2018 SIM PCMH Initiative Regional Summit

Seamless Partnerships for Effective Patient Care

THE HOLIDAY INN MUSKEGON - HARBOR

939 THIRD STREET

MUSKEGON, MI

Welcome - Overview

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Policy, Planning, and Legislative Services Administration
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Disclosures

There is no conflict of interest for anyone with the ability to control content for this activity.

Participants who successfully attend the entire conference event and complete the online CE request process, including required evaluation with email address, will earn 4.5 contact hours.

This continuing nursing education activity was approved by the Ohio Nurses Association, an accredited approver by the American Nurses Credentialing Center's Commission on Accreditation. (OBN-001-91) ONA # 21757

Disclosures

The project described was supported by Grant Number CMS-1G1-14-001 from the Department of Health and Human Services, Centers for Medicare & Medicaid Services. The contents of this publication are solely the responsibility of the authors and do not necessarily represent the official views of the U.S. Department of Health and Human Services or any of its agencies. The research presented here was conducted by the awardee. Findings might or might not be consistent with or confirmed by the findings of the independent evaluation contractor.

Requirements for Nursing, Social Work, and Commission for Case Manager Certification CE Contact Hours

- Attend the entire Summit
- Sign in upon arrival
- Complete the evaluation
  - Access the evaluation on the MDHHS SIM PCMH Initiative Summit registration web page or click here

Note: For a Certificate of a Completion use the above web link

Instructions for Obtaining CE Credit or a Certificate of Completion

To receive Nursing, Social Work, or CCMC continuing education contact hours or a certificate of completion for “Michigan State Innovation Model (SIM) Patient Centered Medical Home (PCMH) Initiative Summit 2018”:

Access the Summit evaluation form and certificate request by clicking on this link to the MDHHS SIM Summit web page, scroll down the page to Summit West-Muskegon, and click on “Muskegon Summit Evaluation".

- You will need to use your MiCMRC dashboard log in.

- If you do not have a MiCMRC dashboard, you will need to create a dashboard login on the micmrc.org website.
- Please note that after creating your login, you will need to return to the MDHHS SIM Summit web page .

To request CE or a Certificate of Completion, complete the brief form and click submit

- Next, complete the evaluation and submit. This step generates an email to you containing the certificate
- If you do not receive the email with attached certificate in your Inbox, please check your Junk/Spam email
- You will also have the option to download your certificate directly from your dashboard

For technical assistance please e-mail: micmrc-requests@med.umich.edu

Agenda - Morning

8:00 - 9:00 AM	Registration and Continental Breakfast Resource Table / Networking
9:00 - 9:30 AM	Welcome: Michigan's SIM PCMH Initiative Regional Summit and Objectives
9:30 - 10:45 AM	Plenary: Effective Patient Care Delivery: Patient Identification and Medical Behavioral and Social Need Support
10:45 - 11:00 AM	BREAK
11:00 - 12:00 PM	Concurrent Breakout Sessions A. Social Determinants of Health and Community Resources B. Medicaid Tracking Codes C. Behavioral Health
12:00 - 12:45 PM	LUNCH: Boxed Lunches available, Informal Networking Opportunity

Agenda - Afternoon

12:45 - 2:00 PM	Concurrent Breakout Sessions D. Practice Workflow for Target Populations E. Medicaid Tracking Codes *(Repeat of Morning Session)* F. Behavioral Health *(Repeat of Morning Session)*
2:00 - 2:15 PM	BREAK
2:15 - 3:15 PM	Plenary: Sustainability Post-SIM
3:15 - 3:30 PM	Wrap-Up and Closing

Welcome - State of the State

KATHY STIFFLER
ACTING DIRECTOR MEDICAL SERVICES ADMINISTRATION
MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES

Learning Objectives

- Identify SIM Successes
- Year 2 progress to date and opportunities
- Year 3 looking ahead

Before SIM – There Was MiPCT

The Michigan Primary Care Transformation demonstration was a 5 year multi-payer program sponsored by the Centers for Medicare and Medicaid Services (CMS). With the goal of supporting advanced primary care including care coordination, improved access, patient education, etc.

MiPCT Statistics:

- Over 1800 providers participated
- 346 PCMH practices were involved
- Over 1,158,650 patients were attributed
- MiPCT supported the hiring and training of over 500 care managers

Overall MiPCT demonstrated:

- Better patient experience
- Improved cost and utilization with high risk patients
- Improved adult quality indicators

MiPCT offered many foundational elements to further advanced primary care delivery in Michigan.

SIM was designed to:

- Provide Michiganders with improved access to healthcare and increased connection with community resources
- Create capacity for resource coordination and promote strategy alignment across stakeholders
- Enhance patient-centered outcomes
- Promote more efficient and effective healthcare expenditures

SIM Components

Care Delivery

- Patient-centered medical homes
- Advanced payment models

Population Health

- Community health innovation regions

Focused on:
Clinical-community linkage

Supported by:

- Stakeholder engagement
- Data sharing and interoperability
- Consistent performance metrics

SIM Care Delivery Goals

1. Champion models of care which engage patients using comprehensive, whole person-oriented, coordinated, accessible and high-quality services centered on an individual's health and social well-being.
2. Support and create clear accountability for quantifiable improvements in the process and quality of care, as well as health outcome performance measures.
3. Create opportunities for Michigan primary care providers to participate in increasingly higher level Alternative Payment Methodologies.

The PCMH Initiative

SIM PCMH Initiative Participants:

355 practices:

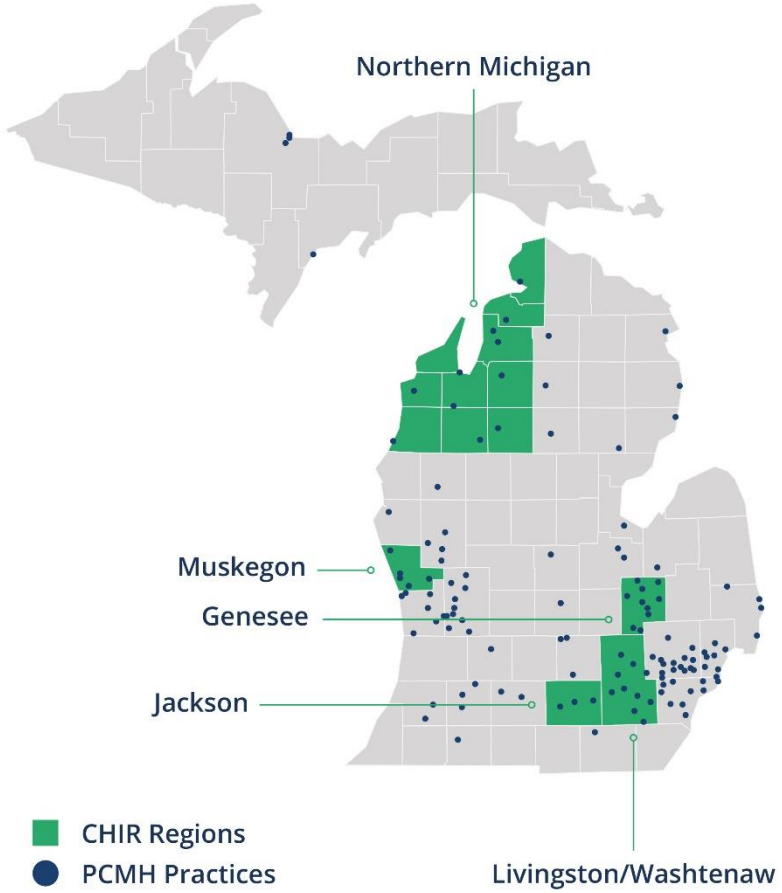
- 328 members of a Physician Organization
- 18 Federally Qualified Health Center sites
- 9 Single Practice sites

238 previous MiPCT participants

125+ CPC+ (track 1 & 2) participants

206 within a SIM Test Region
150 outside of a SIM Test Region

Capacity and experience with PCMH capabilities including comprehensive coordinated care, and screening for social need varied across participants



PCMH Initiative: Successes

Clinical Community Linkages

- Significant effort in the development of Social Determinants of Health Screening processes and workflows
- Over 50% of participants implement a screening system that allows patients to self-administer the screening or for staff to administer the screening
- While Care Managers and Coordinators play a large role in the administration and review of completed screenings, many team members are involved in the whole process

- Over 250,000 screenings have been completed to date!
  - Areas of Greatest Reported Need:
    - Healthcare (Behavioral Health)
    - Food Assistance
    - Transportation

- 68% of providers have reported using Social Determinants of Health Screening data to inform treatment/service delivery
- 94.3% practices strongly believe they have an important role in identifying/addressing their patient's social needs

Care Management and Coordination

- Preliminary Reports indicate that in 2017 alone over 14,000 Medicaid Beneficiaries received at least one Care Management/Coordination service as a result of the SIM PCMH Initiative
- SIM patients were more likely than other Medicaid beneficiaries to receive multiple CM/CC services (illustrating provision of longitudinal relationships)
- Almost half of the SIM patients with a CM/CC claim had a face to face visit
- SIM patients are more likely to receive a CM/CC service following an inpatient hospitalization

Note: only 2017 data has been analyzed at this time and MDHHS acknowledges that the data is likely an underrepresentation of the overall services provided within the SIM PCMH Initiative due to claims optimization processes that occurred in late 2017 and early 2018.

PCMH Initiative: Opportunities

- Provider/Patient Attribution
  - Support Policies and processes to ensure appropriate patient attribution to providers
- Care Management and Coordination
  - Support processes to ensure appropriate and timely adjudication of care management and coordination claims
  - Support opportunities to explore how the provision of similar services to the same beneficiaries can be coordinated across Medicaid Health Plans, Providers, Community Partners, etc.
- Social Determinants of Health
  - Define and Standardize Social Determinants of Health Priority data and sharing amongst appropriate partners

PCMH Initiative: Looking to the Future

MDHHS Values:

- The Patient Centered Medical Home
- Comprehensive Whole Person-Centered Care
- Access to resources to address health and social service needs
- Care Managers and Coordinators

- <u>Future Challenges:</u>
  - Impending Election
  - Ever Changing Healthcare Landscape

- <u>Future Opportunities:</u>
  - SIM Plan for Improving Population Health
  - Proposal for Change

Behavioral Health:
We Can and Must do Better

PHIL BATY MD

No relevant disclosures


with ny
Peeps

"Primary care cannot be practiced without addressing mental health concerns, and all attempts to do so result in inferior care."

FRANK DEGRUY III, M.D., MSFM, Woodward-Chisholm professor and chair of the Department of Family Medicine at the University of Colorado

Learning Objective

- Describe effective patient care delivery addressing Patient Identification, Medical, Behavioral and/or Social Determinants (SDoH) Support

Agenda

- Mental Health in Primary Care
- Usual Care management
- Collaborative Care care management
- Benefits


Q1 Q2 Q3 Q4 FINAL
MATHMATICS
SCIENCE
SPELLING
PHYSICAL EDUC
ART

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Daily Mail
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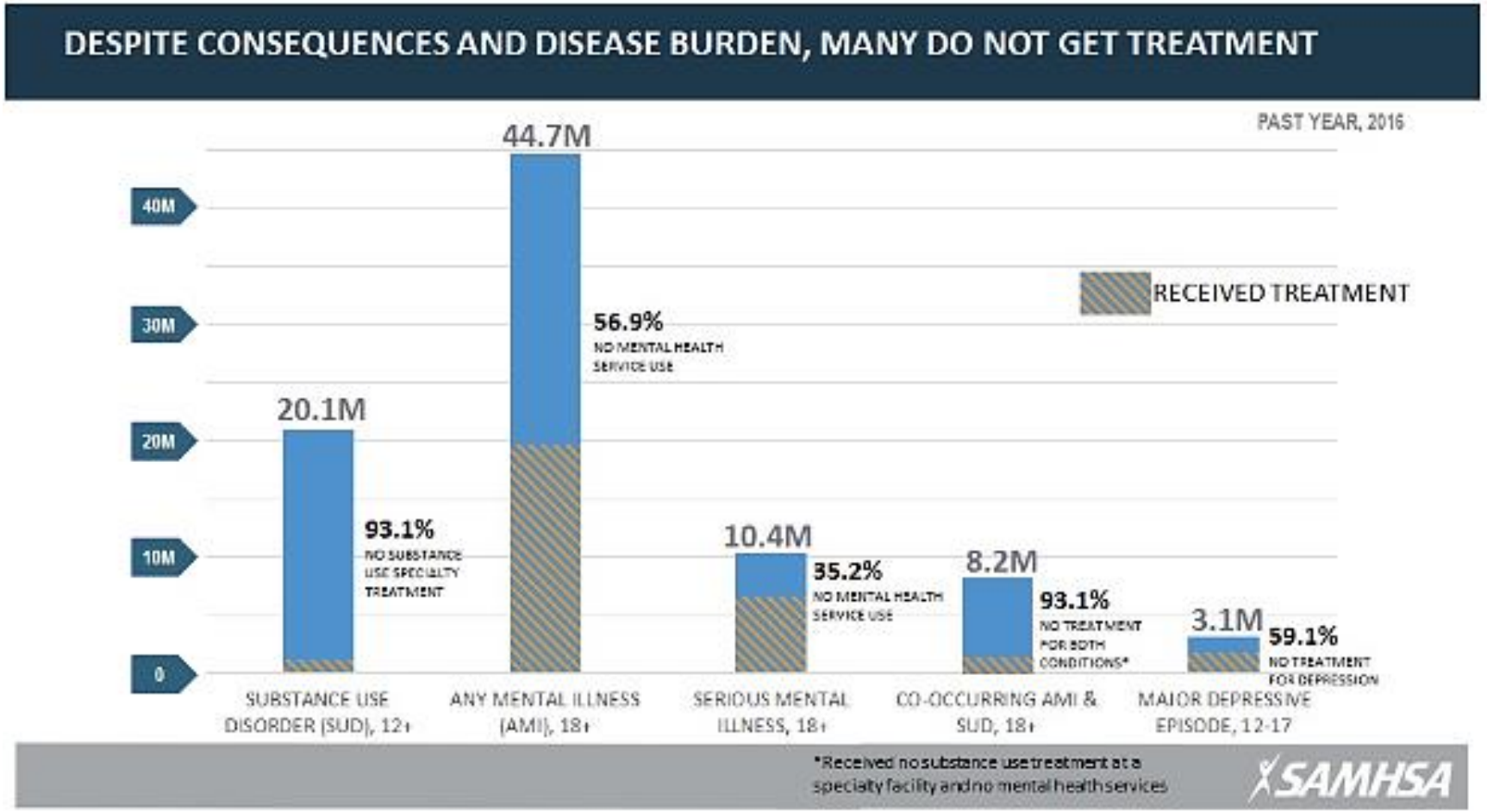
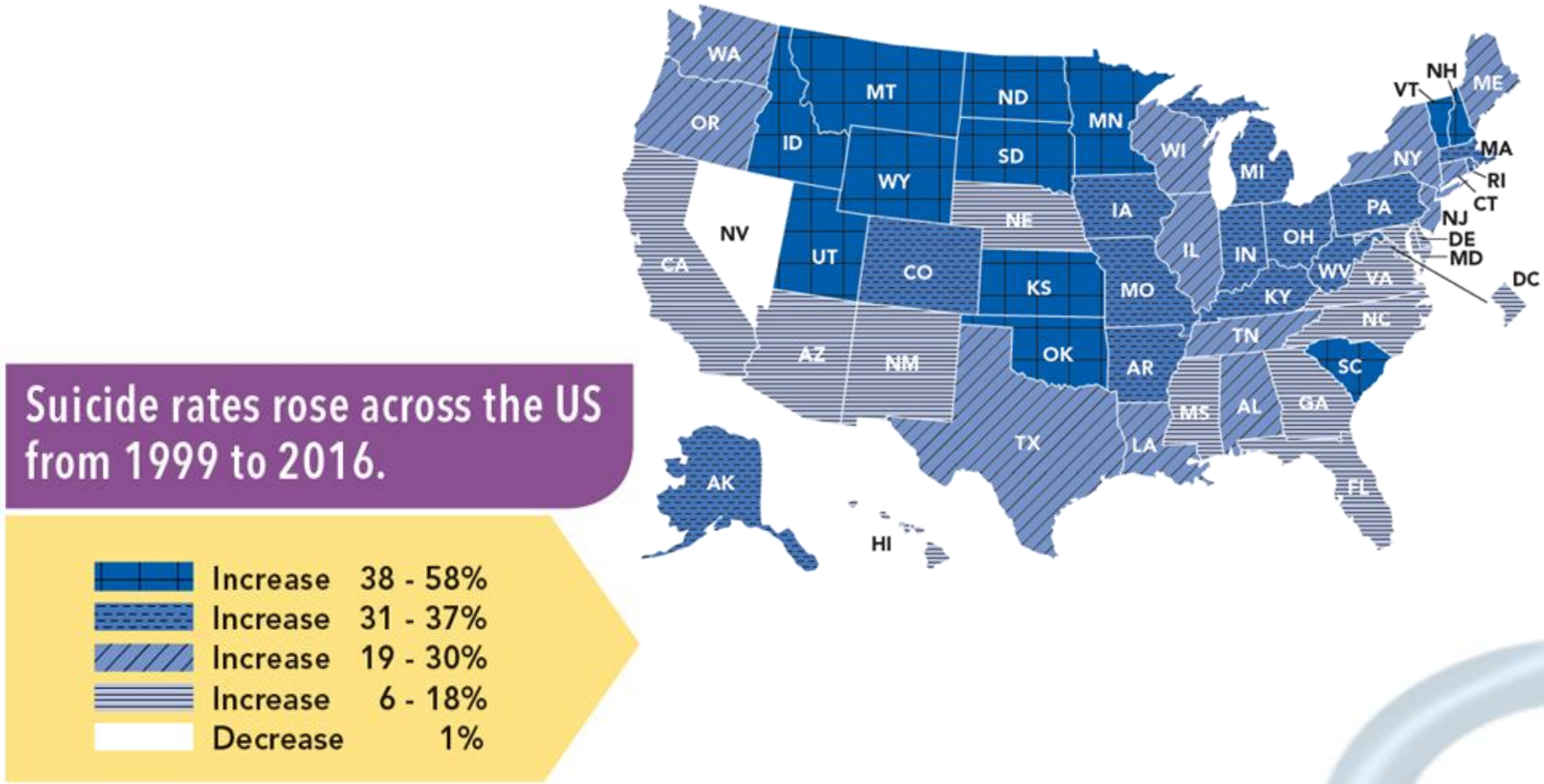
Mental Illness is Woefully Undertreated

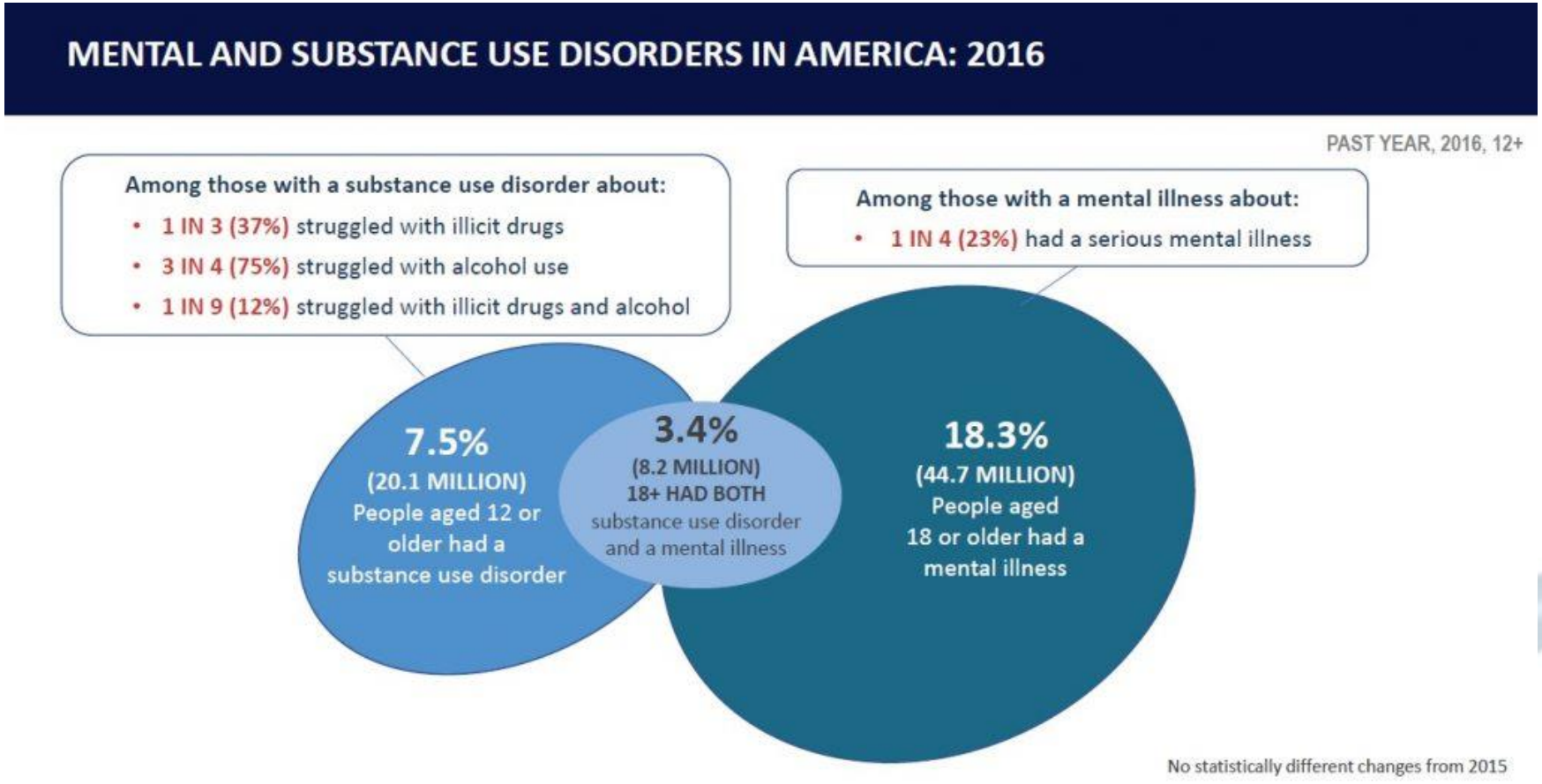


SAMSHA (2016). *SAMSHA Data Outcomes 2016.* Retrieved from: https//www.samhsa.gov/disorders



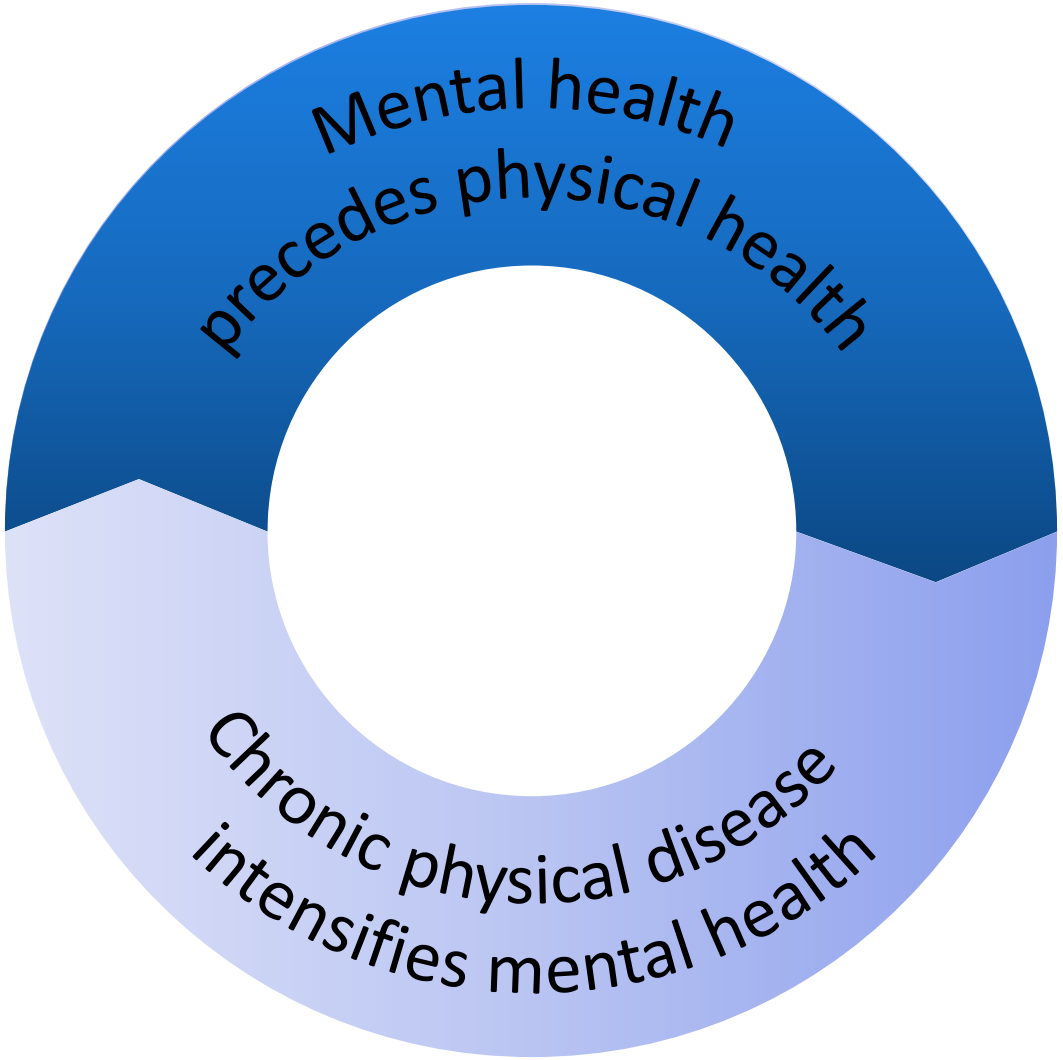
CDC Vital Signs (June 2018). *Suicide Rates Across the US*. Retrieved from: https://www.cdc.gov/vitalsigns/suicide/index.html

