC Complex Care Management Course registration
  - http://micmrc.org/training/micmrc-complex-care-management-course/registration

- Questions for MiCMRC, please submit to micmrc-requests@med.umich.edu

# SIM Training Requirements for Care Coordinator and Care Manager

Resources:

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Michigan Department of Health & Human Services

# Discussion

Michigan Department of Health & Human Services

# Thank You

*State Innovation Model*

*Patient Centered Medical Home Initiative*

Reminder Future Quarterly Updates:

**Quarter 3; 09/21/2017** | REGISTER HERE

**Quarter 4; 12/14/2017** | REGISTER HERE