Mental Illness Spawns Mental Illness



Lipari, R., Struther L. (2107). *Trends in Substance Abuse Disorders Among Adults Aged 18 or Older.* Retrieved from: https://www.samhsa.gov/data/sites/default/files/report_2790/ShortReport-2790.html

Mental Illness Spawns Physical Illness



Primary Care, The Frontline Of Mental Health

- Mental health care provider shortage
- Financial
- Stigma

Primary Care, The Frontline Of Mental Health

- 80% of people with a behavioral health disorder will visit a primary care provider at least once a year
- 50% of all behavioral health disorders are treated in primary care
- 48% of appointments for all psychotropic agents are with a non-psychiatric primary care provider

Kessler, R. C., Demler, O., Frank, R. G., Olfson, M., Pincus, H. A., Walters, E. E., … Zaslavsky, A. M. (2005). US prevalence and treatment of mental disorders: 1990–2003. The New England Journal of Medicine, 352(24), 2515–2523. http://doi.org/10.1056/NEJMsa043266

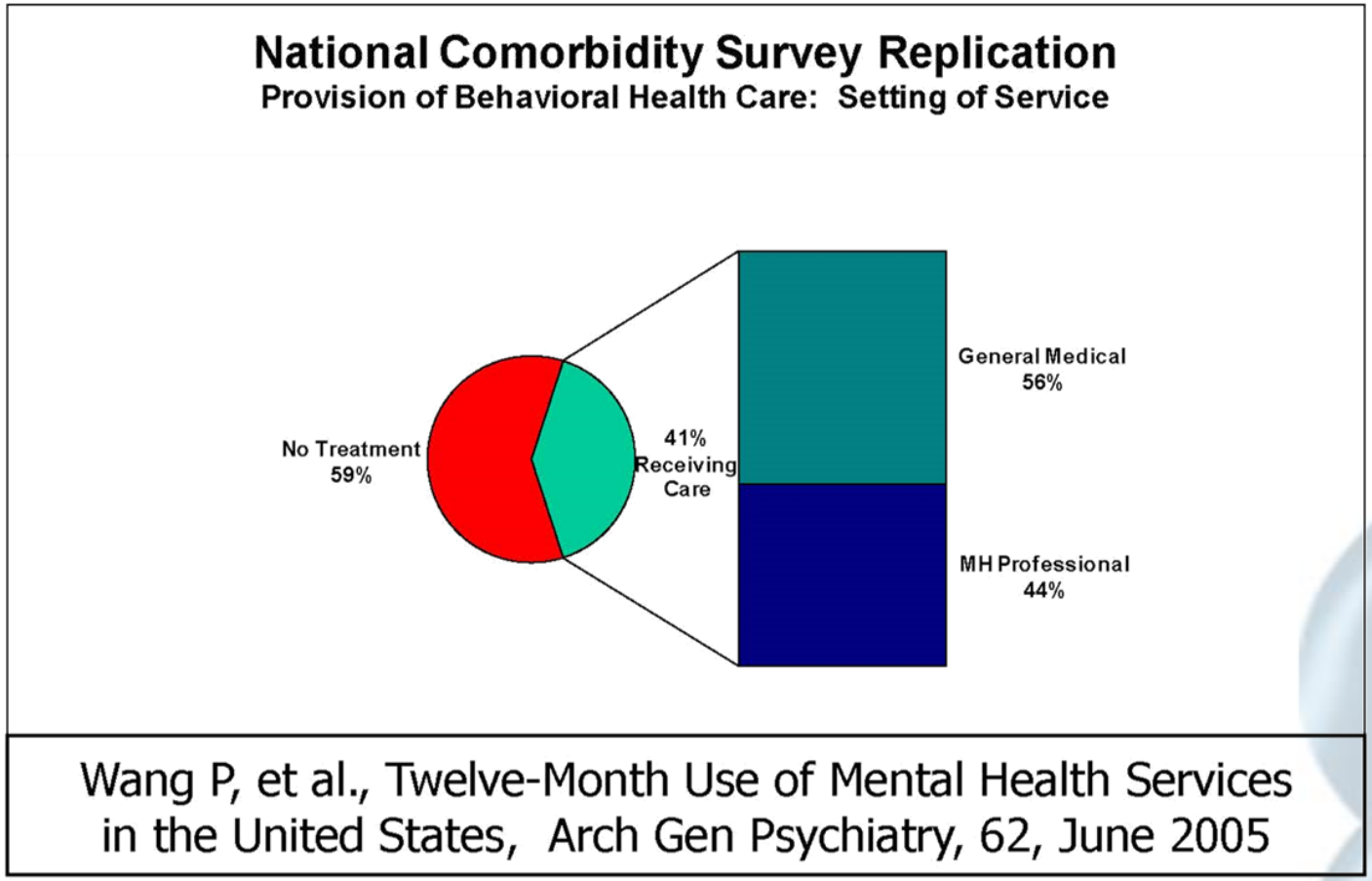
Pincus, H.A., Tanielian, T., Marcus, S., Olfson, M., Zarin, D.A., Thompson, J.W., & Zito, J.M. (1998). Prescribing trends in psychotropic medications: primary care, psychiatry, and other medical specialties. JAMA, 279 7, 526-31.

Primary Care, The Frontline Of Mental Health

- 45% of those dying by suicide saw their primary care physician in the month before their death.
- Only 20% saw a mental health professional in the preceding month.

Luoma, J. B., Martin, C. E., & Pearson, J. L. (2002). Contact With Mental Health and Primary Care Providers Before Suicide: A Review of the Evidence. *The American Journal of Psychiatry*, *159*(6), 909–916. http://doi.org/10.1176/appi.ajp.159.6.909

Primary Care is the 'De Facto' Mental Health System



Wang P, et al., Twelve-Month Use of Mental Health Services in the United States, Arch Gen Psychiatry, 62, June 2005

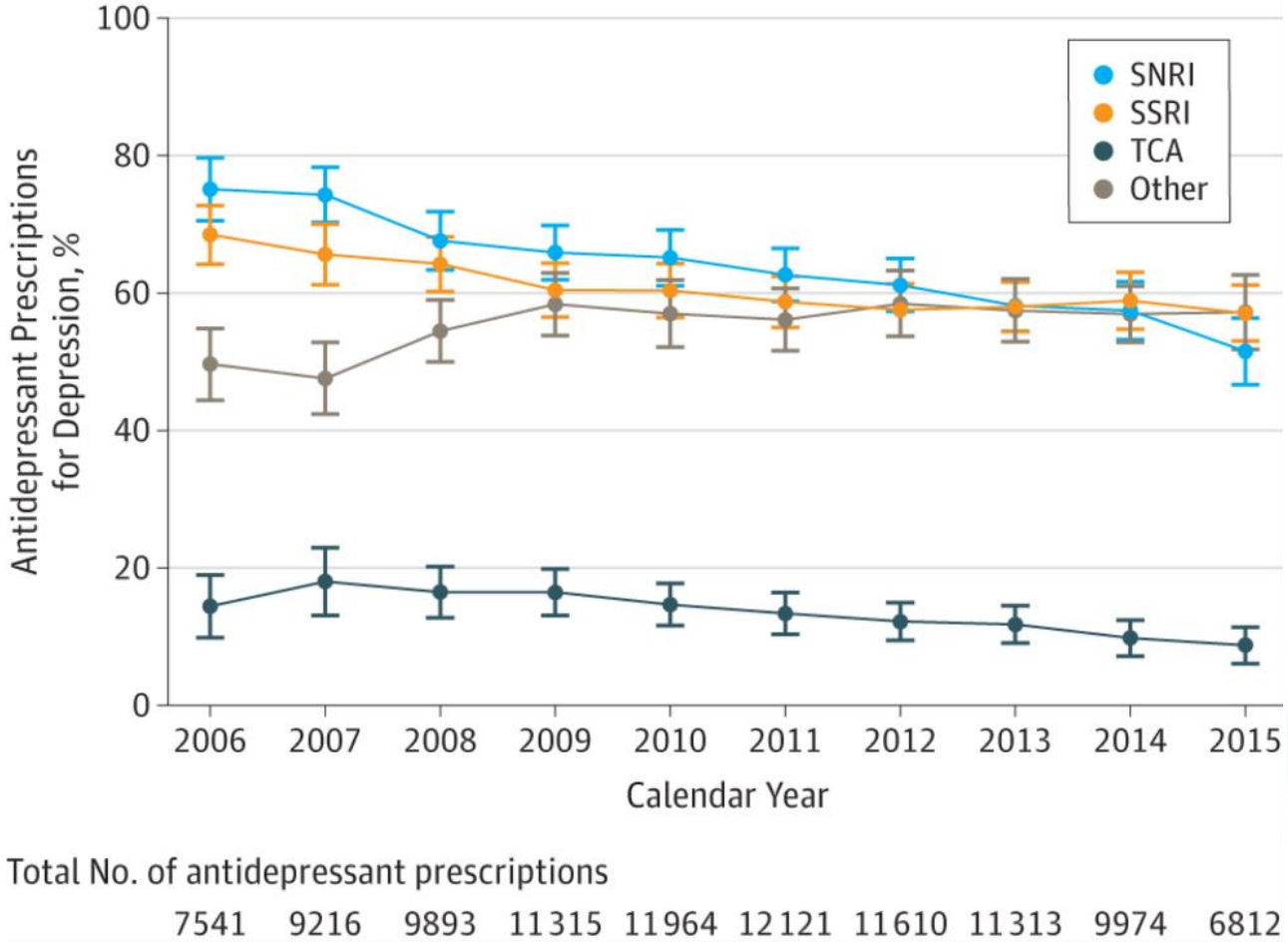
The Good the Bad and the Ugly

- Primary care is identifying depression better.
- Comorbid alcohol problems frequently remain unidentified and thus untreated.
- Treatment is often too short or otherwise inadequate.
- Suicidal thoughts and suicidal behavior are poorly managed.

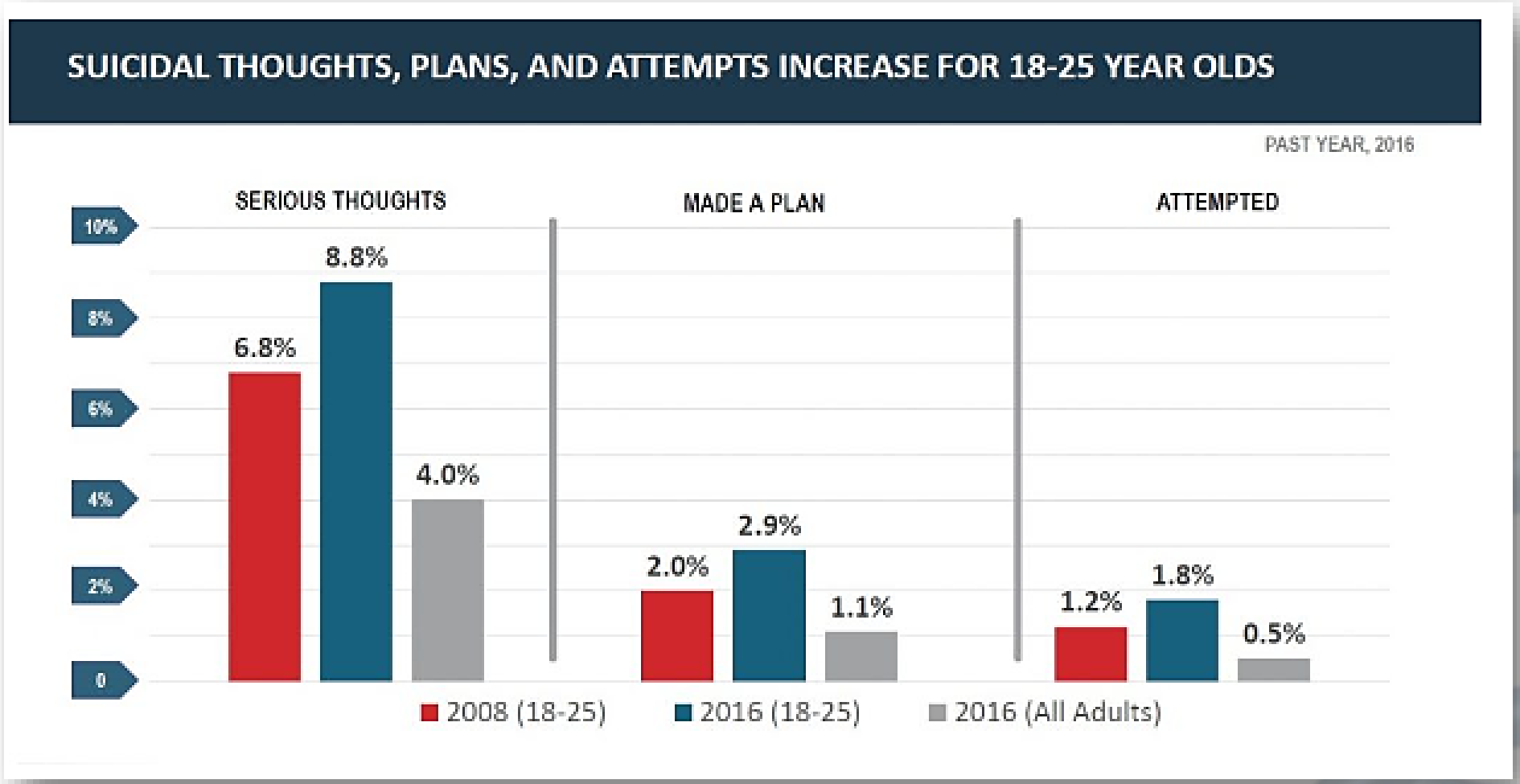
McDowell, A. K., Lineberry, T. W., & Bostwick, J. M. (2011). Practical Suicide-Risk Management for the Busy Primary Care Physician. *Mayo Clinic Proceedings*, *86*(8), 792–800. http://doi.org/10.4065/mcp.2011.0076

From: **Treatment Indications for Antidepressants Prescribed in Primary Care in Quebec, Canada, 2006-2015**

JAMA. 2016;315(20):2230-2232. doi:10.1001/jama.2016.3445



Serious Mental Illness (SMI)

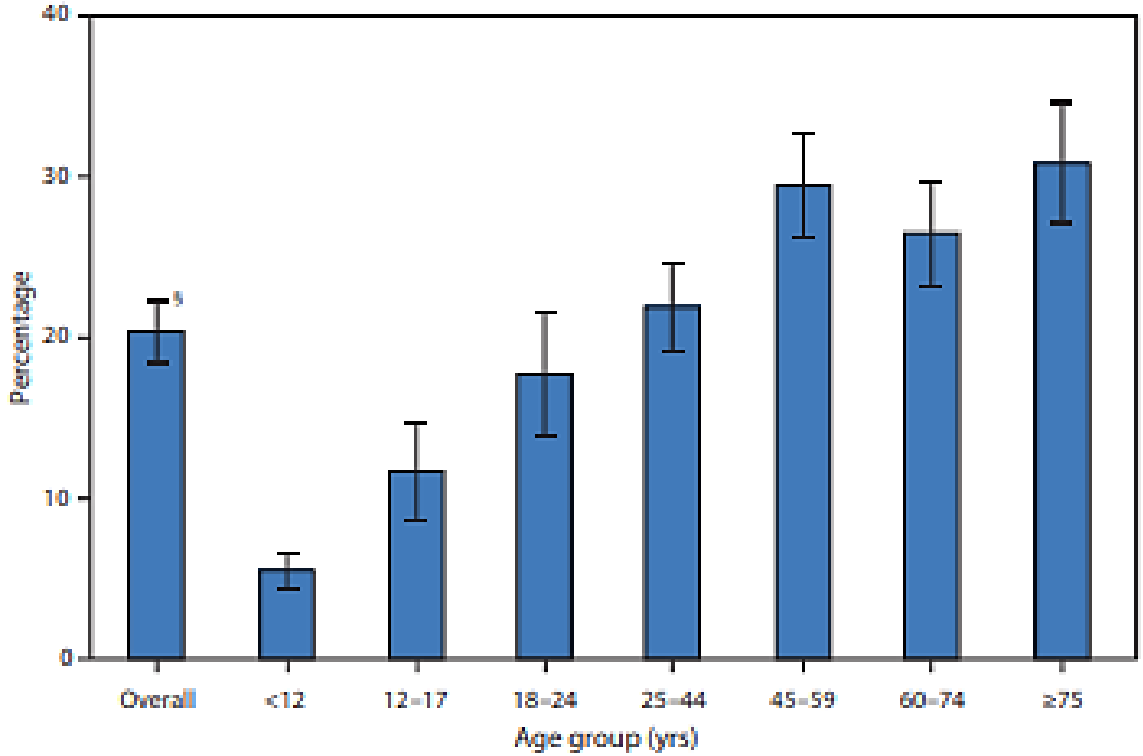


Blader, J., Suicidal Thoughts and Behaviors Increased Among Young Adults. Why?, Journal of the American Academy of Child & Adolescent Psychiatry , Volume 57 , Issue 1 , 18 - 19

Primary Care Role In Mental Health

FROM THE NATIONAL CENTER FOR HEALTH STATISTICS

Percentage of Mental Health–Related* Primary Care† Office Visits, by Age Group — National Ambulatory Medical Care Survey, United States, 2010



Olfson M, Kroenke K, Wang S, Blanco C Trends in office based mental health care provided by psychiatrists and primary care physicians, J Clinical Psychiatry 201 4:75,247-53

Primary Care

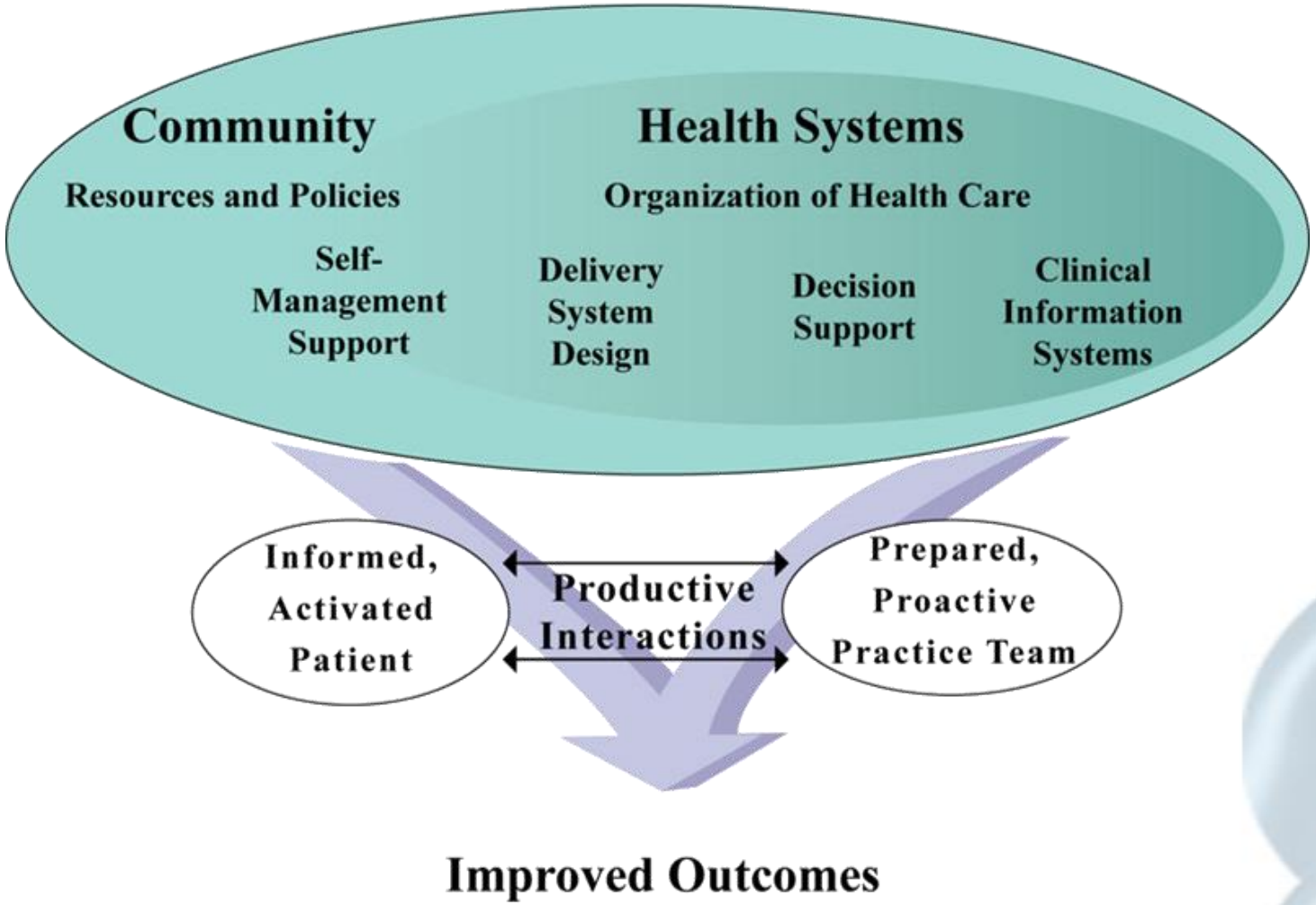
Primary Care Expectations for Panel of Patients

- 3.7 hours per day for acute care
- 7.4 hours per day for prevention in panel of patients
- 10.6 hours a day to provide chronic care

Prevention of Chronic Disease 2009;6(2):A59. , American Journal of Public Health. 2003;93:635–641; Annals of Family Medicine 2005;3:209-214

Too Many Jelly Beans in One Cup

The Chronic Care Model



Care Manager

Roles of Care Managers

- Acute management
- Transition management
- Chronic Management/Clinical Monitoring
- Clinical guidelines
- Problem identification
- Collaboration with treatment team
- Collaboration with medical neighborhood

http://micmrc.org/system/files

MiPCT: Care Managers Heart of the Demonstration Project

- 757,000 Medicare and Medicaid patients
- Medicaid patients improved Diabetes measures
- Improved all cause hospital admissions and 30 day readmissions
- Rated highly
  - Access to care, patient engagement and self-management, quality improvement, and health information technology
- Rated very Highly
  - Office staff, shared decision-making, and communication
- Medicare savings between $140 and $295 million

June 2017 Evaluation of the Multi-Payer Advanced Primary Care Practice (MAPCP) Demonstration Final Report—Appendices Prepared for Suzanne G. Wensky, PhD Centers for Medicare & Medicaid Services, RTI Project Number 0212790.005

State Innovation Model

- Patient Centered Medical Home Initiative
  - Care management and care coordination (CMCC) services
  - Embedded staff
  - Support clinical-community linkages
  - Brief screening tool to assess social needs
  - Screen all patients in the practice
  - Linking patients to appropriate community-based resources

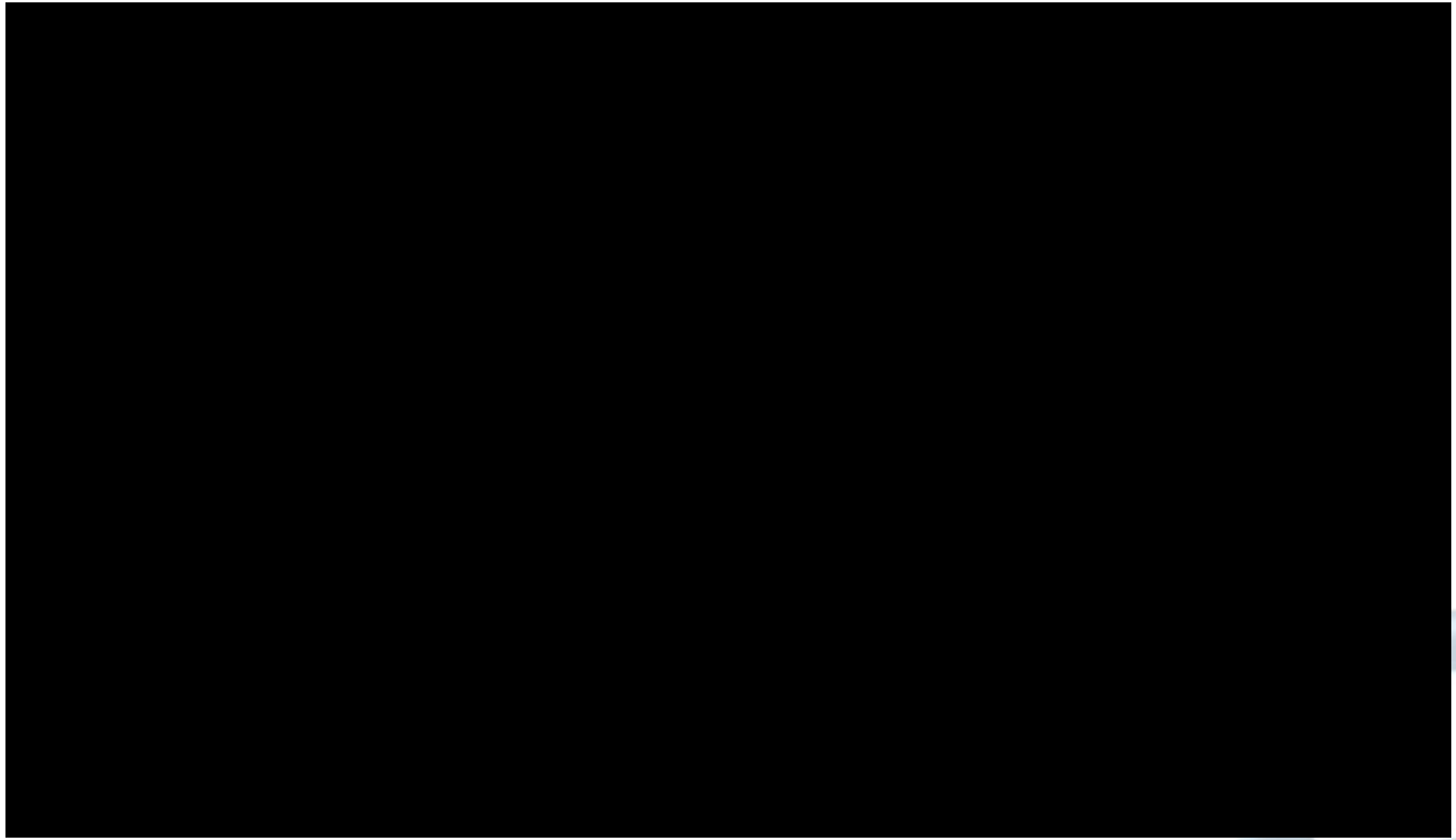
Care Management for Depression

"On average, practices used fewer than one care management process for depression, and this level of use has not changed since 2006–07, regardless of practice size."

-Health Affairs March 2016

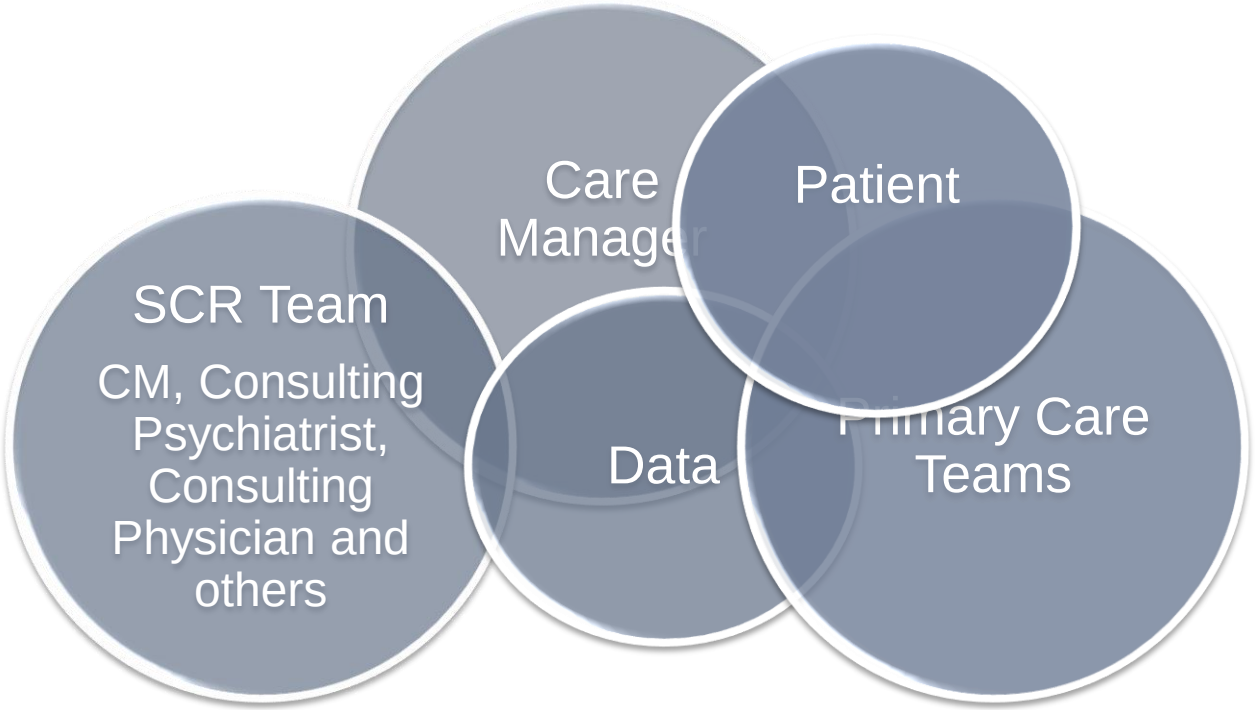
Bishop, T, Ramsay, P, et al, (March 2016). Retrieved from: https://doi.org/10.1377/hlthaff.2015.1068

Collaborative Care Key Components	Care Management Process
Enrollment	• Pre-screening • Patient identification
Care Plan development Population management	• Assessment and care planning
Outcome oriented CM	• Implementation, follow-up and monitoring
Care planning and routine follow-up	• Case closure and evaluation



Collaborative Care

Roles and Responsibilities

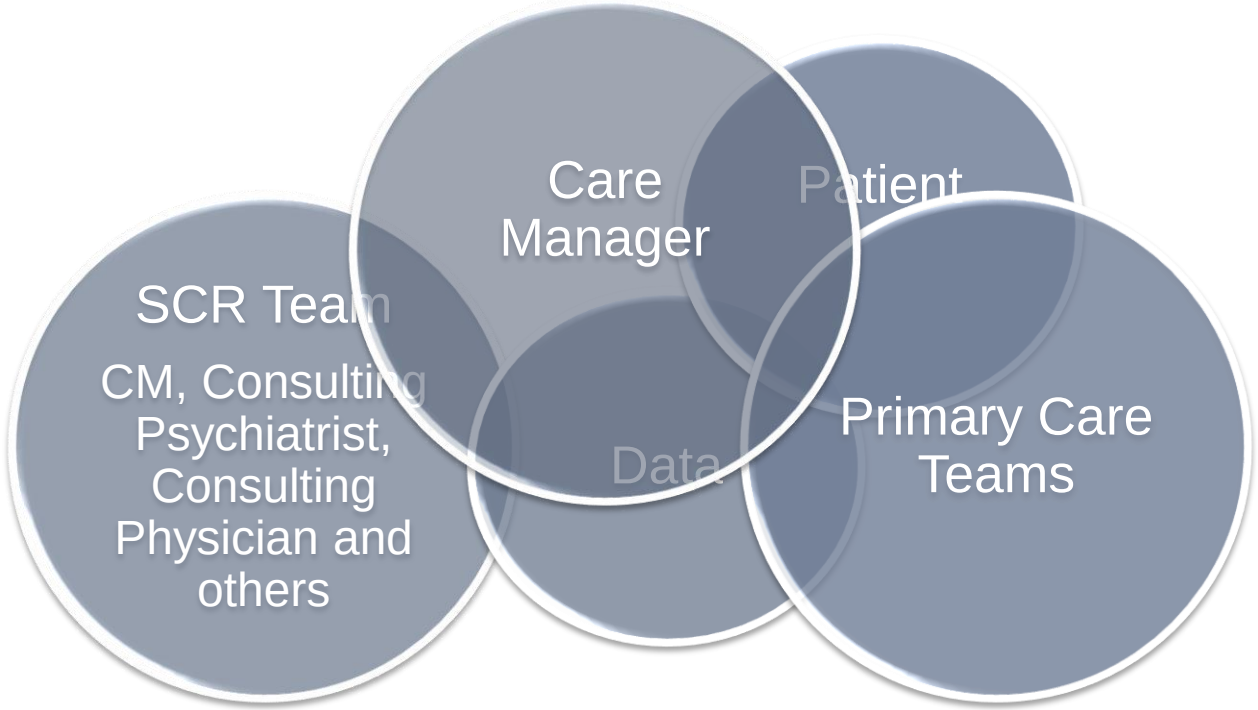


Patient

- Active member of the team
  - Participant in treatment planning
  - Self-management strategies

Collaborative Care

Roles and Responsibilities

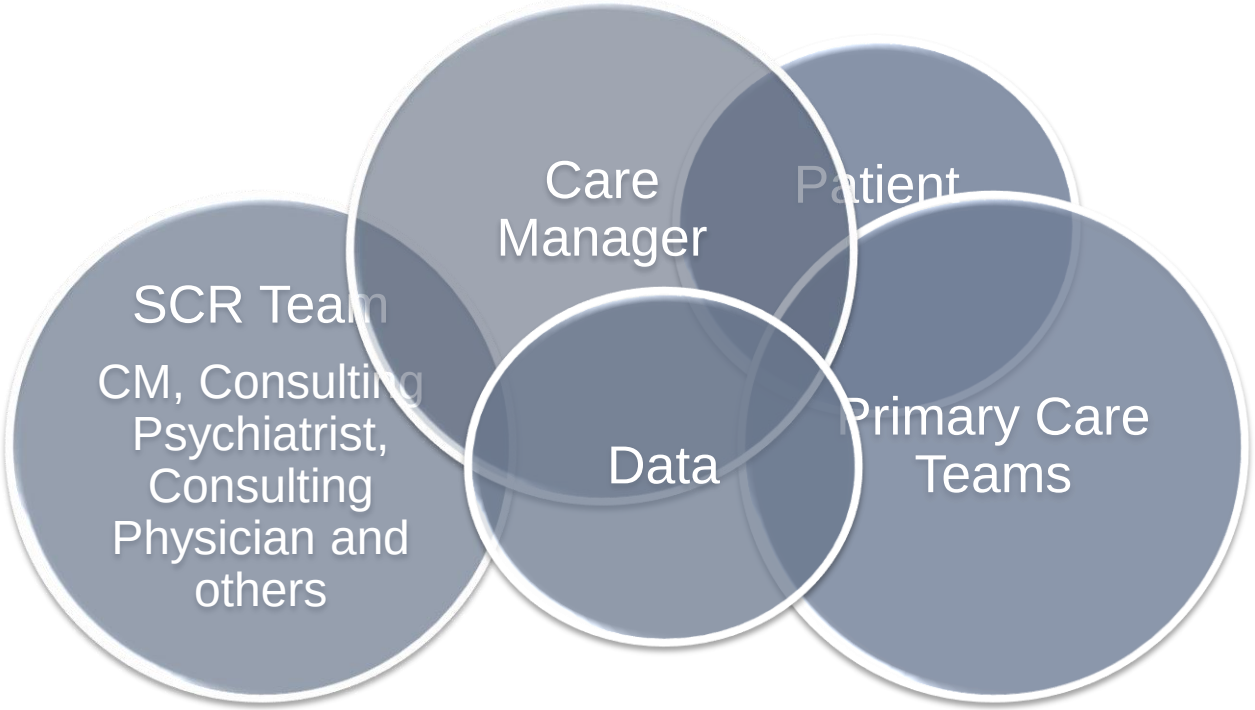


Care Manager

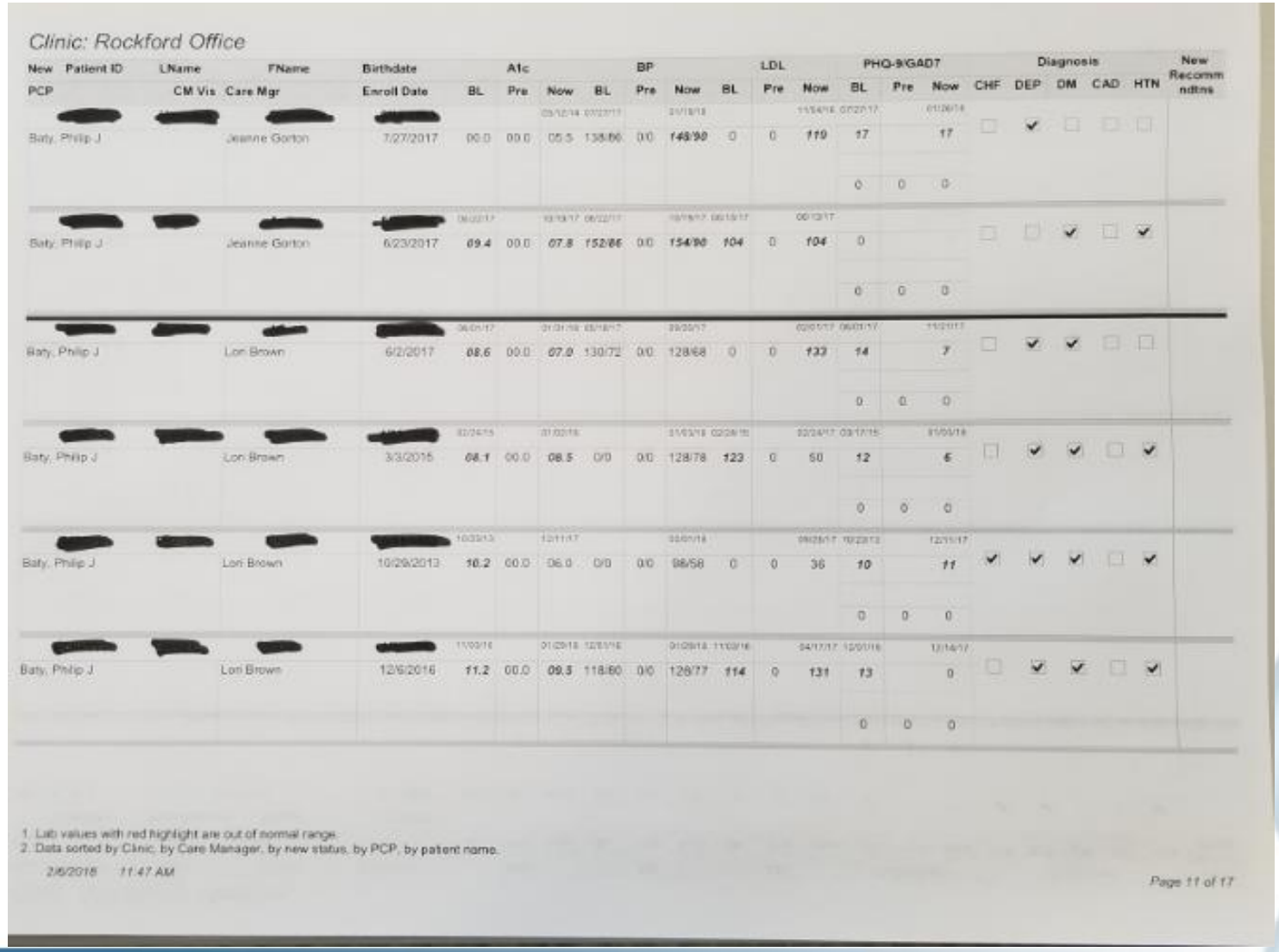
- Care Coordination
  - PCP and team
  - Systematic case review team
  - Patient
  - Ancillary staff (MSW, pharmacist)

Collaborative Care

Roles and Responsibilities



Excel Data



Clinic: Rockford Office

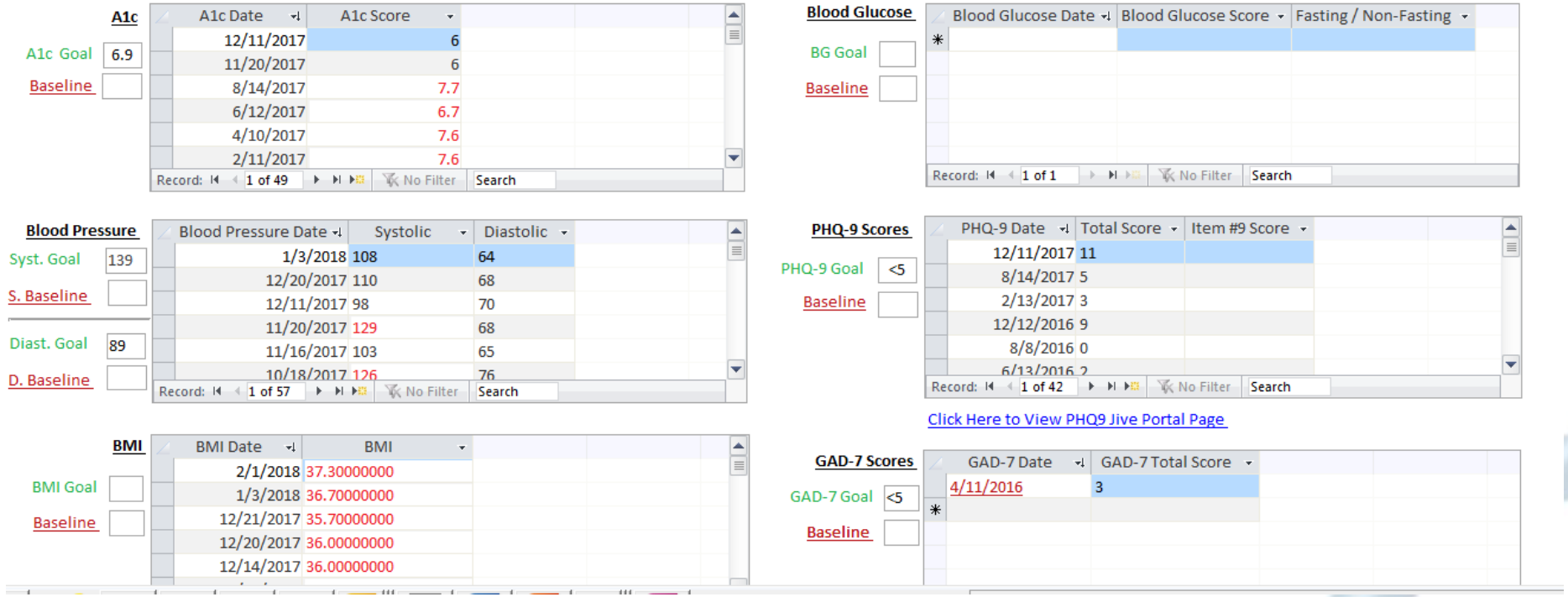
New PCP	Patient ID	LName CM	Vis	FName Care Mgr	Birthdate Enroll Date	A1c BL	A1c Pre	A1c Now	BP BL	BP Pre	BP Now	LDL BL	LDL Pre	LDL Now	PHQ-9/GAD7 BL	PHQ-9/GAD7 Pre	PHQ-9/GAD7 Now	Diagnosis CHF	Diagnosis DEP	Diagnosis DM	Diagnosis CAD	Diagnosis HTN	New Recomm ndtns
Baty, Philip J	[redacted]	[redacted]		Jeanne Gorton	7/27/2017	00.0	00.0	05.5	0/0	0/0	148/90	0	0	119	17		17	☐	☑	☐	☐	☐	
															0	0	0						
Baty, Philip J	[redacted]	[redacted]		Jeanne Gorton	6/23/2017	09.4	00.0	07.8	0/0	0/0	154/90	104	0	104	0			☐	☐	☑	☐	☑	
															0	0	0						
Baty, Philip J	[redacted]	[redacted]		Lori Brown	6/2/2017	08.6	00.0	07.0	130/72	0/0	128/68	0	0	133	14		7	☐	☑	☑	☐	☐	
															0	0	0						
Baty, Philip J	[redacted]	[redacted]		Lori Brown	3/3/2015	08.1	00.0	08.5	0/0	0/0	128/78	123	0	50	12		6	☐	☑	☑	☐	☑	
															0	0	0						
Baty, Philip J	[redacted]	[redacted]		Lori Brown	10/29/2013	10.2	00.0	06.0	0/0	0/0	98/58	0	0	36	10		11	☑	☑	☑	☐	☑	
															0	0	0						
Baty, Philip J	[redacted]	[redacted]		Lori Brown	12/6/2016	11.2	00.0	09.5	118/80	0/0	128/77	114	0	131	13		0	☐	☑	☑	☐	☑	
															0	0	0						

1. Lab values with red highlight are out of normal range.
2. Data sorted by Clinic, by Care Manager, by new status, by PCP, by patient name.

2/5/2018 11:47 AM

Page 11 of 17

Access Database



A1c

A1c Goal 6.9

Baseline

A1c Date	A1c Score
12/11/2017	6
11/20/2017	6
8/14/2017	7.7
6/12/2017	6.7
4/10/2017	7.6
2/11/2017	7.6

Record: 1 of 49 No Filter Search

Blood Glucose

BG Goal

Baseline

Blood Glucose Date	Blood Glucose Score	Fasting / Non-Fasting

Record: 1 of 1 No Filter Search

Blood Pressure

Syst. Goal 139

S. Baseline

Diast. Goal 89

D. Baseline

Blood Pressure Date	Systolic	Diastolic
1/3/2018	108	64
12/20/2017	110	68
12/11/2017	98	70
11/20/2017	129	68
11/16/2017	103	65
10/18/2017	126	76

Record: 1 of 57 No Filter Search

PHQ-9 Scores

PHQ-9 Goal <5

Baseline

PHQ-9 Date	Total Score	Item #9 Score
12/11/2017	11	
8/14/2017	5	
2/13/2017	3	
12/12/2016	9	
8/8/2016	0	
6/13/2016	2	

Record: 1 of 42 No Filter Search

Click Here to View PHQ9 Jive Portal Page

BMI

BMI Goal

Baseline

BMI Date	BMI
2/1/2018	37.30000000
1/3/2018	36.70000000
12/21/2017	35.70000000
12/20/2017	36.00000000
12/14/2017	36.00000000

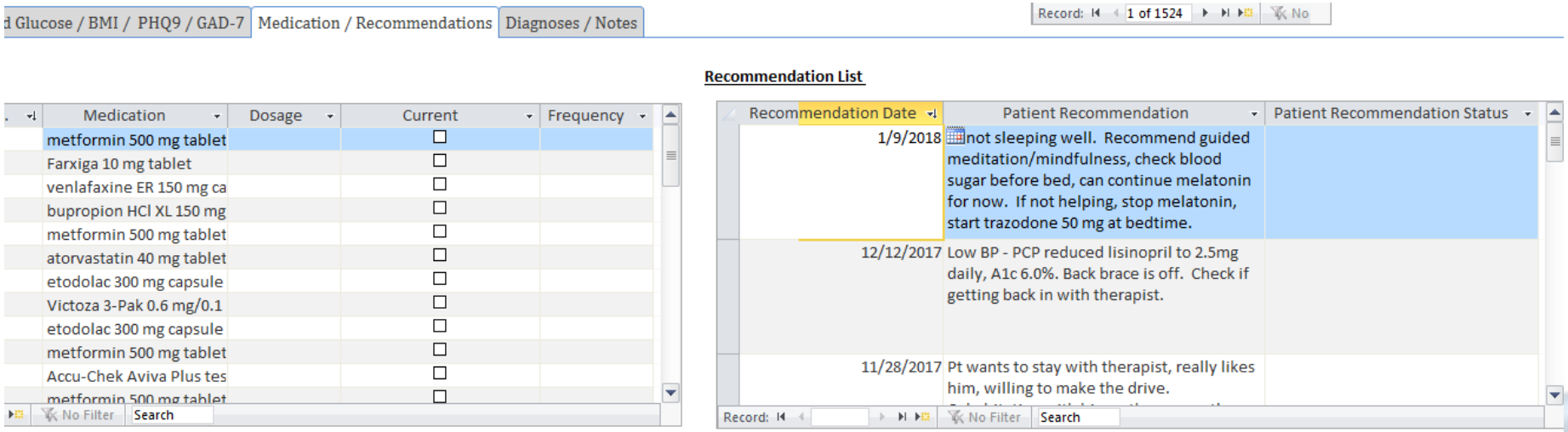
GAD-7 Scores

GAD-7 Goal <5

Baseline

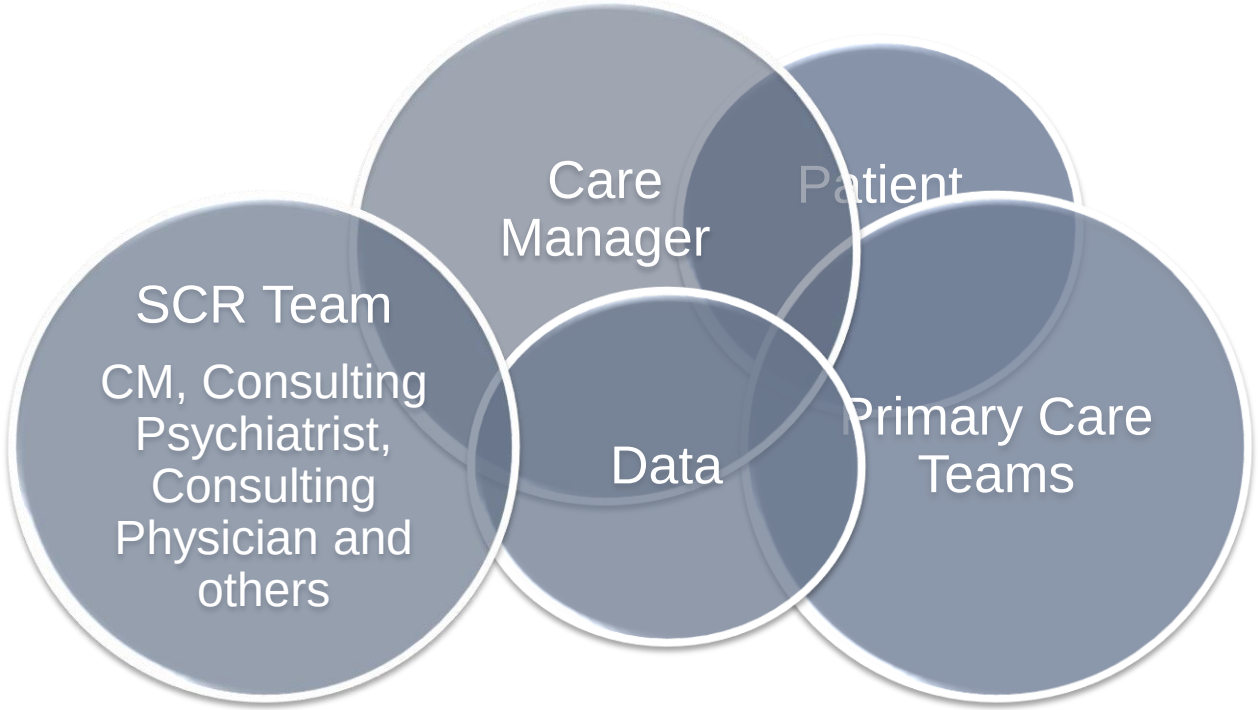
GAD-7 Date	GAD-7 Total Score
4/11/2016	3

Access Database



Collaborative Care

Roles and Responsibilities

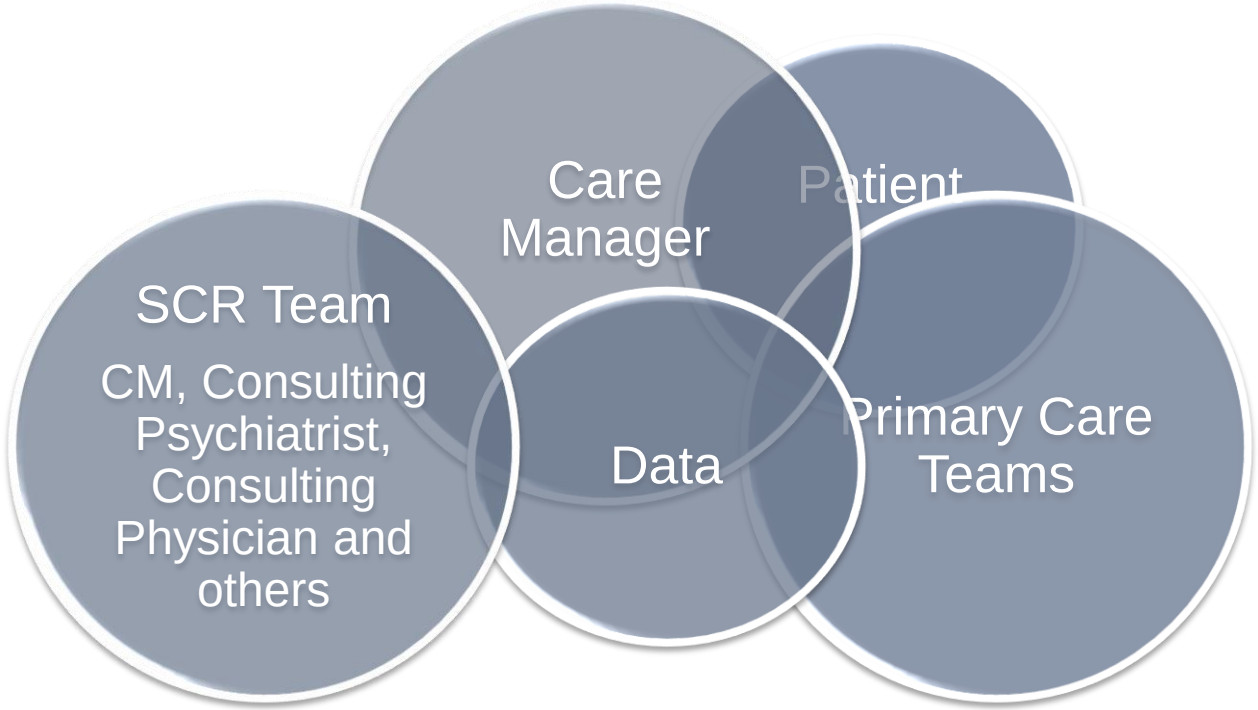


Psychiatrist Role

- Curb side consultant
  - Diagnosis
  - Treatment planning and modifications
  - Does not see the patient – provides recommendations

Collaborative Care

Roles and Responsibilities

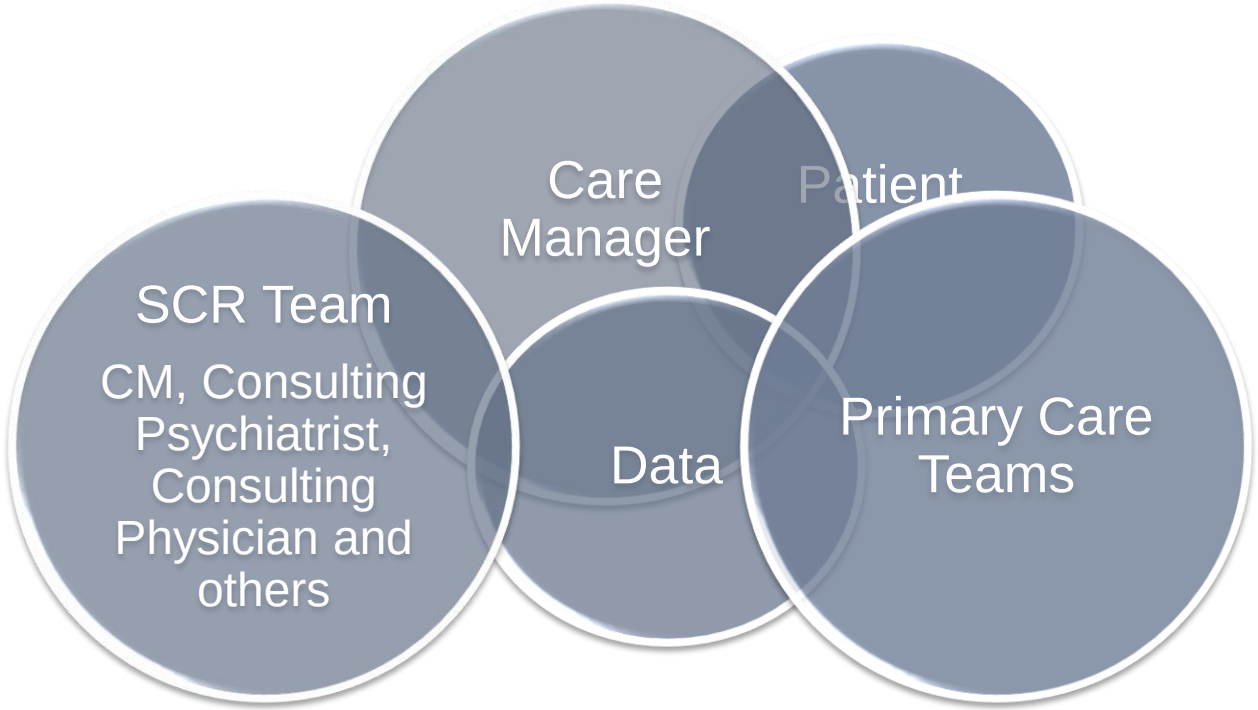


Medical Consultant

- Curb side consultant for the medical conditions (diabetes, CAD)
  - Medical management
  - Treatment planning and modifications
  - Not the patients primary care physician

Collaborative Care

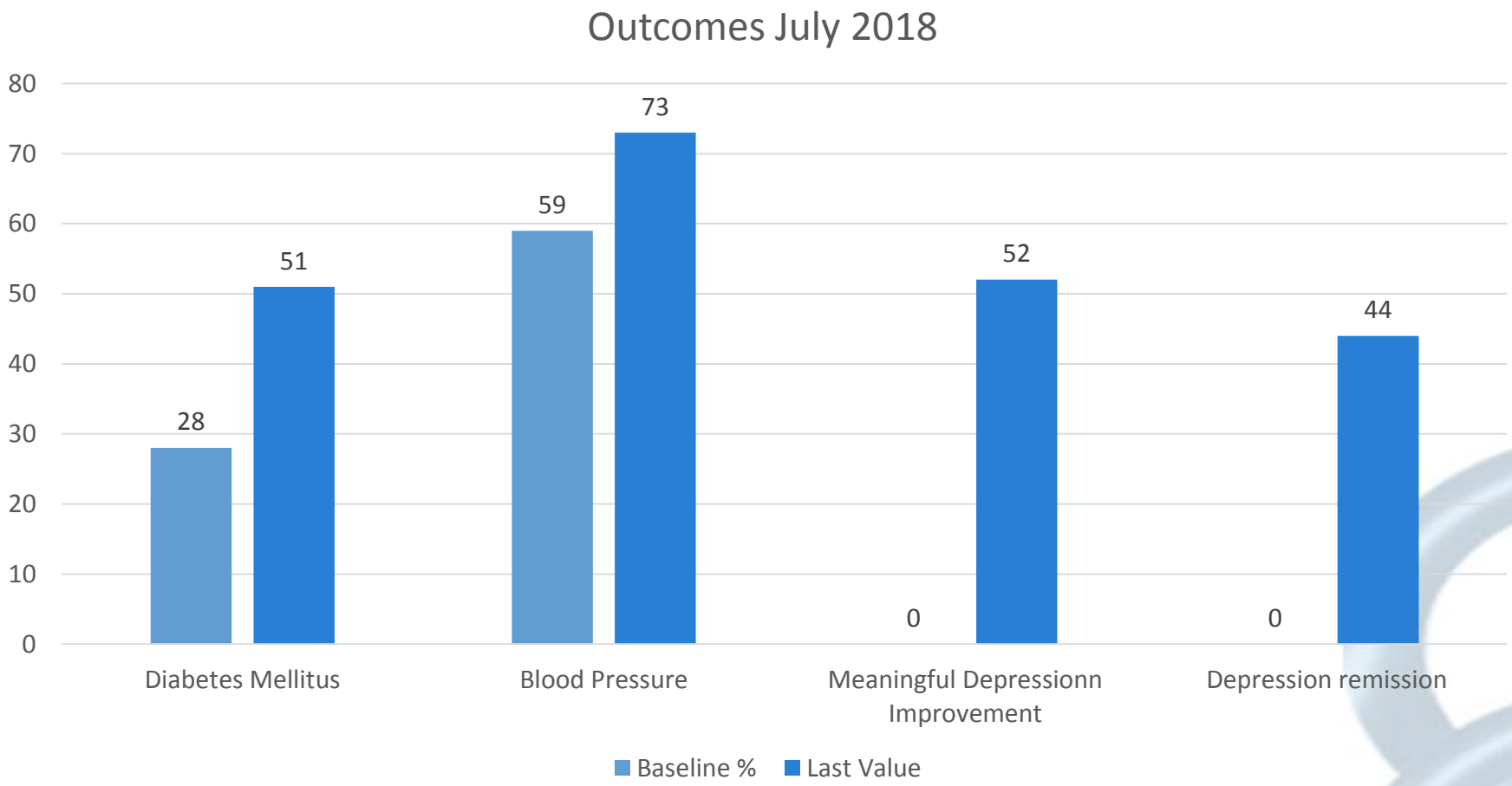
Roles and Responsibilities



Primary Care Team

- Screen and identify candidates
- Learn and use care managers to help at risk patients
- Evaluate/Implement Systematic Case Review recommendations

West Michigan N=471



Collaborative Care Works

- 1995 first randomized trial
  - N=217
  - Improved medication adherence
  - Improved depression control

Katon W, Von Korff M, Lin E, et al. Collaborative Management to Achieve Treatment GuidelinesImpact on Depression in Primary Care. JAMA. 1995;273(13):1026–1031. doi:10.1001/jama.1995.03520370068039

Improving Mood and Promoting Access to Collaborative Treatment N=1,801 (IMPACT)

- IMPACT doubles depression care effectiveness
- Less physical pain
- Better functioning
- Higher quality of life
- Greater patient and provider satisfaction
- More cost-effective

Unützer J, Katon W, Callahan CM, et al. Collaborative Care Management of Late-Life Depression in the Primary Care Setting A Randomized Controlled Trial. *JAMA*. 2002;288(22):2836–2845. doi:10.1001/jama.288.22.2836

Collaborative Care Helps Cochrane Review 2012

- Collaborative care is associated with significant improvement in depression and anxiety outcomes compared with usual care, and represents a useful addition to clinical pathways for adult patients with depression and anxiety.

Archer J, Bower P, Gilbody S, Lovell K, Richards D, Gask L, Dickens C, Coventry P. Collaborative care for depression and anxiety problems. Cochrane Database of Systematic Reviews 2012, Issue 10. Art. No.: CD006525. DOI: 10.1002/14651858.CD006525.pub2

Collaborative Care helps mental and physical Health outcomes N=214

- Significant improvement in A1c, systolic blood pressure LDL cholesterol and depression scores

Katon, W. J., Lin, E. H. B., Von Korff, M., Ciechanowski, P., Ludman, E. J., Young, B., … McCulloch, D. (2010). Collaborative Care for Patients with Depression and Chronic Illnesses. The New England Journal of Medicine, 363(27), 2611–2620. http://doi.org/10.1056/NEJMoa1003955

Collaborative Care Helps Mental and Physical Health Outcomes N=3,609

- COMPASS initiative significant difference in A1c, blood pressure and depression scores

General Hospital Psychiatry, 2017-01-01, Volume 44, Pages 69-76

Collaborative Care is Faster

Persistent Depression Symptoms

- Usual care 154 d
- CoCare 31 d

Depression Remission

- Usual Care 614 d
- CoCare 86 d

Waitzfelder, B., Stewart, C., Coleman, K.J. et al. J GEN INTERN MED (2018) 33: 1283. https://doi.org/10.1007/s11606-017-4297-2

Collaborative Care Prevents Suicide Ideation

- Prevention of Suicide in Primary Care Elderly: Collaborative Trial (PROSPECT) N=599
  - Improve remission rates of major depression at
    - 4 (26.6% vs 15.2%),
    - 8 (36.0% vs 22.5%),
    - 24 months (45.4% vs 31.5%).
  - 2.2 times less suicidal ideation at 24 months

  "The adoption and widespread use of collaborative care models for depression could result in reduced suicide rates nationally."

McDowell, A. K., Lineberry, T. W., & Bostwick, J. M. (2011). Practical Suicide-Risk Management for the Busy Primary Care Physician. *Mayo Clinic Proceedings*, *86*(8), 792–800. http://doi.org/10.4065/mcp.2011.0076

Collaborative Care Saves Lives

- Improving Mood and Promoting Access to Collaborative Treatment (n=272)
  - 8 years after intervention significantly less likely to experience a serious (including fatal) cardiovascular event than patients who received usual depression treatment

Psychosomatic Medicine. 76(1):29–37, JAN 2014

Collaborative Care Saves Money

- Improving Mood and Promoting Access to Collaborative Treatment (n=272)
  - $3,365 per patient benefit over 4 years
  - $6 saved for every $1 spent
- $1,129 per patient benefit in elderly adults with Depression and Diabetes over 2 years

Lipsitt, D. R. (2003). Psychiatry and the general hospital in an age of uncertainty. *World Psychiatry*, *2*(2), 87–92.

Secret Sauce

Secret Sauce

- Frequent supportive interactions

Gen Hosp Psychiatry. 2017 Jan - Feb;44:86-90

Retrospective Chart Review Patients with Diabetes in Poor Disease Control

(HbA_{1c}, SBP, & LDL)
N=161,697

- 20% - 23% poor adherence
- Among those with adequate adherence, **30% - 47%** had no evidence of treatment intensification
- Poor adherence and lack of treatment intensification were found in 53% - 68% of patients with poor disease control

JA Schmittdiel, CS Uratsu, AJ Karter, M Heisler, U Subramanian, Why don't diabetes patients achieve recommended risk factor targets? Poor adherence versus lack of treatment intensification, Journal of general internal medicine 23 (5), 588-594

Secret Sauce

Treat-to-target

- Treatment titration
  - Frequent and consistent
  - Relentless, incremental increases
- Always
  - Increase to next step
  - If not, discuss why
- TTT Algorithm
  - Simplified and uniform approaches across conditions to achieve targets
    - Riddles et all, Diabetes Care, 2003
    - Kaiser Permanente, Care Management Institute

When to Start Intensive Therapy

- United Kingdom Prospective Diabetes Study (UKPDS)
  - 50% have evidence of Diabetes related tissue damage at diagnosis

Retrieved from: https://www.dtu.ox.ac.uk/ukpds_trial/protocol.php

Suicide Facts & Figures:
Michigan 2018*

On average, one person dies by suicide every seven hours in the state.

More than twice as many people die by suicide in Michigan annually than by homicide.

The total deaths to suicide reflect a total of 27,778 years of potential life lost (YPLL) before age 65.

Suicide cost Michigan a total of **$1,501,780,000** of combined lifetime medical and work loss cost in 2010, or an average of **$1,189,058 per suicide death**.

*Based on most recent 2016 data from CDC. Learn more at **afsp.org/statistics**.

10th leading cause of death in Michigan

2nd leading cause of death for ages 15-34

4th leading cause of death for ages 35-54

8th leading cause of death for ages 55-64

19th leading cause of death for ages 65 & older

Suicide Death Rates

	Number of Deaths by Suicide	Rate per 100,000 Population	State Rank
Michigan	**1,364**	**13.27**	**34**
Nationally	44,695	13.42	

Retrieved from: ASP.ORG/STATEFACTS; American Foundation for Suicide Prevention

afsp.org/StateFacts

American Foundation for Suicide Prevention

"Primary care cannot be practiced without addressing mental health concerns, and all attempts to do so result in inferior care."

FRANK DEGRUY III, M.D., MSFM, Woodward-Chisholm professor and chair of the Department of Family Medicine at the University of Colorado

Closing Comments

"Never doubt that a small group of thoughtful, committed, citizens can change the world. Indeed, it is the only thing that ever has."

~Margaret Mead

Questions

10:45 - 11:00 AM

BREAK

SIM
MDHHS State
Innovation Model

5:00

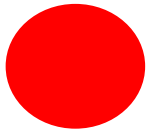
Concurrent Breakout Sessions
11:00 – 12:00

Social Determinants of Health and Community Resources
Ramona Wallace, DO, IFM, ABFM, ABOFM

Yellow Dot

President & Governor Breakout Room

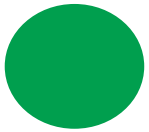
Medicaid Tracking Codes
Theresa Landfair



Red Dot

Diplomat Breakout Room

Behavioral Health
Laurisa Cummings, LMSW



Green Dot

Congress & Senate Breakout Room

Social Determinants of Health & Community Resilience

Ramona Wallace, DO, IFM, ABFM, ABOFM
Chief Medical Officer
Muskegon Family Care

Learning Objectives

- Outline successful strategies for SDoH screening, engaging patients and family, and follow up of the linkages with community resources

- Summarize key steps for SDoH screening, assessing the high priority needs of your practice's patient population and building the Clinical-Community Linkages

Agenda

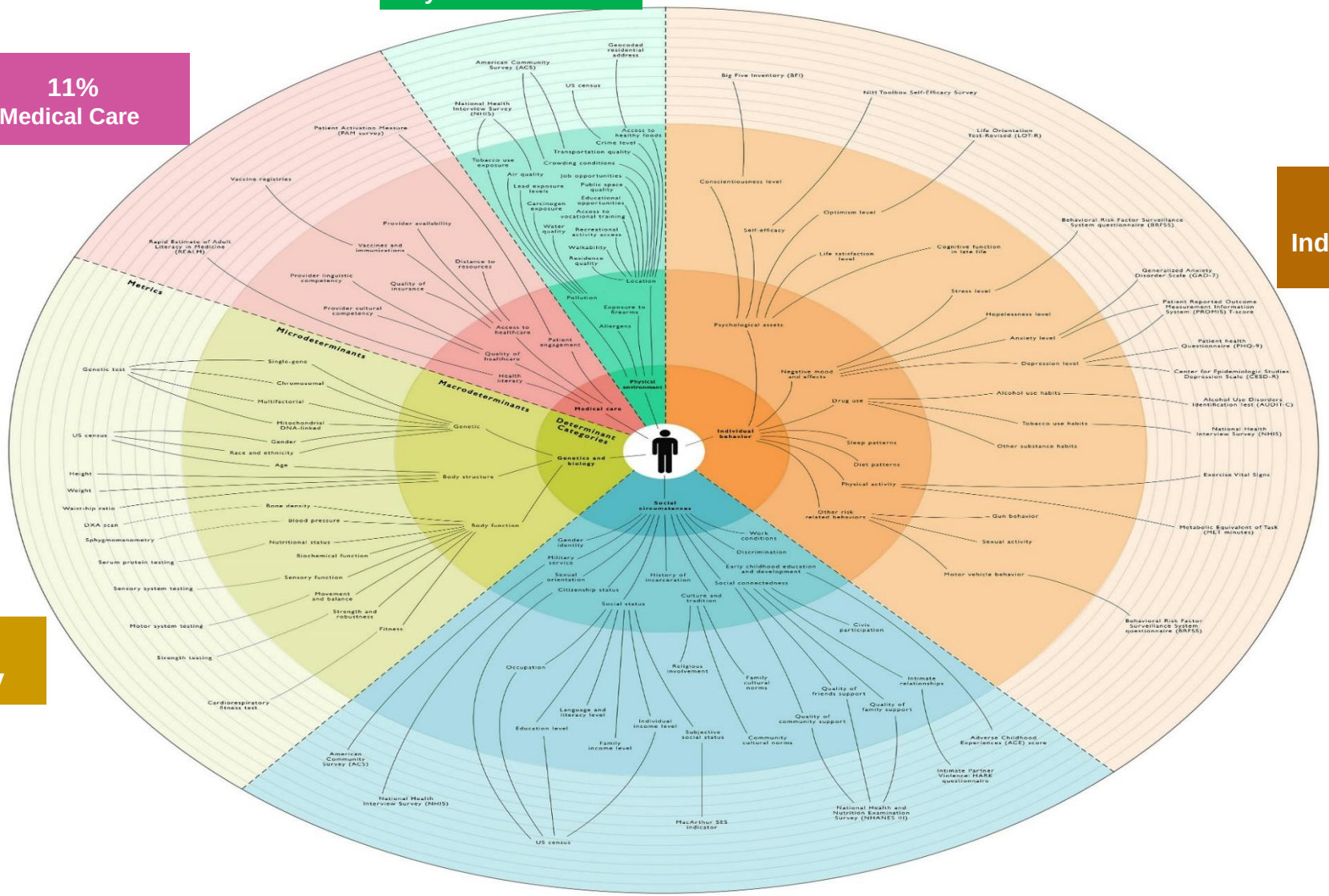
- Show that Social Circumstances and Physical Environment affect health

- Explain how we as Medical Providers can identify and address these issues both within our practice and through Community Linkages

7%
Physical Environment

11%
Medical Care

38%
Individual Behavior

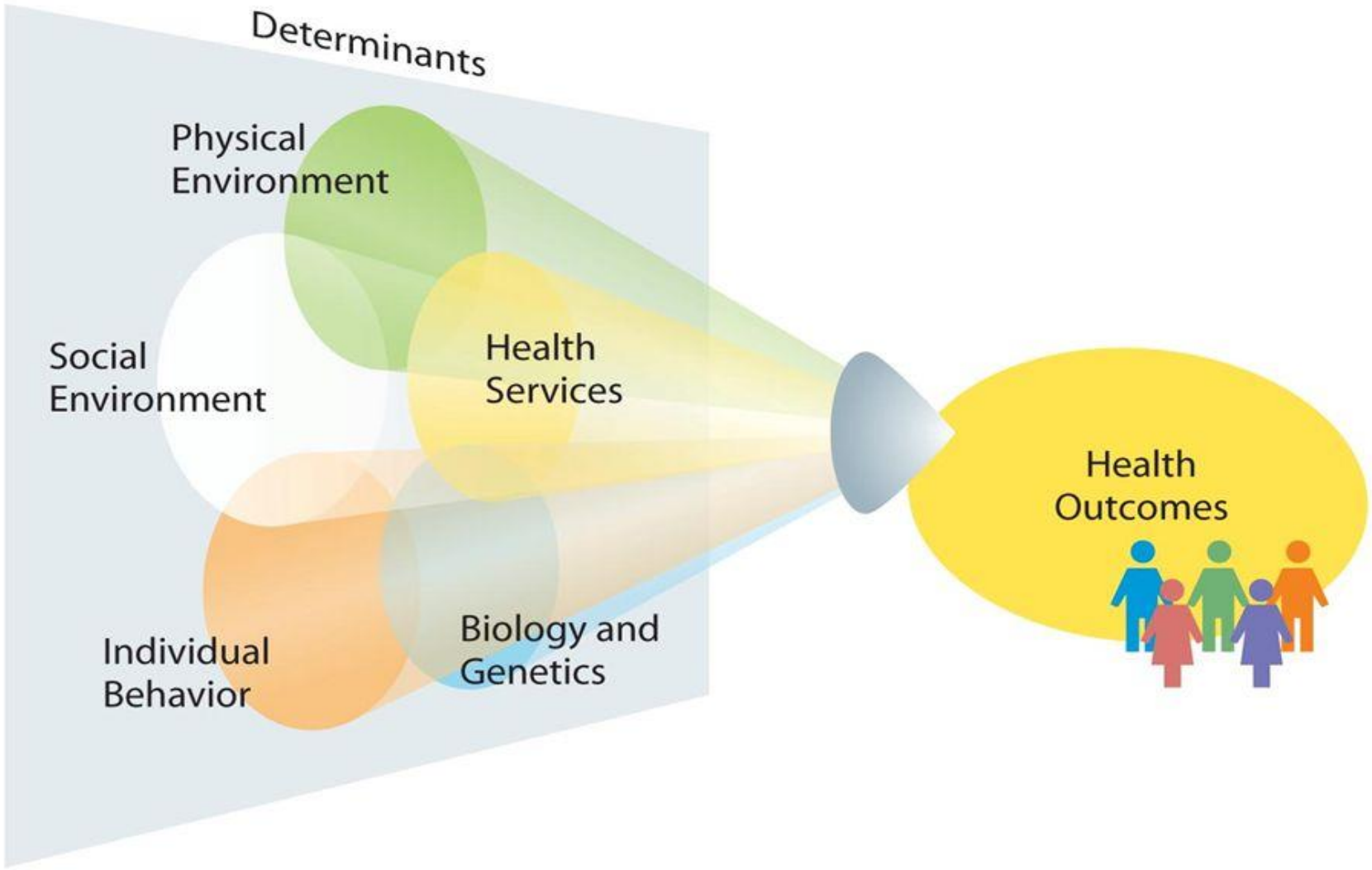


21%
Genetics & Biology

23%
Social Circumstances

Retrieved from: https://www.goinvo.com/features/determinants-of-health/

Healthy People 2020 Determinants of Health



“Our human nature is to resist vulnerability, we are taught to hide our weaknesses and pretend they are not there”

Brene Brown

Social Determinants of Health

Social Determinants of Health

“The Forgotten Vital Sign”

“Nobody has ever asked me that”

Rosalind Berry

The Ten SDoH Domains of the SIM PCMH Initiative

1. Healthcare
2. Food
3. Employment and Income
4. Housing and Shelter
5. Utilities
6. Family Care
7. Education
8. Transportation
9. Personal and Environmental Safety
10. General

Figure 2

Social Determinants of Health

Economic Stability	Neighborhood and Physical Environment	Education	Food	Community and Social Context	Health Care System
Employment	Housing	Literacy	Hunger	Social integration	Health coverage
Income	Transportation	Language	Access to healthy options	Support systems	Provider availability
Expenses	Safety	Early childhood education		Community engagement	Provider linguistic and cultural competency
Debt	Parks	Vocational training		Discrimination	Quality of care
Medical bills	Playgrounds	Higher education			
Support	Walkability				

Health Outcomes

Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations

Artiga, S., & Hinton, E. (2018). Beyond health care: The role of social determinants in promoting health and health equity. Kaiser Family Foundation. Retrieved from https://www.kff.org/disparities-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/

Adjustment Disorder

Symptoms

1. Depressed Mood
2. Impaired Occupation/Social Functioning
3. Agitation
4. Physical Complaints
5. Conduct Disturbances
6. Withdrawal
7. Anxiety, Worry, Stress, and Tension

Symptoms do not last longer than 6 months

Fibromyalgia

- Depression
- Chronic widespread pain
- Fatigue
- Lack of focus
- Withdrawal

ACEs

Adverse Childhood Experiences

Adverse Childhood Experiences

SAMHSA.(2018) Adverse Childhood Experiences. Retrieved from: https://www.samhsa.gov/capt/practicing-effective-prevention/prevention-behavioral-health/adverse-childhood-experiences

WHAT ARE THEY?

ACEs are ADVERSE CHILDHOOD EXPERIENCES

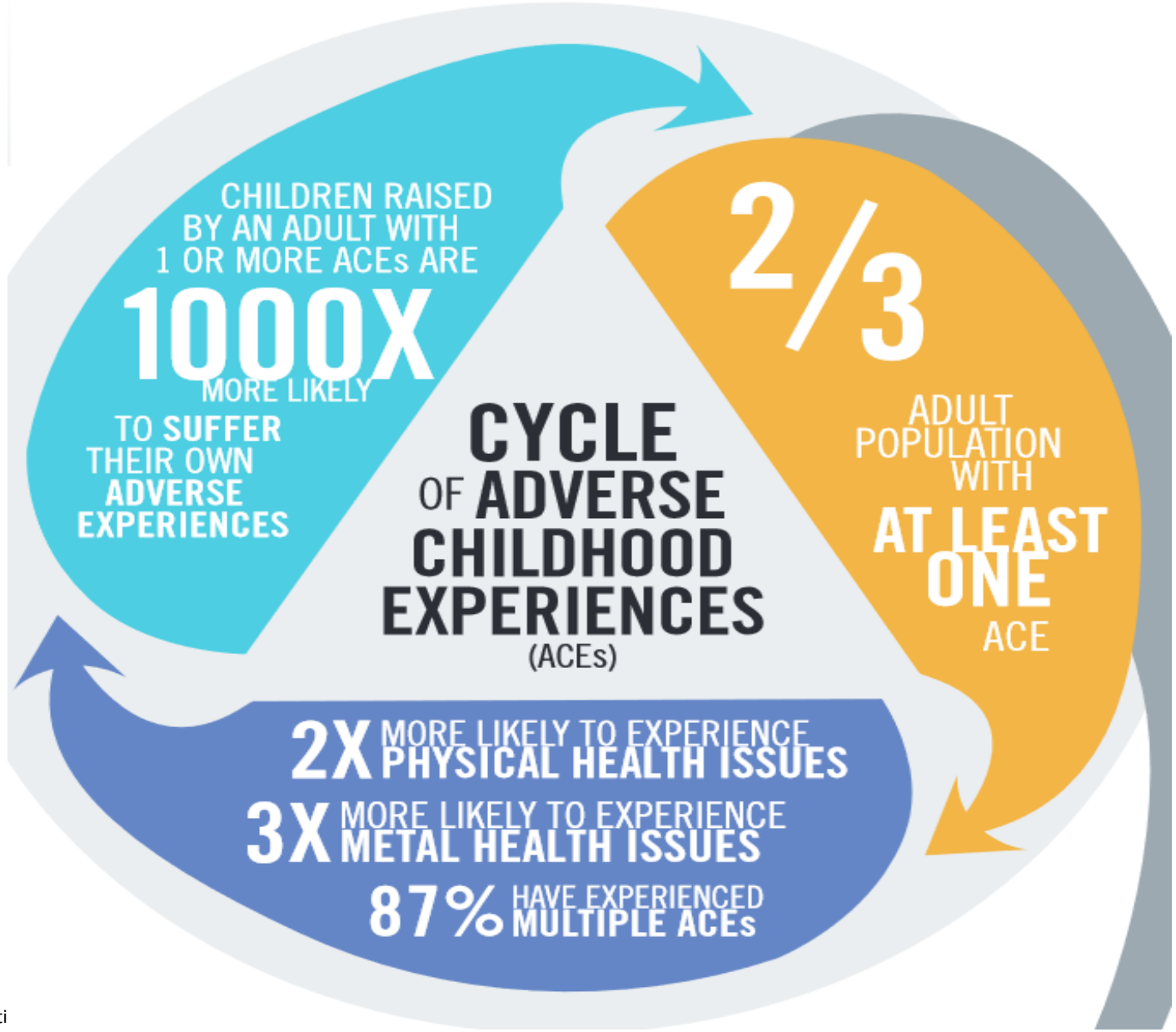
The three types of ACEs include

ABUSE	NEGLECT	HOUSEHOLD DYSFUNCTION	
Physical	Physical	Mental Illness	Incarcerated Relative
Emotional	Emotional	Mother treated violently	Substance Abuse
Sexual		Divorce	

HOW PREVALENT ARE ACEs?

WHAT IMPACT DO ACEs HAVE?

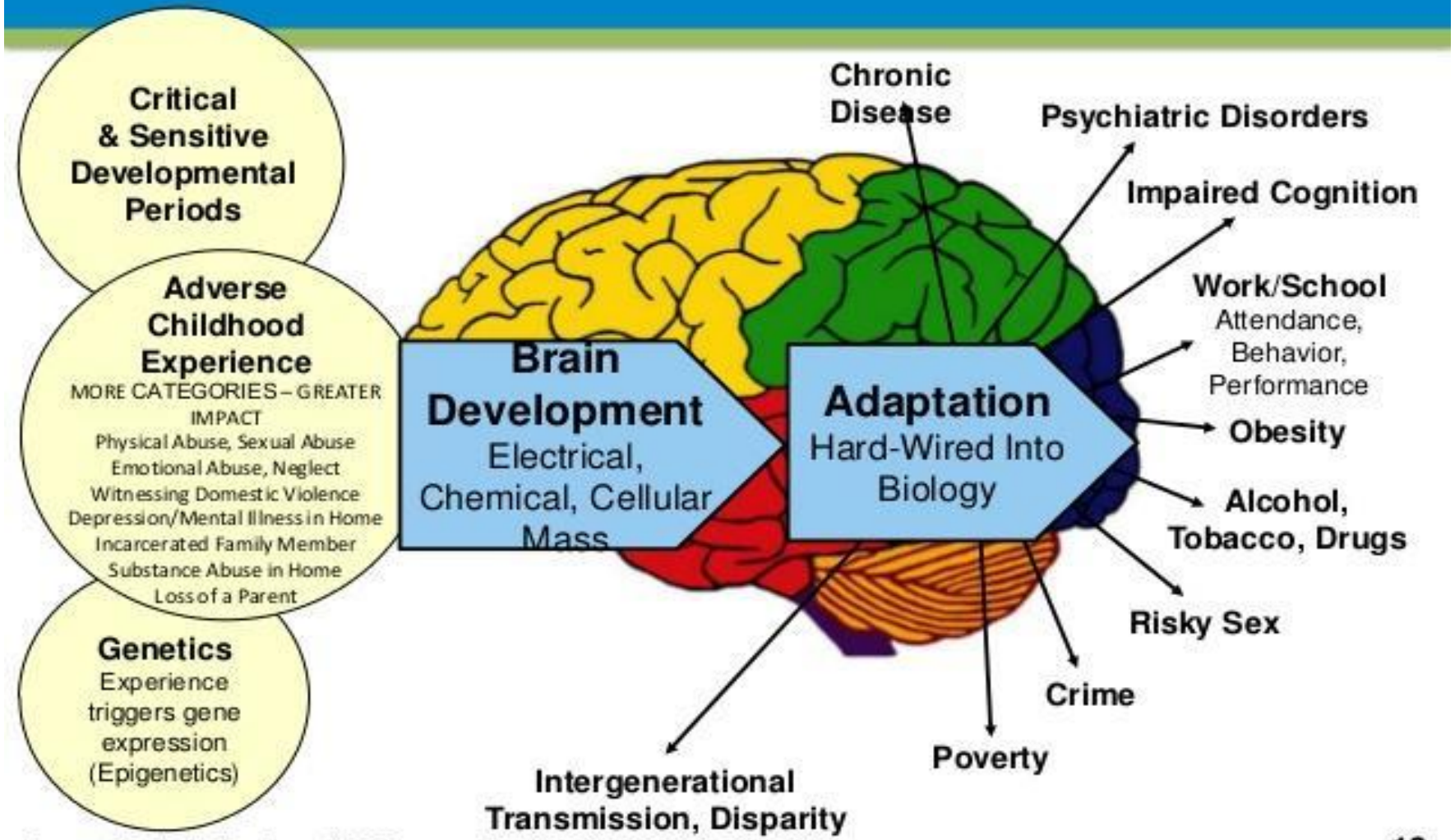
Robert Wood Johnson Foundation. (2018) The truth about ACES. Retrieved from: https://www.rwjf.org/en/library/infographics/the-truth-about-aces.html?cid=xsh_rwjf_ec_00046841



Asphn & NWA Webinar Series. (2017, October). Nutriti
the Life Course: Prevention Opportunities

Biological Affects of SDoH and ACEs

Lifespan Impacts of ACEs



Source: Family Policy Council, 2012

The fight or flight response

Dilation of pupil

Dry mouth

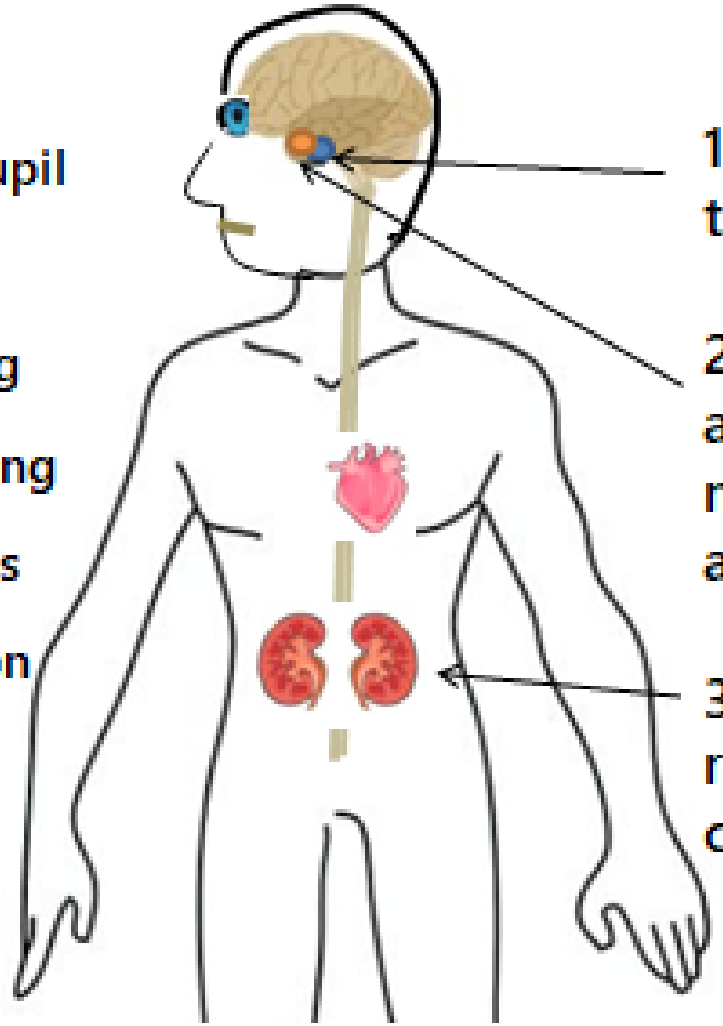
Fast breathing

Heart pounding

Tense muscles

Slow digestion

Sweating of palms



1. The amygdala reacts to threat

2. The hypothalamus activates the sympathetic nervous system, release of adrenaline

3. The adrenal cortex releases cortisol for continued alertness

Venho, N. (2018). Part 1: Fight or Flight Response. Retrieved from http://www.moodmetric.com/fight-flight-response/

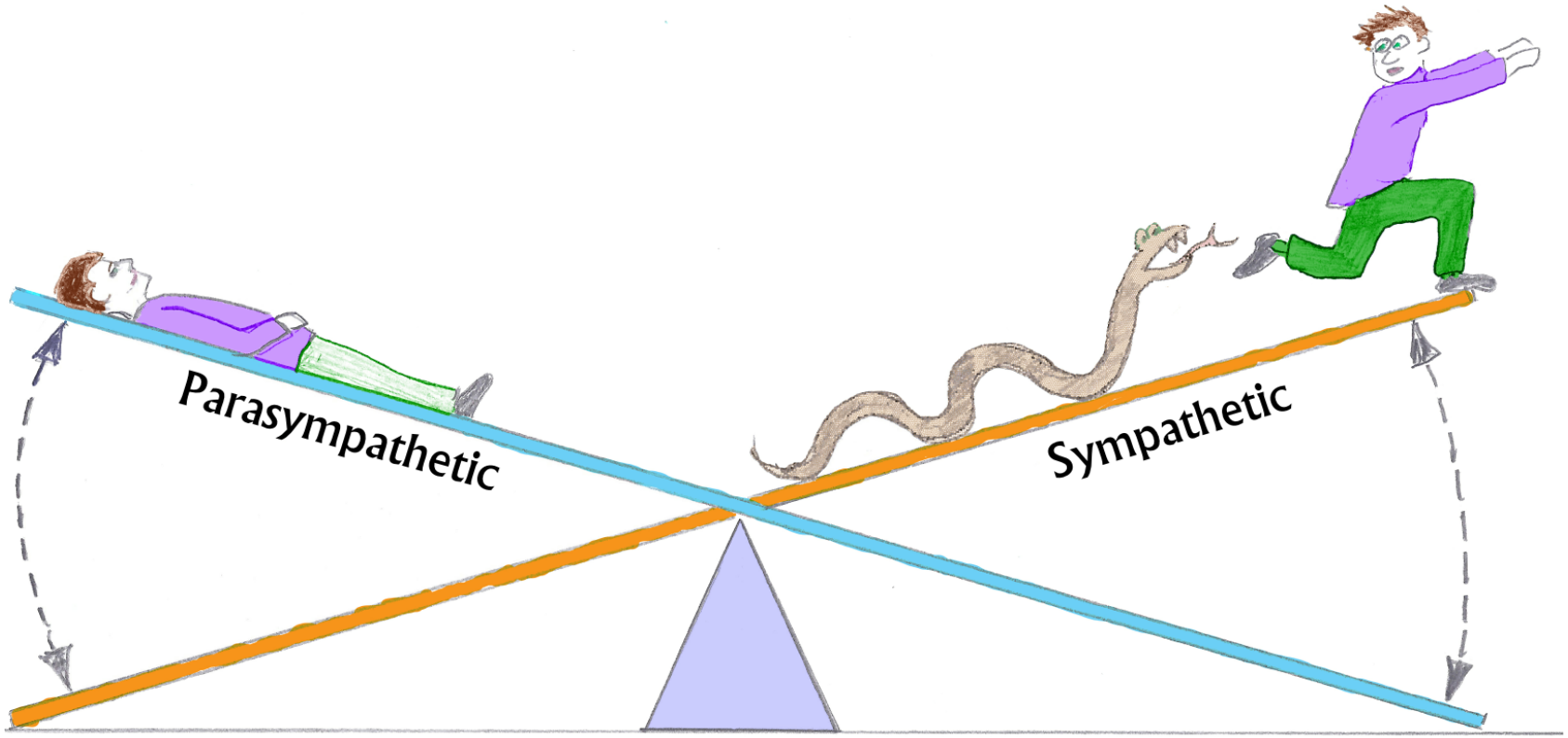
Addressing SDoH and ACEs through Biology

Three Things That Change Our Biology

- Food
- Sleep
- Sex

Why? How?

Homeostasis is a dynamic balance between the autonomic branches.



Rest and digest:
Parasympathetic
activity dominates

Fight or flight:
Sympathetic activity
dominates

Dis-ease

Dopamine

The Happy Hormone

Unnatural Ways to Get Dopamine

- Medications
- Drugs
- Sugar
- Extreme Behaviors

Health Manifestations Epigenetics

Adjustment Disorder

Symptoms

1. Depressed Mood
2. Impaired Occupation/Social Functioning
3. Agitation
4. Physical Complaints
5. Conduct Disturbances
6. Withdrawal
7. Anxiety, Worry, Stress, and Tension

Symptoms do not last longer than 6 months

Fibromyalgia

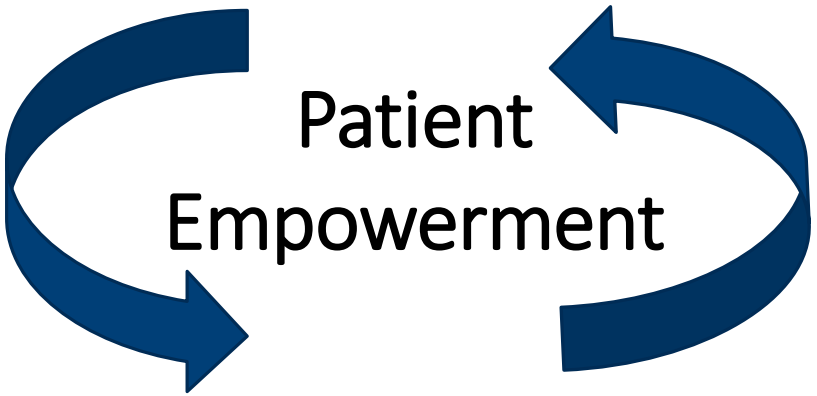
- Depression
- Chronic widespread pain
- Fatigue
- Lack of focus
- Withdrawal

Provider Engagement

Patient Engagement Readiness Model (PERM)

Patient

- Awareness
- Willingness
- Knowledge
- Skills
- Autonomy
- Self-determination



Healthcare Provider

- Patient centered care
- Patient enablement
- Patient involvement
- Patient activation
- Shared decision making

Case Management

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐

CAGE and CAGE-AID Questions

1. In the last three months, have you felt you should cut down or stop drinking or *using drugs*?
   Yes No

2. In the last three months, has anyone annoyed you or gotten on your nerves by telling you to cut down or stop drinking or *using drugs*?
   Yes No

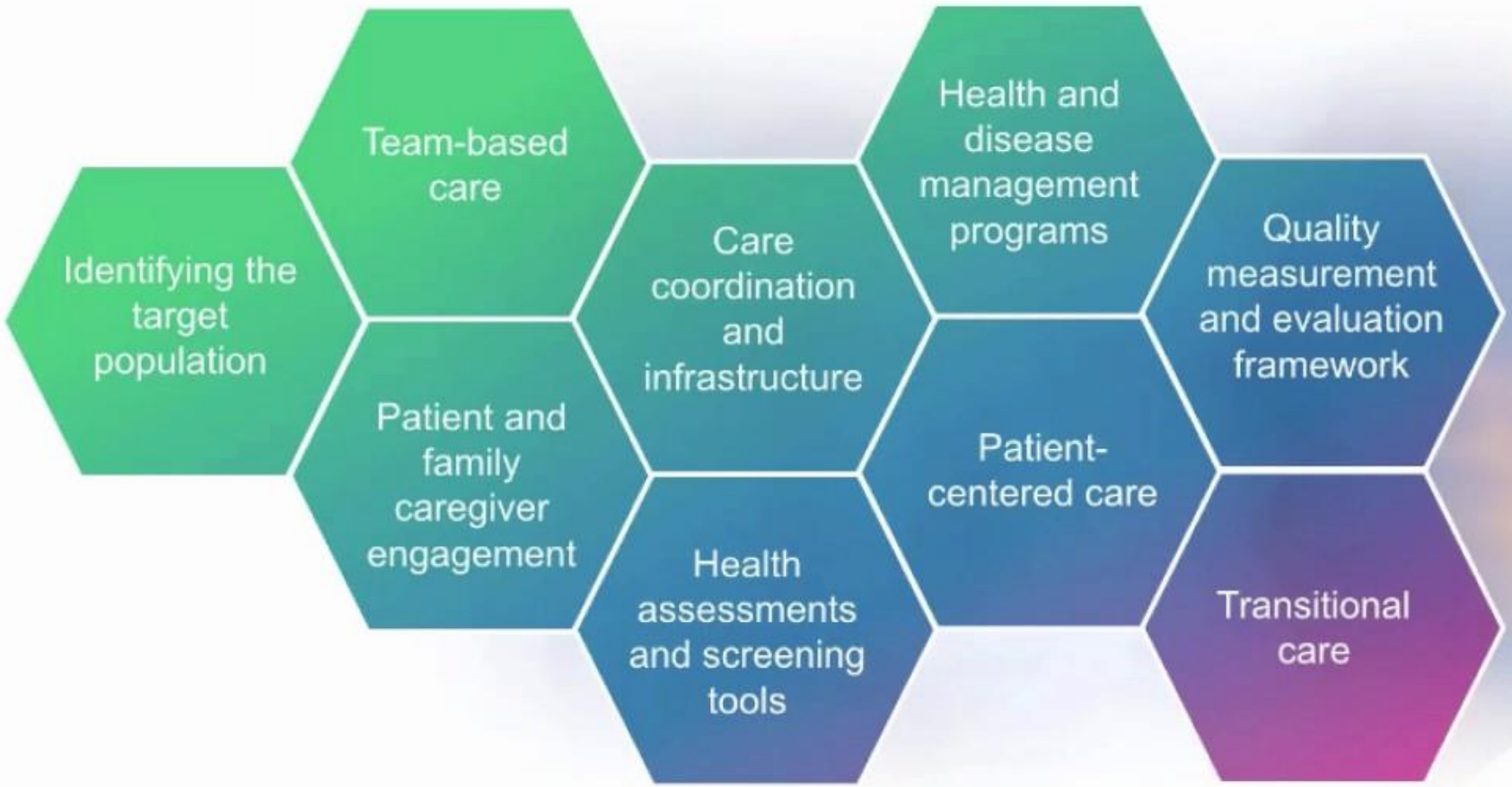
3. In the last three months, have you felt guilty or bad about how much you drink *or use drugs*?
   Yes No

4. In the last three months, have you been waking up wanting to have an alcoholic drink *or use drugs*?
   Yes No

Each affirmative response earns one point. One point indicates a possible problem. Two points indicates a probable problem.

From: The Society of Teachers of Family Medicine. Project SAEFP Workshop Materials, Screening and Assessment Module, page 18. Funded by the Division of Health Professionals, HRSA, DHHS, Contract No. 240-89-0038. Reprinted by permission.

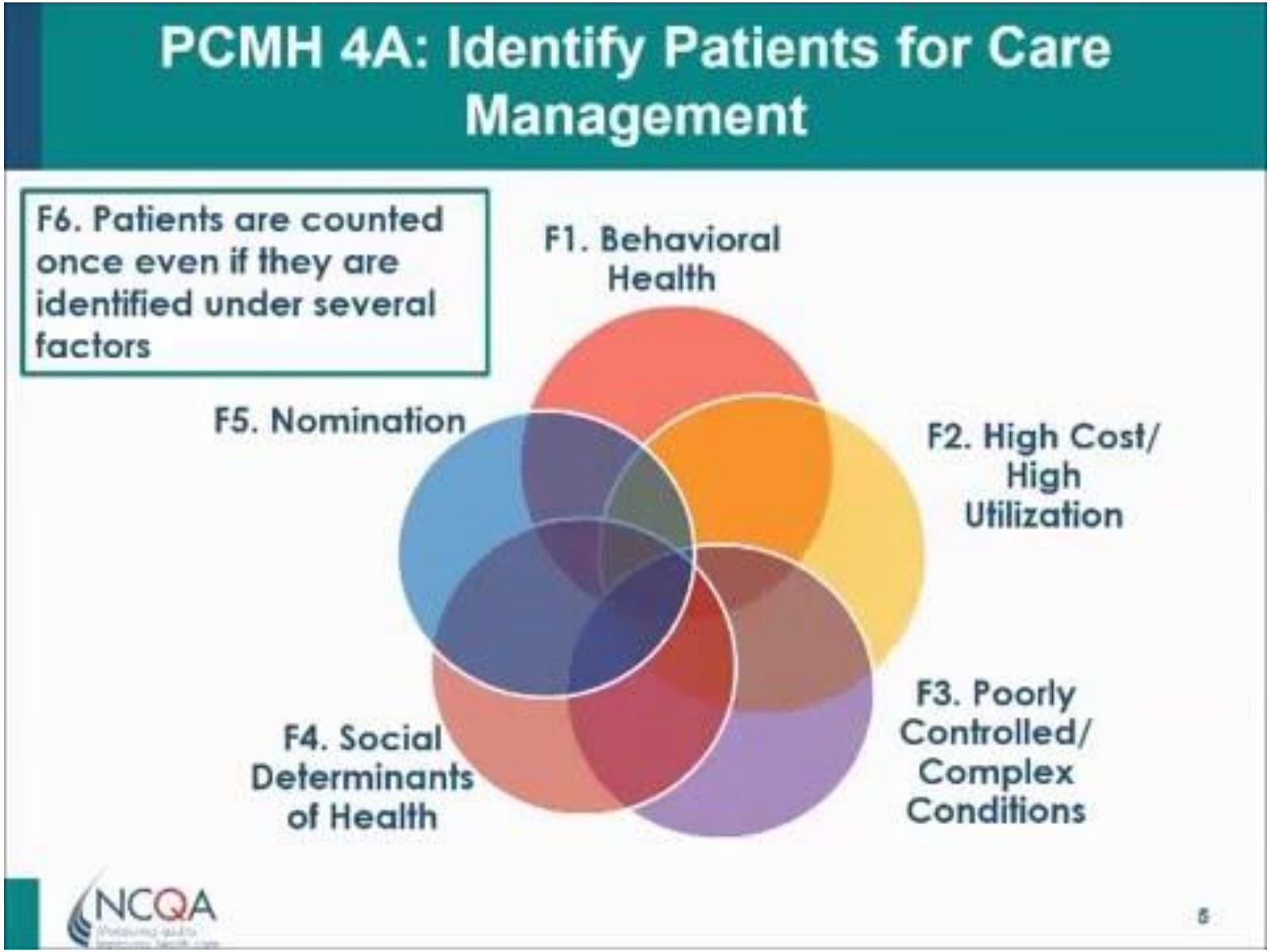
Building Blocks of Care Management



HealthCatalyst
ignite outcomes improvement

Clay,K. (2017, August). Care Management – Critical Component of Effective Population Health Management. Retrieved from *https://www.slideshare.net/healthcatalyst1/care-management-critical-component-of-effective-population-health*

SIM MDHHS State Innovation Model



Vermont Child Health Improvement Program, PCMH Standards and Guidelines NCQA 2014, retrieved from https://slideplayercom/slide/6201431

Community Involvement


Stages of Community Readiness
Professionalization
Confirmation/Expansion
Stabilization
Initiation
Preparation
Preplanning
Vague Awareness
Denial/Resistance
No Awareness

Examples of Community Involvement

Community Involvement

- Oral Health Coalition
- Way to Wellville
- Resilience
- Healthcare Provider Workgroup
- Muskegon Area Intermediate School District (MAISD)
- Faith Based Organizations
- Municipalities
- Food Councils
- Arts and Theatre
- Lakeshore Fitness Board Member

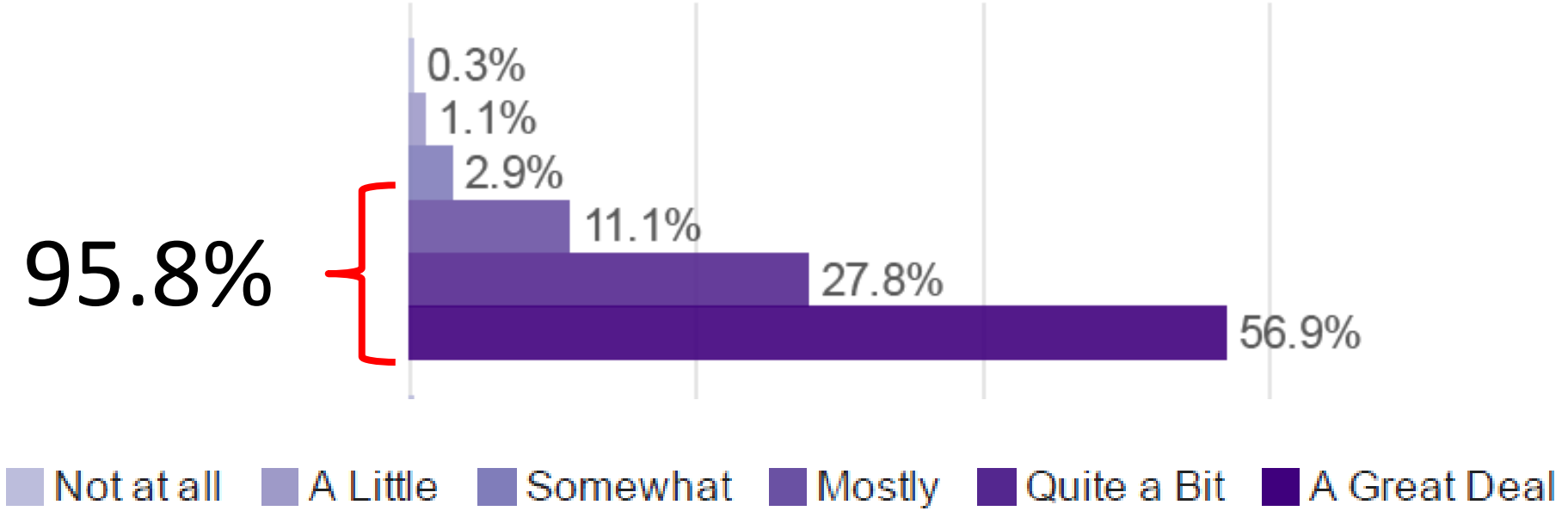
Statistics

Source:
SIM PCMH Initiative Provider Survey (Summer, 2018)
Data Analysis completed by Jason Almerigi, Michigan Public Health Institute

- Preliminary Results
- 451 PCPs, CM, PCMH and PO Administrators
- 38 POs, 143 Practices (52.6% in CHIRs)

Screening for SDoH Needs

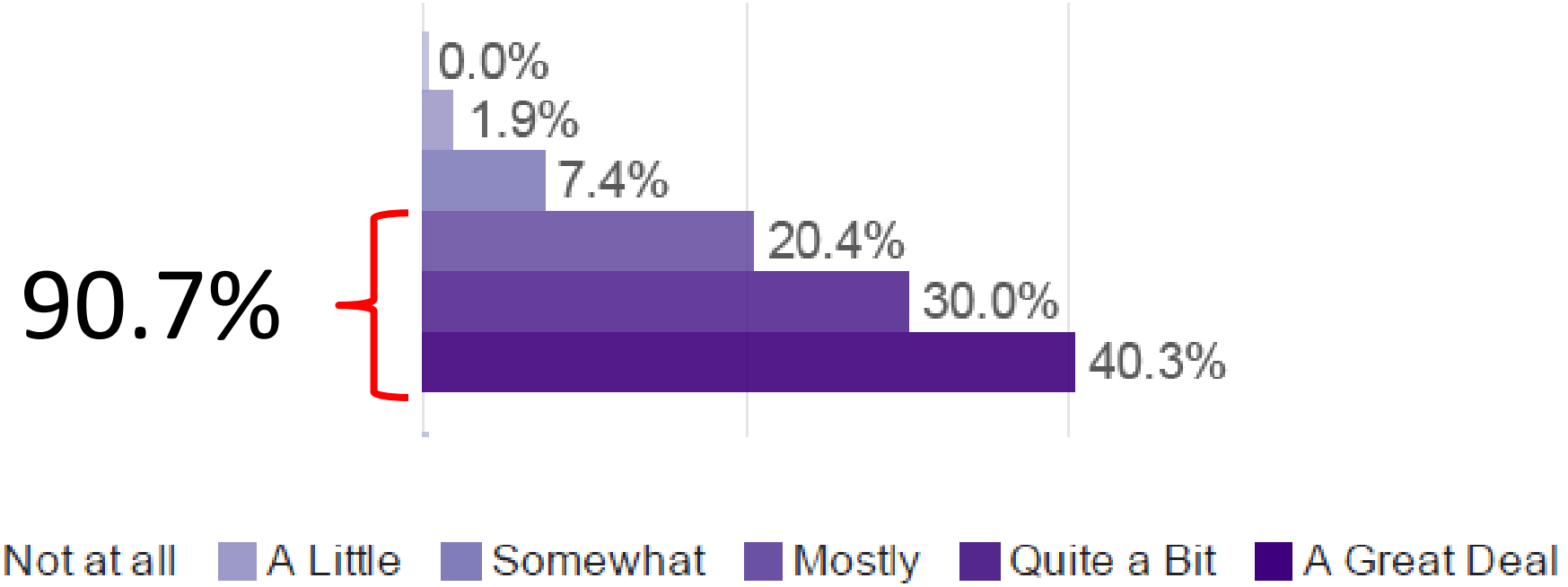
At my practice, we understand the impact of social needs on the health and well-being of patients.



Data Analysis completed by Jason Almerigi, Michigan Public Health Institute

Screening for SDoH Needs

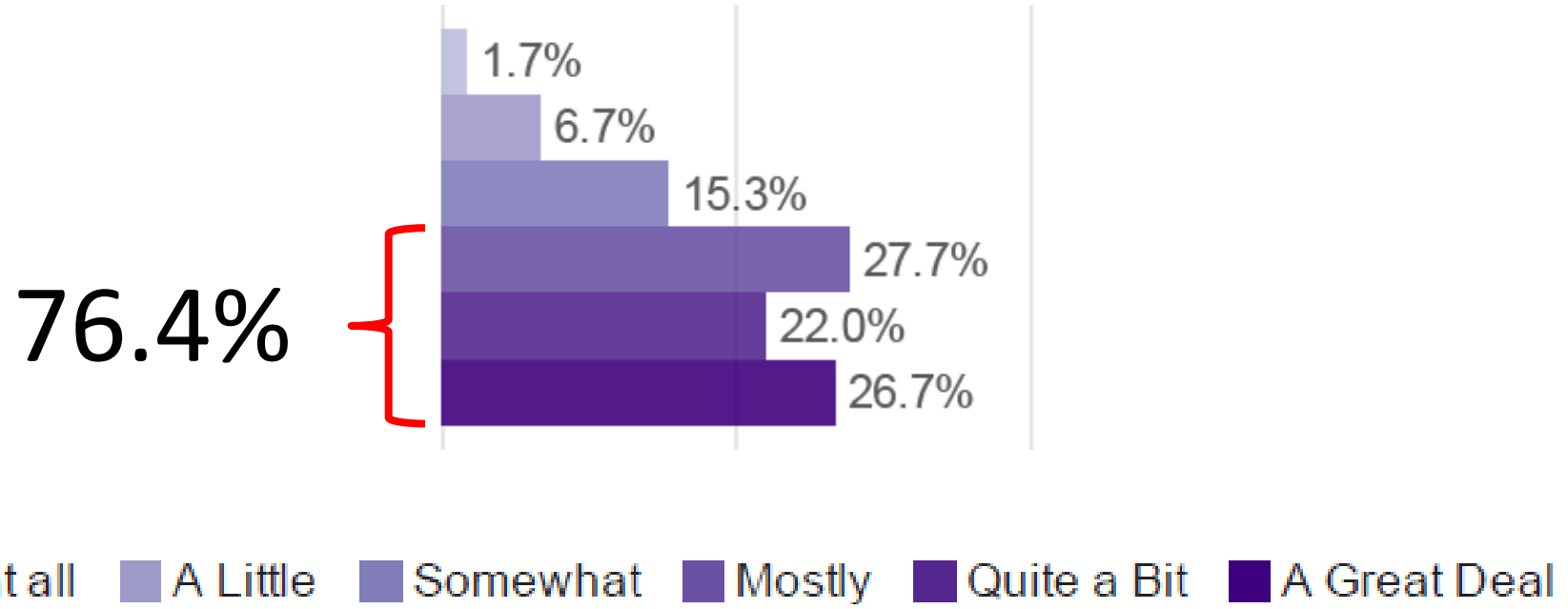
At my practice, we are aware of the major social needs of our patients.



Data Analysis completed by Jason Almerigi, Michigan Public Health Institute

Screening for SDoH Needs

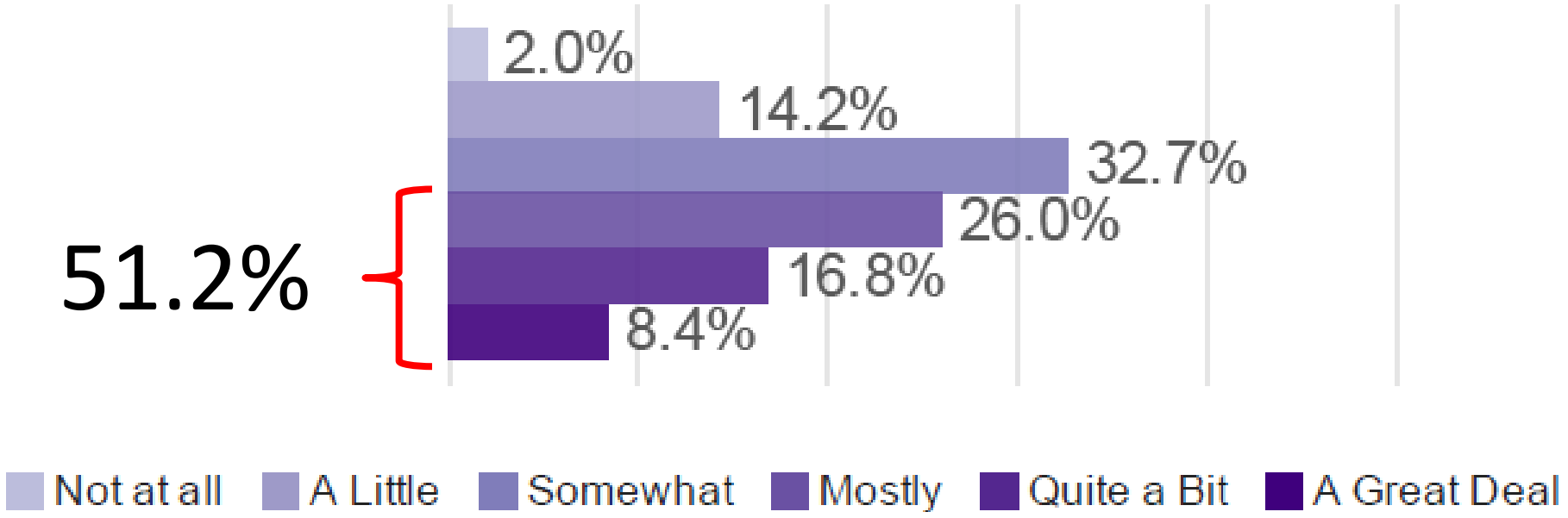
At my practice, we have the resources (e.g., funding, staffing, materials) to effectively implement screening and referral for social services.



Data Analysis completed by Jason Almerigi, Michigan Public Health Institute

Screening for SDoH Needs

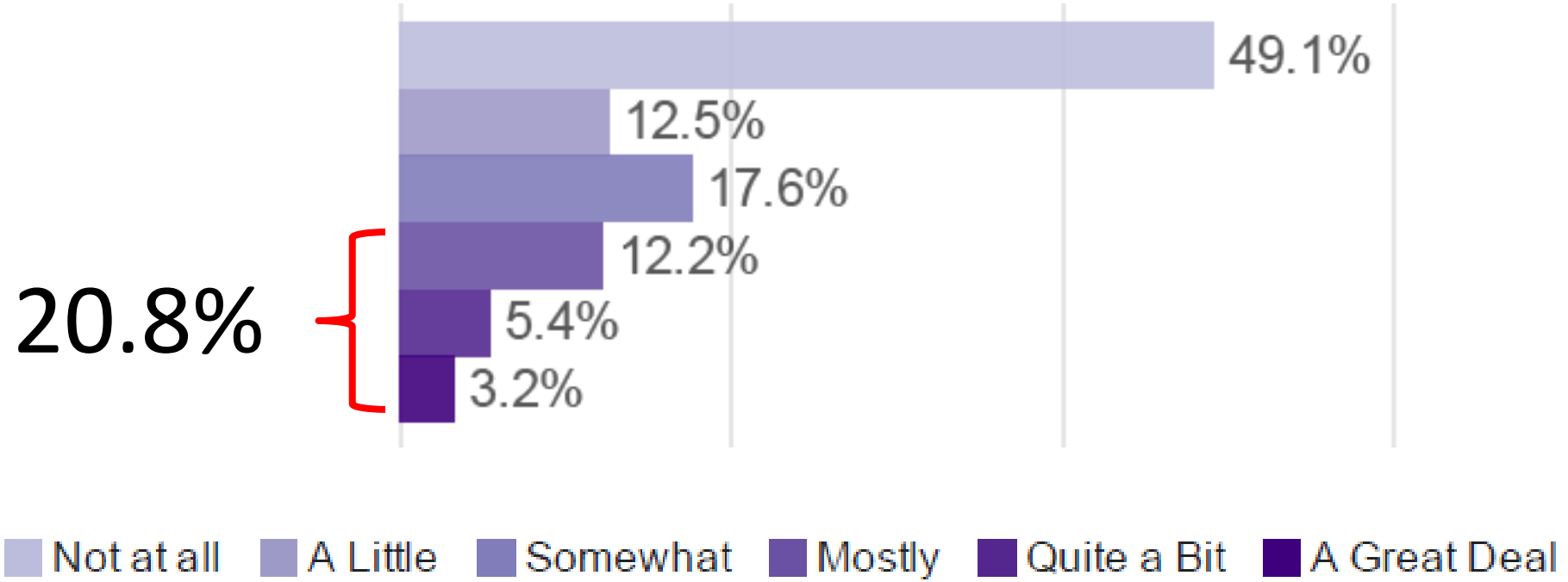
Because of screening and referral for social services, patients are getting healthier.



Data Analysis completed by Jason Almerigi, Michigan Public Health Institute

Screening for SDoH Needs

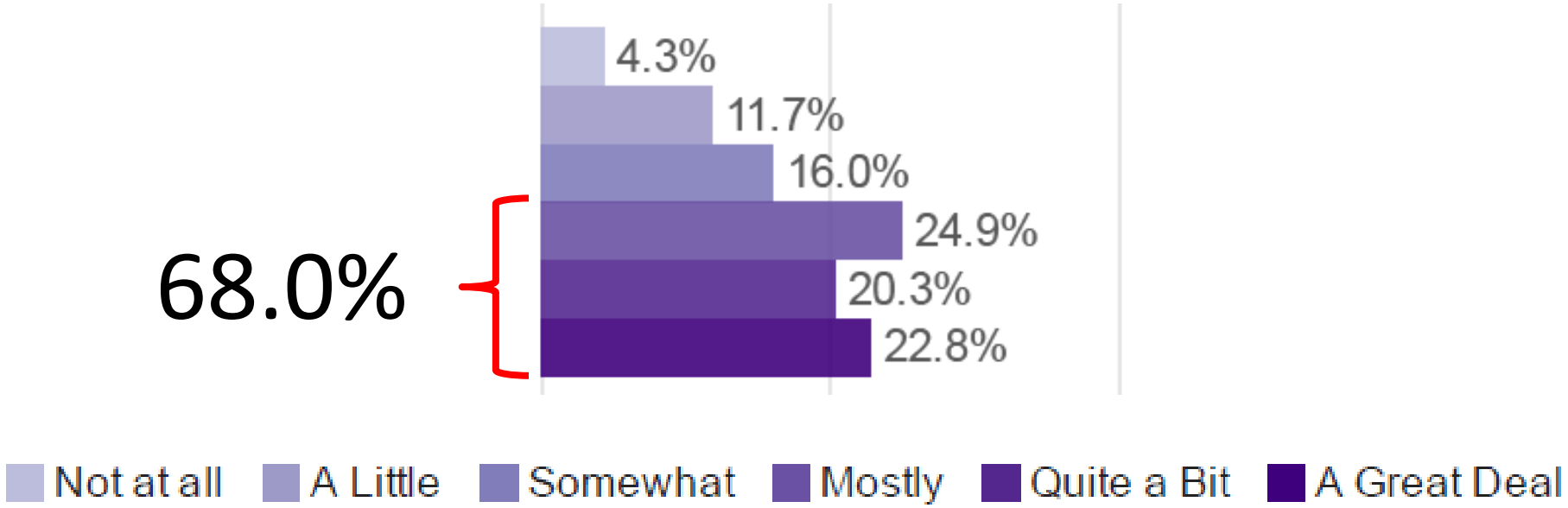
Because of our coordination efforts with health and social services, our staff/providers have a reduced workload.



Data Analysis completed by Jason Almerigi, Michigan Public Health Institute

Screening for SDoH Needs

Because of our coordination efforts with health and social services, the benefits to our patients outweighs the added work/challenges.



Data Analysis completed by Jason Almerigi, Michigan Public Health Institute

Questions?


SPECTRUM HEALTH

Spectrum Health Medical Group Ambulatory Care Management

JOE JOOSTENS, RN CARE MANAGER

SPECTRUM HEALTH

SHMG SIM Tracking Code Data

All SHMG Offices (Spectrum PO) 2.14%

SHMG Enhanced Primary Care 8%

Unintentional:

- We did not have specific goal or focus on SIM Tracking Codes
- We do approach coding across payers as part of our overall process of management and coordination
- Having been contacted for achieving these results we set out to examine how we generated SIM Tracking Code success.

Foundation: Care Management Process

- Patient Identification
- Assessment/Care Plan – Episodic, Longitudinal
- Implementation and Monitoring/Follow up
- Case Closure

Patient Identification

- Team Referrals
  - Provider, Mid-Level, Allied Health, other staff
- Transitions of Care
  - Hospital Discharges, warm handovers from within hospital, ED high-utilizers
- Proactive Outreach:
  - Both Risk stratification and Payer Initiatives.
  - Combined payers into 1 outreach list

Tracking Codes

- Attach Care Management Codes to each encounter:
  - Face to Face, Telephone, Care Conference
- Measures our work and productivity, but doesn't always result in a charge to patient.
- Dropped by all Allied Health members in certain circumstances:
  - Care Manager, Behavioral Health, Pharmacist

Key to Success: Teamwork

- Referrals within the team:
  - Providers and staff know the patients best.
- All Allied Health members using Care Management codes:
  - United effort and goals.
- Collaboration between team members:
  - Promotes our overall goal: To improve patient outcomes and the health of the communities we serve!

Where Can We Improve?

- Make patient identification easier for entire team:
  - Recently added a two-step risk stratification tool built into our EHR, working to get all staff engaged in utilizing this.
  - Combine data onto one list: combining payer initiatives and risk stratification.
- Move our focus further from reactive to proactive:
  - Do we need more resources for this? Team Growth?
- Evaluate Allied Health productivity:
  - Continually monitor via tracking codes and address shortfalls.

Evaluate: PDSA (Plan, Do, Study, Act)

- Patient identification: Make it as easy as possible for the team
- Continue to Streamline data to one list, aligning payer initiatives
- Risk Stratification 2- Step process
- Looking where we can be proactive, not just reactive

Continued……

- Review/Evaluate productivity for the Care Management department
  - Supervisors discuss productivity monthly with individual Care Managers
  - Conduct targeted audits to analyze processes
- Team growth → Care Manager, Behavioral Health Specialists, Pharmacists
  - Can see who from the team is “dropping” codes

Questions?


SPECTRUM HEALTH

Care Management, Coordination and Tracking Code Success

WATTLES PARK FAMILY PRACTICE

Identifying Patients

- Targeted conditions: chronic conditions such as diabetes, depression, uncontrolled hypertension, and pain management; multiple comorbidities; financial issues
- Risk adjustment score – AAFP risk adjustment and clinical intuition as two identifiers
- Social Determinants of Health Screening Tool
- ADT (Patient Ping) notification

Establishing a Process

- When you see a baby elephant in the room what do you do??
- Educate: The entire team must be educated and buy in to their part to play
- Key triggers for team members:
  - Patient is upset
  - Can’t afford co-payment
  - Loss of a family member
  - Lack of knowledge regarding medication or medical diagnosis
- Patient awareness about care management services
  - Patient rooms
  - On the website
  - New patient information
  - Facebook
  - Business cards

Establishing a Process (cont.)

- Involve the care manager
  - Front desk
  - Medical assistant
  - Provider
- Care manager meets patient in the room
  - Recent hospital stay
  - Huddle in the morning with the provider
  - New diagnosis
  - Administration of insulin
  - Follow up after a phone call
  - Medical Assistant engaged CM based on a SDoH need

Establishing a Process (cont.)

- Care manager phone contact
  - Recent hospital admission
  - Results of SDoH form
  - Provider requests CM follow up
  - Medication management issues – cost, adherence
- Care managers meet with patients and provide resources based on patient need
- Develop care plan
- Schedule follow up appointment and place on the schedule
- Document in the patient record

Establishing a Process (cont.)

- Care manager selects the proper coding for tracking purposes
- Medical record is sent to the provider
- Provider reads all care management notes and forwards charts to the billing department
- Care managers track the patient by putting the information into a tracking log
- Care managers look for needs in the patient population
  - CM works outside normal business hours
  - DM classes held at our office
  - Watch for trends

Resources

- Where are the resources?????
  - Community Resource Guide – throughout the office (developed by our Physician Organization – Integrated Health Partners)
  - Attend IHP monthly meetings and quarterly meetings
    - Education on community resources
    - Best practice sharing
  - Bertha.com – internet service listing current resources in area
  - Insurance plans' resources: transportation, care management
  - Establish frequently used contacts at community organizations

Addressing Behavioral Health Needs In The Primary Care Setting

LAURISA CUMMINGS, LMSW
CHILDREN'S MEDICAL GROUP OF SAGINAW BAY

Learning Objectives

- Explain effective mental health management through the care team, including integration of behavioral health into primary care
- Identify best practice and lessons learned when advancing care management services and implementing behavioral health screening into primary care
- Discuss behavioral health screening and follow up, matching resources to address practice population needs

Agenda

- Learners will be able to discuss behavioral health conditions commonly treated in primary care practices
- Learners will be able to identify screening tools in which to screen for particular behavioral health conditions
- Learners will be able to use evidence-based tools for improved assessment and management of behavioral health issues
- Learners will be able to identify referral processes to address behavioral health needs
- Learners will be able to identify additional billing opportunities for care managers who hold a LMSW

Rationale to Address Mental Health Needs in Primary Care

- 56% of American adults with a mental illness did not receive treatment (Mental Health America 2017)
- 1.7 million youth with major depressive episodes did not receive treatment (Mental Health America, 2017)
- One half of all chronic mental illness begins by the age of 14; three-quarters by the age of 24 (National Institute of Mental Health, 2017)
- 90% of those who die by suicide have an underlying mental illness; suicide is the 10th leading cause of death in the U.S. (National Institute of Mental Health, 2017)

Michigan Statistics

- Michigan ranked 23 of all states having lower prevalence of mental health and substance use issues
- Michigan ranked 19 of all states having lower prevalence of mental illness and higher rates of access to care for adults
- Michigan ranked 17 of all states having lower prevalence of mental illness and higher rates of access to care for youth
- Michigan ranked 16 of all states providing access to insurance and mental health treatment for adults and youth
- Michigan ranked 22 of all states providing mental health workforce availability with a ratio of 460:1 (includes psychiatrists, psychologists, LSMWs, counselors, LMFT, and NPs)

(National Institute of Mental Health, 2017)

Why Addressing Behavioral Health Needs In Primary Care Settings Is So Important

- Increased compliance
- Lessen stigma of mental health needs
- Increase self management of chronic mental health needs
- Improved coordination of care
- Decreased morbidity
- Preventative services
- Integration of physical and emotional care

Behavioral Health Integration: Resources For Primary Care Use

- American Academy of Pediatrics (https://www.aap.org)
- SAMHSA-HRSA for Integrated Health Solutions (CIHS) (https://integration.samhsa.gov)
- National Alliance on Mental Health (https://nami.org)
- World Health Organization (https://who.int)

Behavioral Health Integration: Two Example Models

Mental Health Tool Kit, American Academy of Pediatrics

www.aap.org

Mental Health Initiatives, Primary Care Tools

A Global Perspective, World Health Organization

www.who.int/en/

Mental Health, Policies and Services

Where To Begin: Advancing Care Management, Adding Behavioral Health Services

Social Determinants of Health

Domains of Social Determinants of Health:

Healthcare, food, employment & income, housing and shelter, utilities, family care, education, transportation, personal and environmental safety, and general

ACES Screening

Pair of ACEs:

Screening for adverse childhood experiences (ACEs)

Addressing adverse community environments (ACEs)

(http://go.gwu.edu/BCR)

Social Determinants of Health

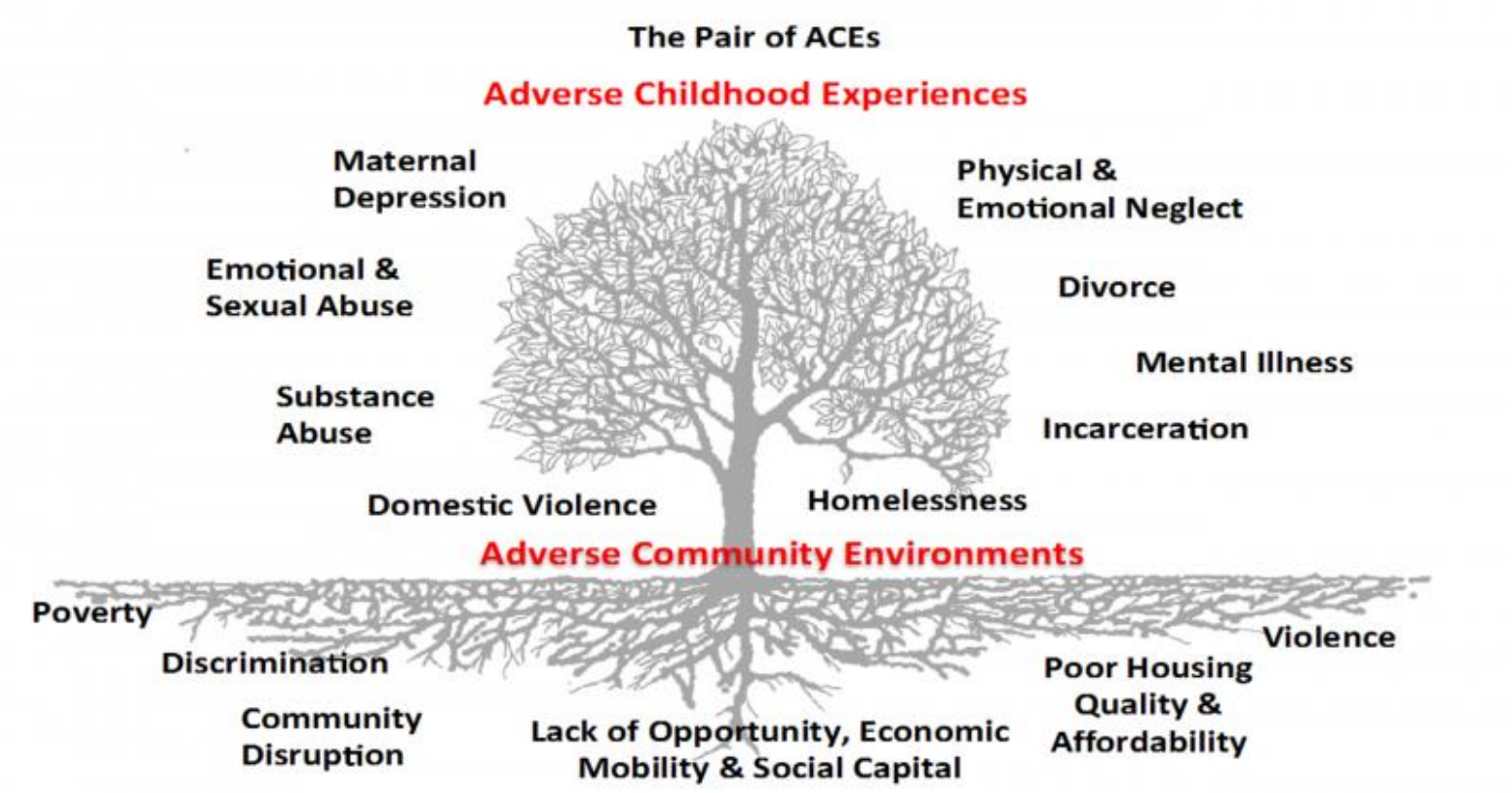
- Healthcare
  - In the past month, did poor health keep you from doing your usual activities, like work, school or a hobby?
  - In the past year, was there a time when you needed to see a doctor but could not because it cost too much?
- Food
  - In the past year, did you ever eat less than you needed to because there was not enough food?
- Employment & Income
  - Is it hard to find work or another source of income to meet your basic needs?
- Housing & Shelter
  - Are you worried that in the next few months, you may not have housing?
- Utilities
  - In the past year, have you had a hard time paying your utility company bills?

Social Determinants of Health, Cont'd

- 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.
- Education
  - Do you want help with school or job training, like finishing a GED, going to college, or learning a trade?
- Transportation
  - Do you ever have trouble getting to school, work, or the store because you don't have a way to get there?
- Personal and Environmental Safety
  - Do you ever feel unsafe in your home or neighborhood?
- 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

Pair of ACEs



Ellis, W., Dietz, W. (2017) A New Framework for Addressing Adverse Childhood and Community Experiences: The Building Community Resilience (BCR) Model. Academic Pediatrics. 17 (2017) pp. S86-S93. DOI information: 10.1016/j.acap.2016.12.011

Screening Tools Used For Behavioral Health In Primary Care Settings

PHQ-9 Initial Depression Screening Tool

KADS-Depression Screening Tool

MDQ-Bipolar Screening Tool

SCARED-Anxiety Screening Tool

Suicide Lethality Screening Tool

MCHAT-R Screening Tool for Autism

AQ-10 Child Screening Tool for Autism (Age 4-11)

AQ-10 Adolescent Screening Tool for Autism (Age 12-15)

Screening Tools Used For Behavioral Health In Primary Care Settings, Cont'd

GAD-7 Anxiety Screening Tool for Adults

Edinburgh Postnatal Depression Scale

AUDIT-Alcohol Use Disorders Identification Test

CAGE AID- Screens for drug and alcohol use

Columbia-Suicide Severity Rating Scale (C-SSRS)

Life Event Checklist-Screens for potentially traumatic events during lifetime

ACEs-Adverse Childhood Experiences

Commonly Identified Behavioral Health Needs In The Primary Care Setting

- ADHD/ADD and Autism
  - Both pediatric and adult
  - Evaluation and treatment options
- General Behavioral Concerns
- Social Pragmatic Communication Disorder

Commonly Identified Behavioral Health Needs In The Primary Care Setting, Cont'd

- Mental Health
  - Depression
  - Anxiety
  - Suicidality
  - Bipolar
  - Need for acute hospitalization
- Delays In Development
  - Referral and treatment options
- Fatigue, Stress from Chronic Conditions

Meeting The Patient's Needs: Behavior Health and Care Management

Care Management and Coordination

- Medication Management
  - PCP vs. Psychiatry written, oversight
- Transportation Needs
  - Community support and coordination
- Appointment Coordination
- Collaborative Communication
  - Internal AND external
  - Team Huddles, coordination and communication with specialists
- Additional Services and Needs
  - Referrals, coordination, and collaboration

Meeting The Patient's Needs: Behavior Health and Care Management, Cont'd

Behavioral Health Needs

- Psychiatry Needs
  - Referral, medication management and oversight
- Counseling Needs
  - Internal referral vs. external referral
- Additional Services and Need
  - Referrals, coordination, and collaboration

Patient Referrals: Differentiating Care Management and Behavioral Health

- Care Management Referrals
  - Completed by care manager, billing G Codes, Phone Codes, and S Code
    - Chronic Disease Management
    - Patient Education
    - Self Management
- Behavioral Health Referrals
  - Completed by mental health specialist credentialed with health insurance provider, billing behavioral health codes
    - Individual, family, group, and crisis behavioral health needs
    - May be referred internally or to external providers

Care Management Coordination of Behavioral Health Needs

Services completed by any trained care manager:

(1) G9001 Assessment and (2) G9002 Face to Face Visits:

- Completed by approved, trained care manager

G9001 – Comprehensive Assessment and Care Plan*
Education: Assessment-G9001

- Include patient and care giver assessment, discussion and collaboration:
  - Beliefs about diagnosis
  - Basic education about diagnosis
  - Dispel myths
  - Provide hope
  - Collaborate with Psychiatrist, PCP

*For details see the SIM Care Management and Coordination Tracking Quick Reference Guide

Care Management Coordination of Behavioral Health Needs, Cont'd

Prevention-G9002 Face to Face Visit

- SIM face to face criteria must be met
  - Triggers
  - Identify and highlight strengths
  - Identify barriers and ways to overcome barriers
  - Collaborate with Psychiatrist, PCP
  - Modify care plan

Management and Rescue-G9002 Face to Face Visit

- SIM face to face criteria must be met
  - Daily treatment
  - Develop rescue, crisis plan
  - Collaborate with Psychiatrist, PCP
  - Modify care plan

Beyond Care Management

Care management may not be enough

- Chronic disease management leads to fatigue, which leads to mood, behavioral concerns
- Services may be limited due to care manager's licensure

Other services that may be necessary

- Behavioral health counseling
- Medication management
- Specialist for further evaluation and treatment

Behavioral Health Services: Internal and External

External behavioral health services

- Psychiatrist, Psychologist, Neuro Psychologist, Physician Assistant, Nurse Practitioner
- Counseling services
- Inpatient, outpatient behavioral health services

Internal behavioral health services

- Psychiatrist, Psychologist, Neuro Psychologist, Physician Assistant, Nurse Practitioner
- Counseling services

LMSW Behavioral Health Billing Opportunities

Behavioral Health Codes

- Becoming Credentialed
  - Coordinate and credential through participating health insurance providers
  - Will be necessary to gain an understanding of contract rules, accepting providers, limitations, billing procedures
- Billing Procedures
  - Develop procedures and policies
  - Develop confident understanding of billing practices
  - Collaborate with other practicing professionals
    - NASW
    - SIM BCBSM collaborative efforts

Behavioral Health Treatment-Internal LMSW Specific Treatment Methods

- Motivational Interviewing
- Cognitive Behavioral Therapy
- Dialectical Behavior Therapy
- Trauma Focused Cognitive Behavior Therapy
- Applied Behavioral Therapy
- Forensic Interviewing

SIM/Behavioral Health Coding Algorithm

Please refer to hand out

Behavioral Health Coding 101 – Commercial Codes

Behavioral Health Coding 101 – Commercial Codes

Assessment-1+ visits, Annual, Significant changes			90791
Face to face visit per minutes	16-37		90832
	38-52		90834
	53+		90837
	60-89		90837,99354
	Each 30+ minutes		90837, 99354, 99355 (#)
Group Therapy 2+ Non-family group			90853
Crisis Visit Per Minutes	30-74	90839	Each 30+ minutes 90840

Behavioral Health Coding 101, Cont'd

Family therapy (27-59 minutes) with patient	90846
Family therapy (27-59 minutes) without patient	90847
Family therapy of 2+ family members	90849
60-89 minutes	99354
60-89 minutes, each 30+ minutes	99354, 99355
Report not for court purposes	90889
Interactive complexity present	90785*

*Interactive Complexity can be added to all behavioral health visits

Behavioral Health Coding 101, Cont'd

Referral and Intake Process

Benefits, Coding and Billing

- Very important to determine benefits of patient BEFORE visits begin
- Submit prior authorizations as required BEFORE visits begin
- Select appropriate coding and bill accurately with each visit

Diagnosis

- Select most specific and appropriate diagnosis with each visit

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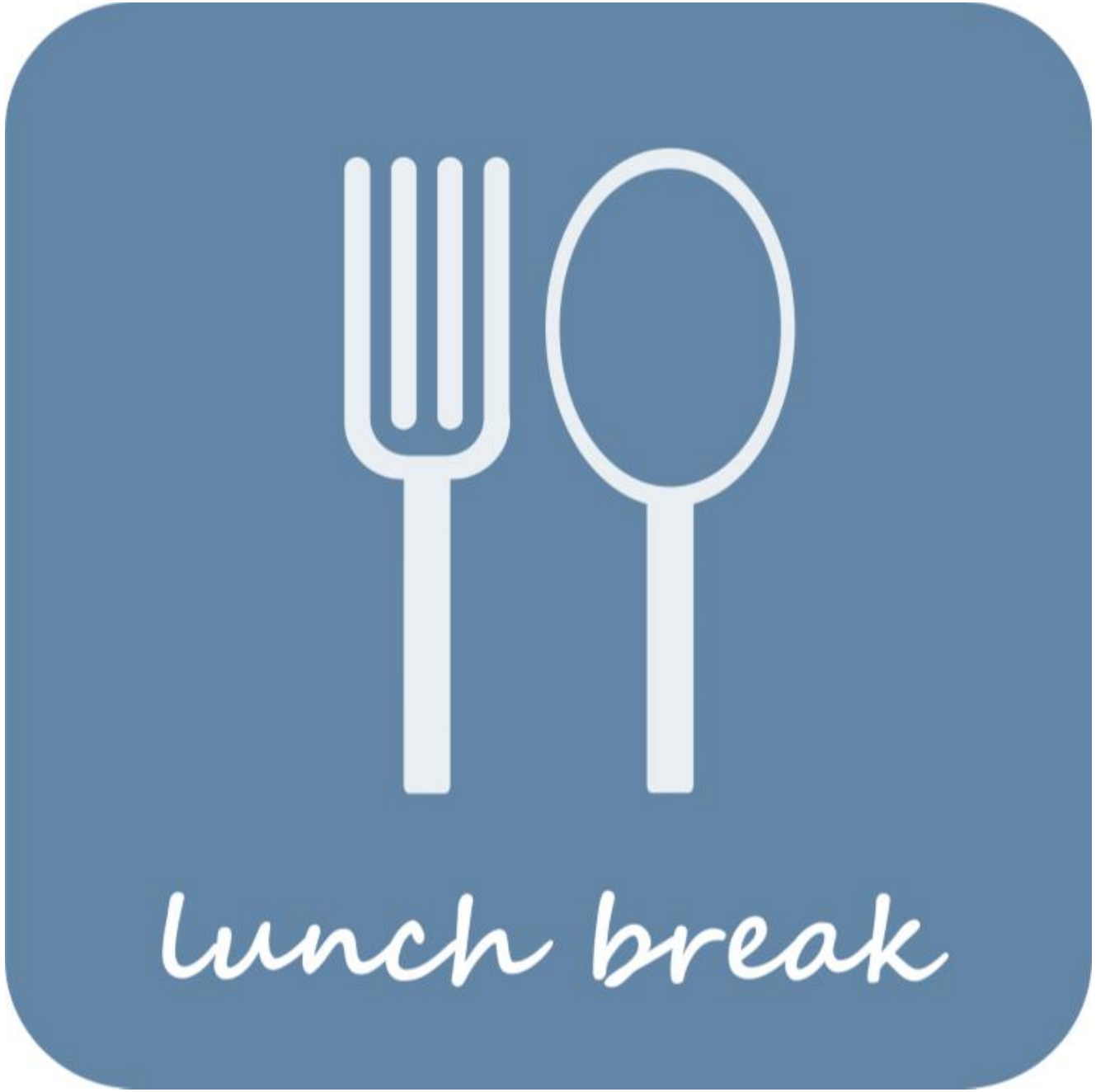
12:00 - 12:45 PM

LUNCH

SIM
MDHHS State
Innovation Model



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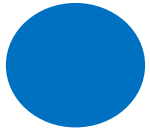
12:45 - 2:00 PM
Concurrent Breakout Sessions

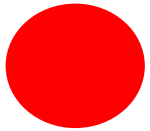
Practice Workflow for Target Populations
Lori Lynn, BSN, RN, CCP.



Blue Dot

President & Governor Breakout Room

Medicaid Tracking Codes
Theresa Landfair



Red Dot

Diplomat Breakout Room

Behavioral Health
Laurisa Cummings, LMSW

Green Dot

Congress & Senate Breakout Room

Practice Workflow for Target Populations: PHQ-9 Referral, Management, and Follow Up

Lori Lynn, BSN, RN, CCP
Clinical Quality Manager
Metro Health Integrated Network

Learning Objective

Describe work flow for a specific patient population, using standard orders, standard activity guides, and/or protocols for at least 2 or more team members

The Journey

- Began in 2012 with the MiPCT Project
- RN Care Managers
- 8 Primary Care Practices
- In 2014, Hired First MSW Care Manager
- In 2018, 15 RN and 7 MSW Care Managers Serving 17 Primary Care Offices in West Michigan

METRO HEALTH INTEGRATED NETWORK

Our Care Team Model

- Defines the standard primary care team roles and responsibilities
- Incorporates both RN and MSW care manager roles
- Provides templates for workflows
- Establishes measurements for target outcomes

METRO HEALTH INTEGRATED NETWORK

Behavioral Health Integration (BHI)

- An effective strategy for improving outcomes
- A necessary component for true practice transformation
- A core principle of the Patient-Centered Medical Home Model of Care

METRO HEALTH INTEGRATED NETWORK

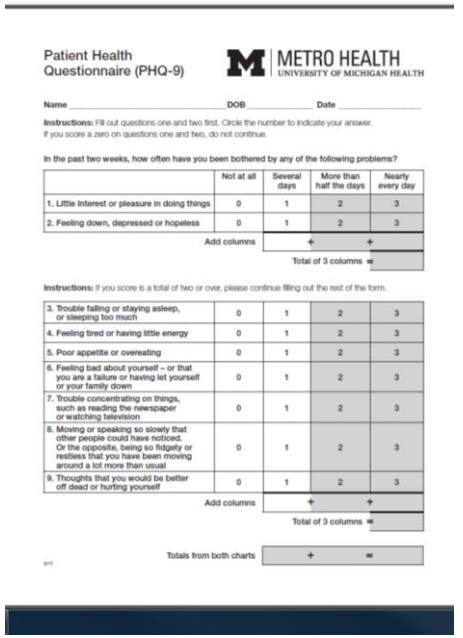
Screening for Depression

- PHQ-2 +7
- 12 and older
- Well Child Check Up
- Adult Wellness Visit
- Physical
- Mental Health Visit

METRO HEALTH INTEGRATED NETWORK

Screenings for Depression

- PHQ-2
- PHQ-4
- PHQ-9
- Geriatric Depression Scale
- Beck Depression Inventory Questionnaire
- Edinburgh Postnatal Depression Scale
- Zung Self-Rating Depression Scale



Patient Health Questionnaire (PHQ-9)

METRO HEALTH
UNIVERSITY OF MICHIGAN HEALTH

Name _____ DOB _____ Date _____

Instructions: Fill out questions one and two first. Circle the number to indicate your answer.
If you score a zero on questions one and two, do not continue.

In the past two weeks, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3
Add columns		+	+	
Total of 3 columns =				

Instructions: If you score is a total of two or over, please continue filling out the rest of the form.

3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or having let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite, being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or hurting yourself	0	1	2	3
Add columns		+	+	
Total of 3 columns =				
Totals from both charts		+	=	

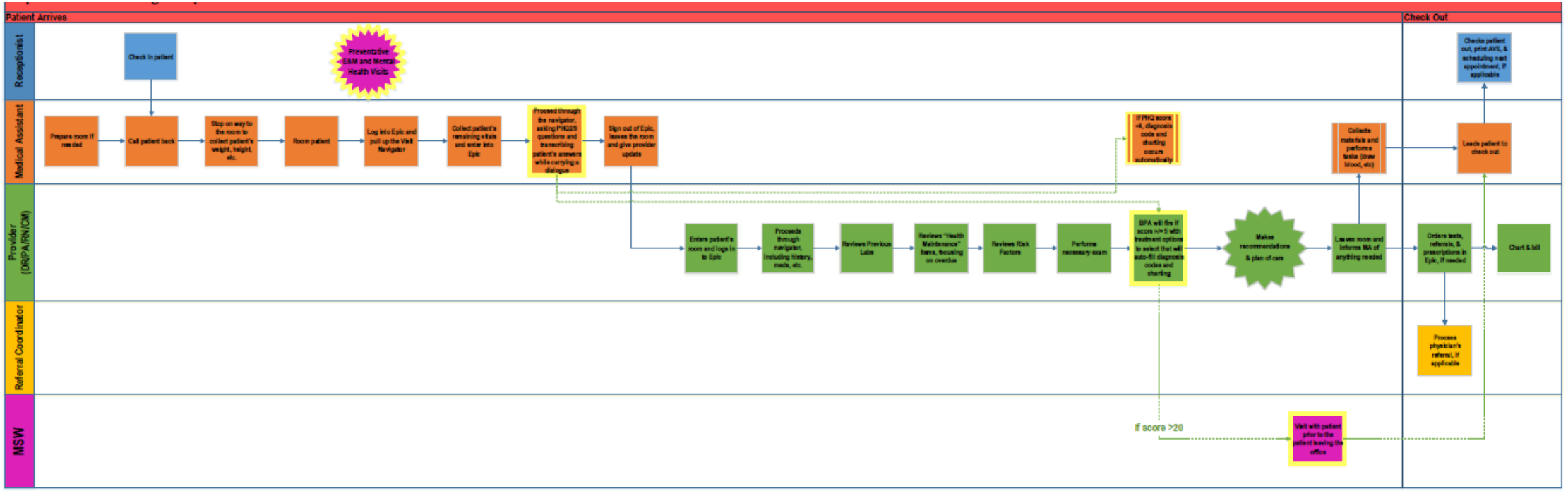
METRO HEALTH INTEGRATED NETWORK

Managing the Patient with Depression

- Involve the Entire Team
- Hire and Train the Right Staff
- Know your Resources
- Work with Your Limitations
- Follow-up and Monitor

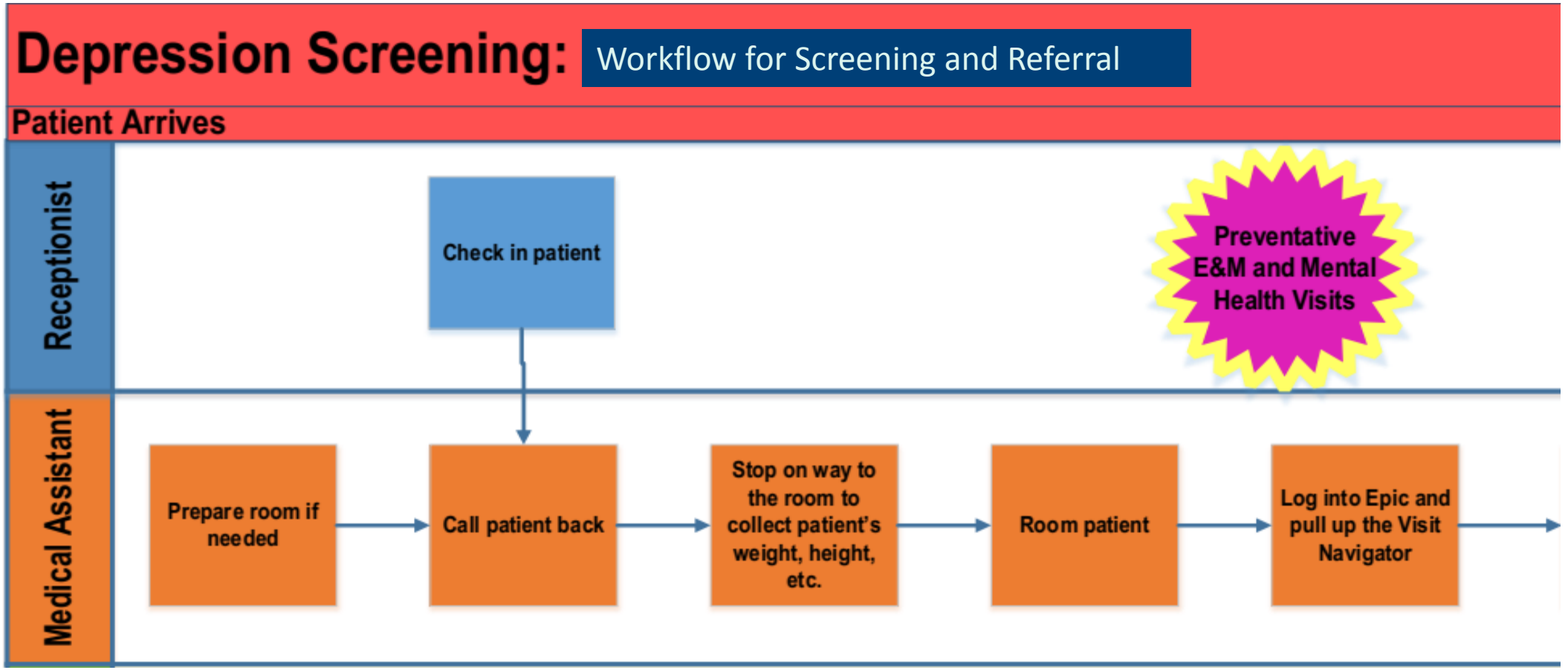
METRO HEALTH INTEGRATED NETWORK

Workflow for PHQ-9 Screen & Referral



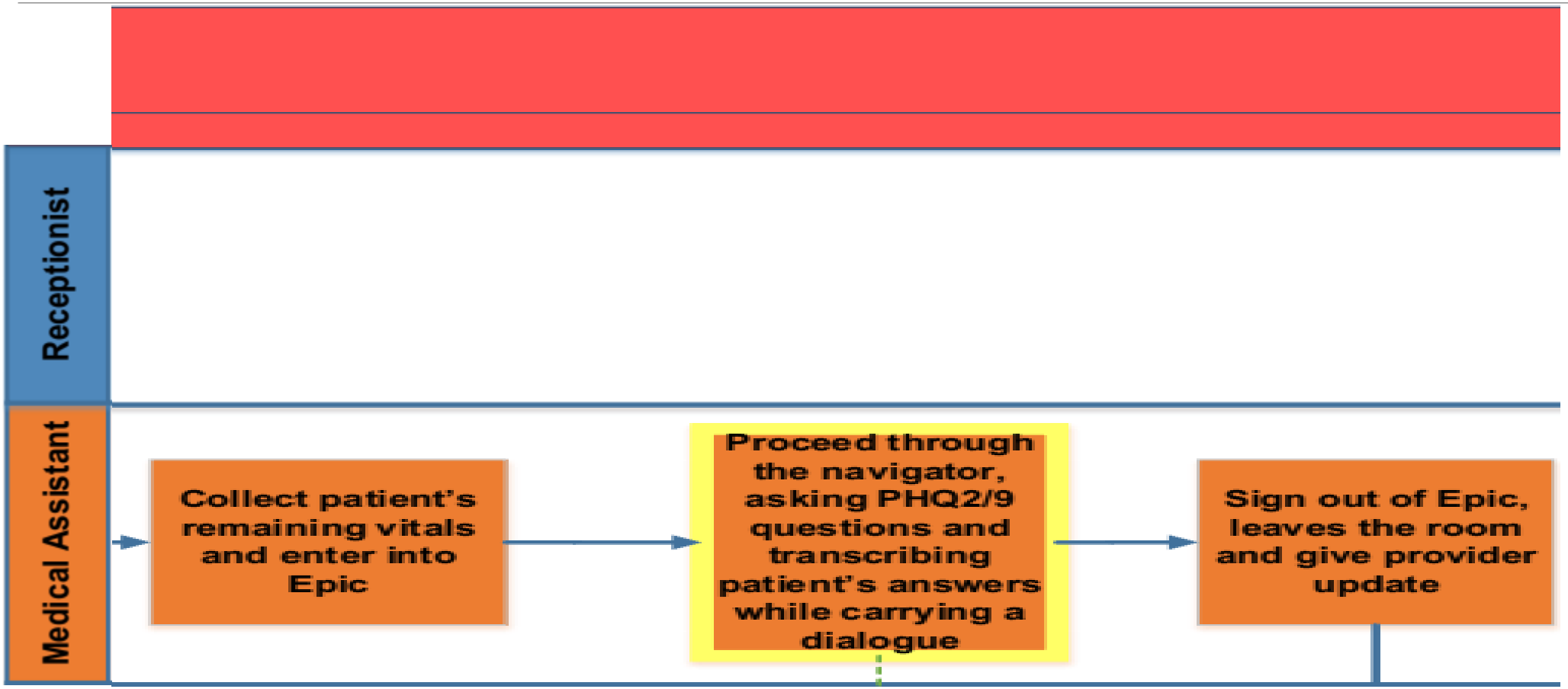
METRO HEALTH INTEGRATED NETWORK

Workflow for PHQ-9 Referral



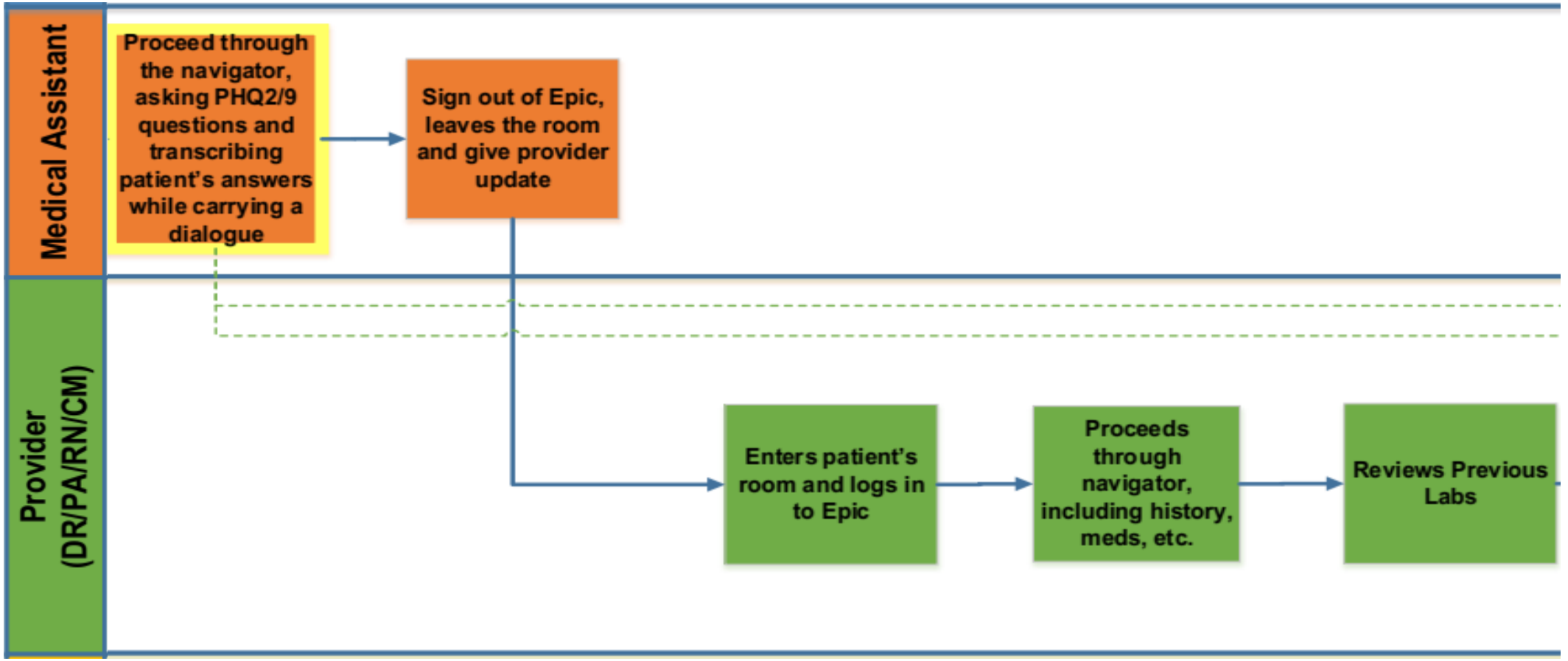
METRO HEALTH INTEGRATED NETWORK

Workflow for PHQ-9 Referral



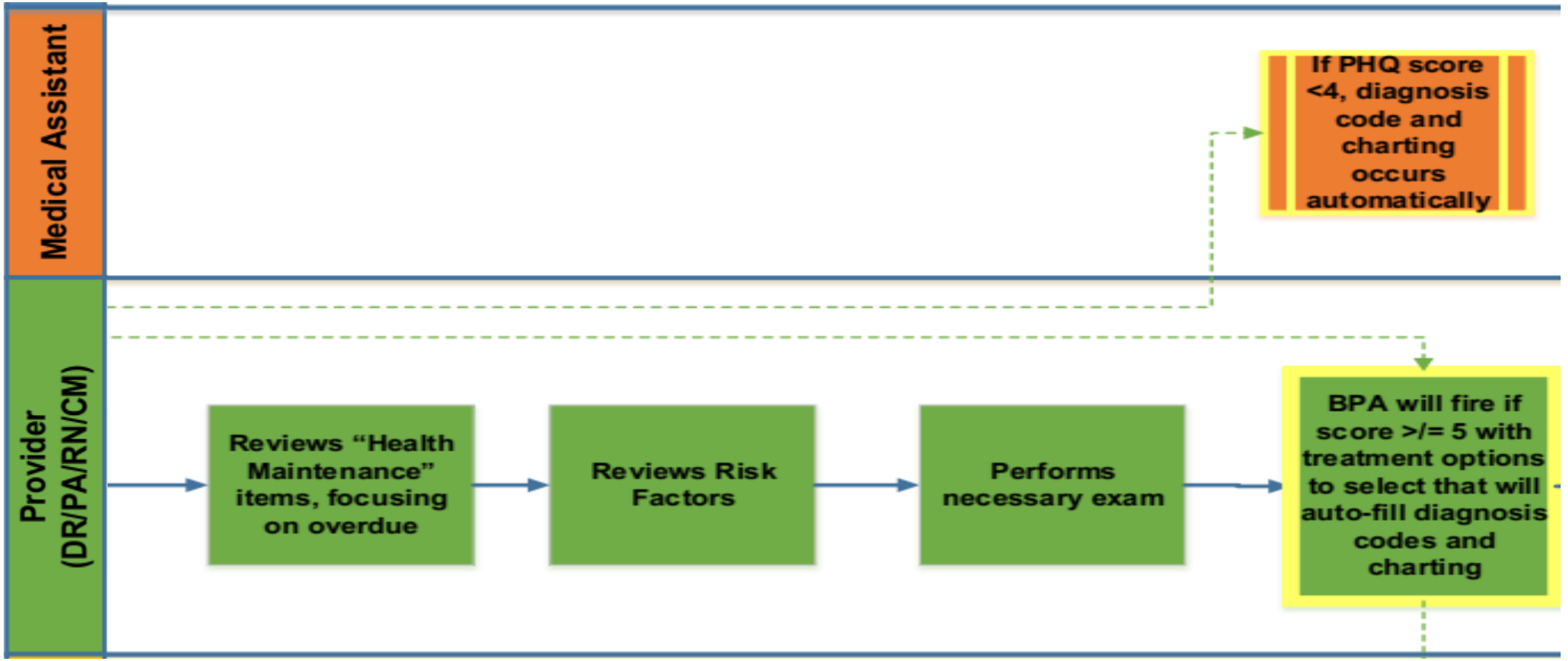
METRO HEALTH INTEGRATED NETWORK

Workflow for PHQ-9 Referral



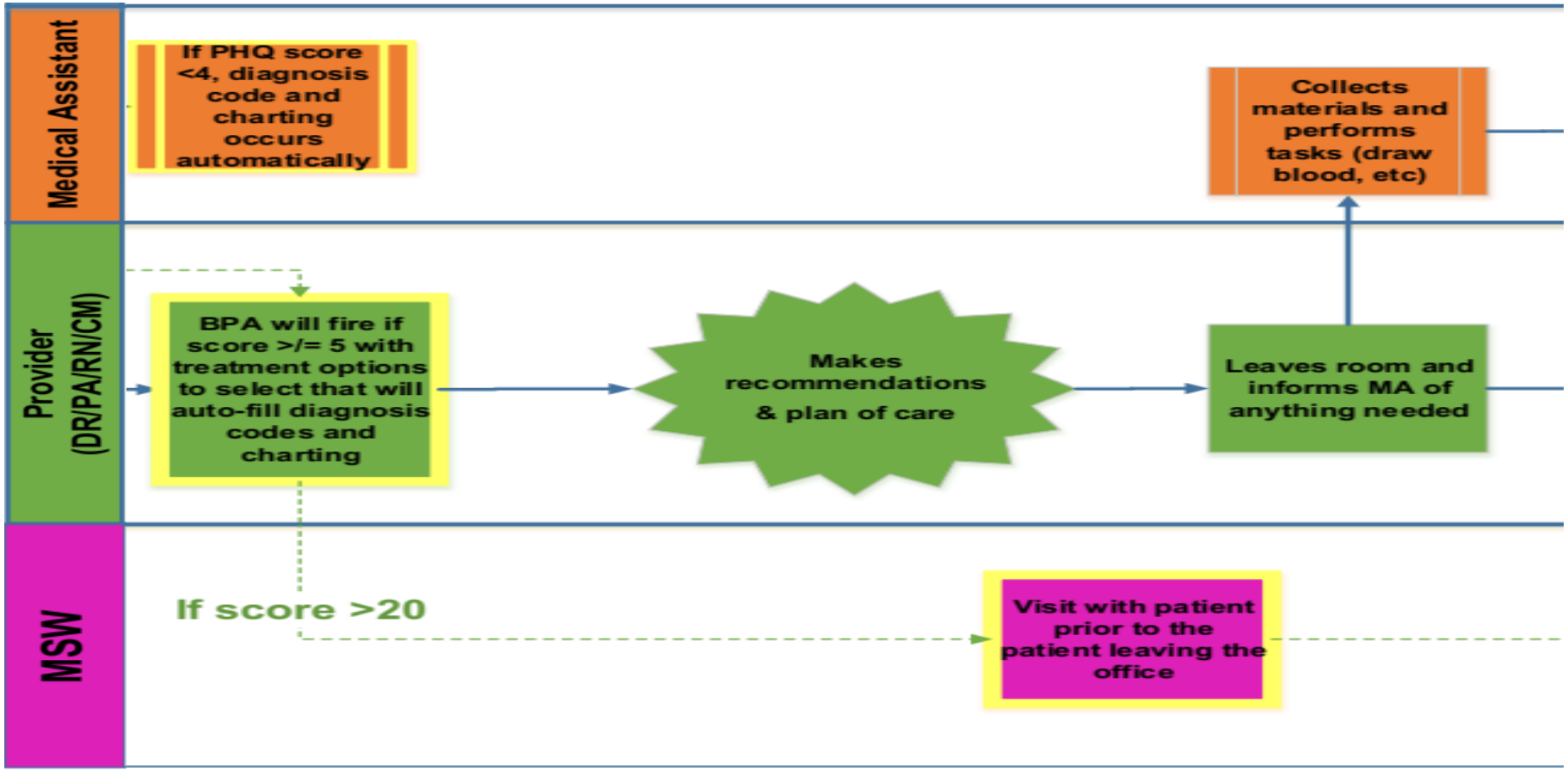
METRO HEALTH INTEGRATED NETWORK

Workflow for PHQ-9 Referral



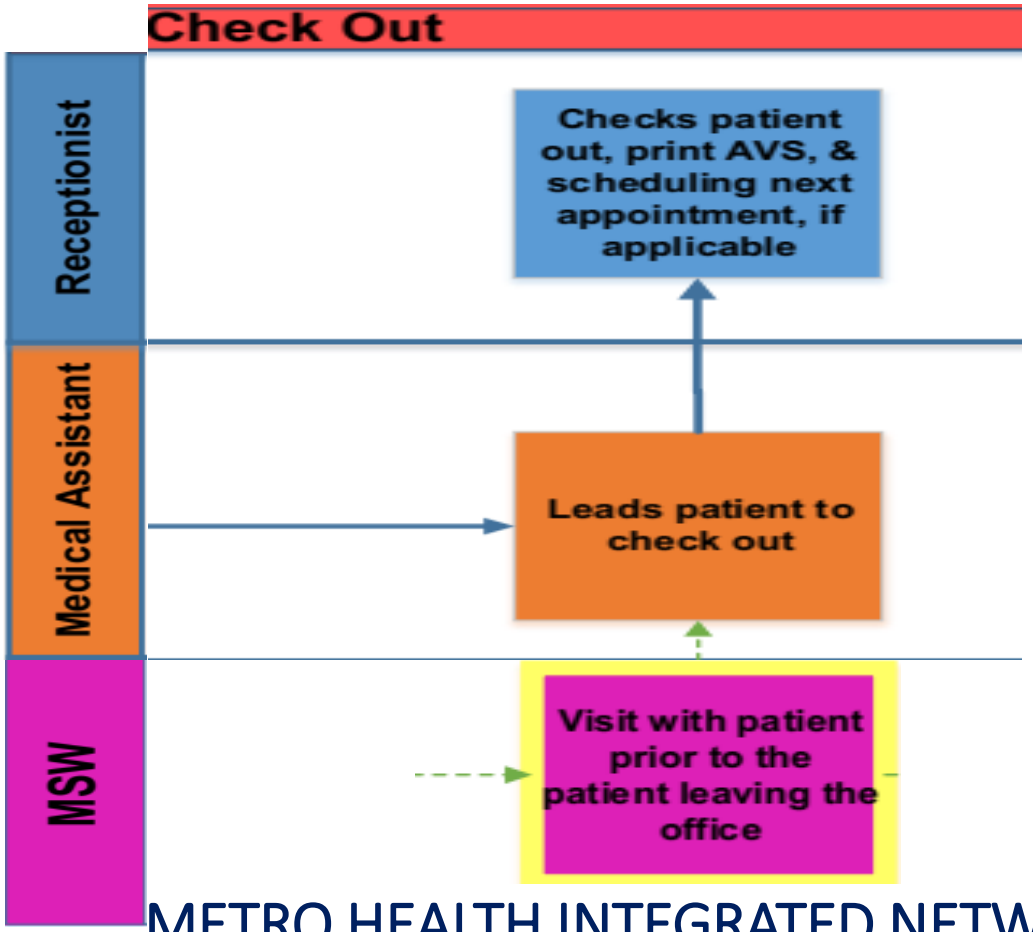
METRO HEALTH INTEGRATED NETWORK

Workflow for PHQ-9 Referral



METRO HEALTH INTEGRATED NETWORK

Workflow for PHQ-9 Referral



METRO HEALTH INTEGRATED NETWORK

PHQ-9 Management and Follow Up

- Pharmacology
- Referral to Treatment
- Care Management Services
- Follow-up in the Office
- Frequent Rescreening

The Role of the RN or MSW Care Manager

- Psychosocial Assessment
- Patient Education
- Action Planning/Goal Setting
- Emotional Support
- Close and Proactive Follow-up
- Care Coordination with BH Services

METRO HEALTH INTEGRATED NETWORK

Lessons Learned

METRO HEALTH INTEGRATED NETWORK

Round Table Discussion

- What are your perceived behavioral health needs? How have you assessed this?
- What are you currently doing to integrate behavioral health services in your organization?
- What challenges have you encountered?
- What workflow changes could you make to meet the behavioral health needs of your patient population?

METRO HEALTH INTEGRATED NETWORK

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SPECTRUM HEALTH

Spectrum Health Medical Group Ambulatory Care Management

JOE JOOSTENS, RN CARE MANAGER

SPECTRUM HEALTH

SHMG SIM Tracking Code Data

All SHMG Offices (Spectrum PO) 2.14%

SHMG Enhanced Primary Care 8%

Unintentional:

We did not have specific goal or focus on SIM Tracking Codes

We do approach coding across payers as part of our overall process of management and coordination

Having been contacted for achieving these results we set out to examine how we generated SIM Tracking Code success.

Foundation: Care Management Process

- Patient Identification
- Assessment/Care Plan – Episodic, Longitudinal
- Implementation and Monitoring/Follow up
- Case Closure

Patient Identification

- Team Referrals
  - Provider, Mid-Level, Allied Health, other staff
- Transitions of Care
  - Hospital Discharges, warm handovers from within hospital, ED high-utilizers
- Proactive Outreach:
  - Both Risk stratification and Payer Initiatives.
  - Combined payers into 1 outreach list

Tracking Codes

- Attach Care Management Codes to each encounter:
  - Face to Face, Telephone, Care Conference
- Measures our work and productivity, but doesn't always result in a charge to patient.
- Dropped by all Allied Health members in certain circumstances:
  - Care Manager, Behavioral Health, Pharmacist

Key to Success: Teamwork

- Referrals within the team:
  - Providers and staff know the patients best.
- All Allied Health members using Care Management codes:
  - United effort and goals.
- Collaboration between team members:
  - Promotes our overall goal: To improve patient outcomes and the health of the communities we serve!

Where Can We Improve?

- Make patient identification easier for entire team:
  - Recently added a two-step risk stratification tool built into our EHR, working to get all staff engaged in utilizing this.
  - Combine data onto one list: combining payer initiatives and risk stratification.
- Move our focus further from reactive to proactive:
  - Do we need more resources for this? Team Growth?
- Evaluate Allied Health productivity:
  - Continually monitor via tracking codes and address shortfalls.

Evaluate: PDSA (Plan, Do, Study, Act)

- Patient identification: Make it as easy as possible for the team
- Continue to Streamline data to one list, aligning payer initiatives
- Risk Stratification 2- Step process
- Looking where we can be proactive, not just reactive

Continued……

- Review/Evaluate productivity for the Care Management department
  - Supervisors discuss productivity monthly with individual Care Managers
  - Conduct targeted audits to analyze processes
- Team growth → Care Manager, Behavioral Health Specialists, Pharmacists
  - Can see who from the team is “dropping” codes

Questions?


SPECTRUM HEALTH

Care Management, Coordination and Tracking Code Success

WATTLES PARK FAMILY PRACTICE

Identifying Patients

- Targeted conditions: chronic conditions such as diabetes, depression, uncontrolled hypertension, and pain management; multiple comorbidities; financial issues
- Risk adjustment score – AAFP risk adjustment and clinical intuition as two identifiers
- Social Determinants of Health Screening Tool
- ADT (Patient Ping) notification

Establishing a Process

- When you see a baby elephant in the room what do you do??
- Educate: The entire team must be educated and buy in to their part to play
- Key triggers for team members:
  - Patient is upset
  - Can't afford co-payment
  - Loss of a family member
  - Lack of knowledge regarding medication or medical diagnosis
- Patient awareness about care management services
  - Patient rooms
  - On the website
  - New patient information
  - Facebook
  - Business cards

Establishing a Process (cont.)

- Involve the care manager
  - Front desk
  - Medical assistant
  - Provider
- Care manager meets patient in the room
  - Recent hospital stay
  - Huddle in the morning with the provider
  - New diagnosis
  - Administration of insulin
  - Follow up after a phone call
  - Medical Assistant engaged CM based on a SDOH need

Establishing a Process (cont.)

- Care manager phone contact
  - Recent hospital admission
  - Results of SDoH form
  - Provider requests CM follow up
  - Medication management issues – cost, adherence
- Care managers meet with patients and provide resources based on patient need
- Develop care plan
- Schedule follow up appointment and place on the schedule
- Document in the patient record

Establishing a Process (cont.)

- Care manager selects the proper coding for tracking purposes
- Medical record is sent to the provider
- Provider reads all care management notes and forwards charts to the billing department
- Care managers track the patient by putting the information into a tracking log
- Care managers look for needs in the patient population
  - CM works outside normal business hours
  - DM classes held at our office
  - Watch for trends

Resources

- Where are the resources?????
  - Community Resource Guide – throughout the office (developed by our Physician Organization – Integrated Health Partners)
  - Attend IHP monthly meetings and quarterly meetings
    - Education on community resources
    - Best practice sharing
  - Bertha.com – internet service listing current resources in area
  - Insurance plans' resources: transportation, care management
  - Establish frequently used contacts at community organizations

Addressing Behavioral Health Needs In The Primary Care Setting

LAURISA CUMMINGS, LMSW
CHILDREN'S MEDICAL GROUP OF SAGINAW BAY

Learning Objectives

- Explain effective mental health management through the care team, including integration of behavioral health into primary care
- Identify best practice and lessons learned when advancing care management services and implementing behavioral health screening into primary care
- Discuss behavioral health screening and follow up, matching resources to address practice population needs

Agenda

- Learners will be able to discuss behavioral health conditions commonly treated in primary care practices
- Learners will be able to identify screening tools in which to screen for particular behavioral health conditions
- Learners will be able to use evidence-based tools for improved assessment and management of behavioral health issues
- Learners will be able to identify referral processes to address behavioral health needs
- Learners will be able to identify additional billing opportunities for care managers who hold a LMSW

Rationale to Address Mental Health Needs in Primary Care

- 56% of American adults with a mental illness did not receive treatment (Mental Health America 2017)
- 1.7 million youth with major depressive episodes did not receive treatment (Mental Health America, 2017)
- One half of all chronic mental illness begins by the age of 14; three-quarters by the age of 24 (National Institute of Mental Health, 2017)
- 90% of those who die by suicide have an underlying mental illness; suicide is the 10th leading cause of death in the U.S. (National Institute of Mental Health, 2017)

Michigan Statistics

- Michigan ranked 23 of all states having lower prevalence of mental health and substance use issues
- Michigan ranked 19 of all states having lower prevalence of mental illness and higher rates of access to care for adults
- Michigan ranked 17 of all states having lower prevalence of mental illness and higher rates of access to care for youth
- Michigan ranked 16 of all states providing access to insurance and mental health treatment for adults and youth
- Michigan ranked 22 of all states providing mental health workforce availability with a ratio of 460:1 (includes psychiatrists, psychologists, LSMWs, counselors, LMFT, and NPs)

(National Institute of Mental Health, 2017)

Why Addressing Behavioral Health Needs In Primary Care Settings Is So Important

- Increased compliance
- Lessen stigma of mental health needs
- Increase self management of chronic mental health needs
- Improved coordination of care
- Decreased morbidity
- Preventative services
- Integration of physical and emotional care

Behavioral Health Integration: Resources For Primary Care Use

- American Academy of Pediatrics (https://www.aap.org)
- SAMHSA-HRSA for Integrated Health Solutions (CIHS) (https://integration.samhsa.gov)
- National Alliance on Mental Health (https://nami.org)
- World Health Organization (https://who.int)

Behavioral Health Integration: Two Example Models

Mental Health Tool Kit, American Academy of Pediatrics

www.aap.org

Mental Health Initiatives, Primary Care Tools

A Global Perspective, World Health Organization

www.who.int/en/

Mental Health, Policies and Services

Where To Begin: Advancing Care Management, Adding Behavioral Health Services

Social Determinants of Health

Domains of Social Determinants of Health:

Healthcare, food, employment & income, housing and shelter, utilities, family care, education, transportation, personal and environmental safety, and general

ACES Screening

Pair of ACEs:

Screening for adverse childhood experiences (ACEs)

Addressing adverse community environments (ACEs)

(http://go.gwu.edu/BCR)

Social Determinants of Health

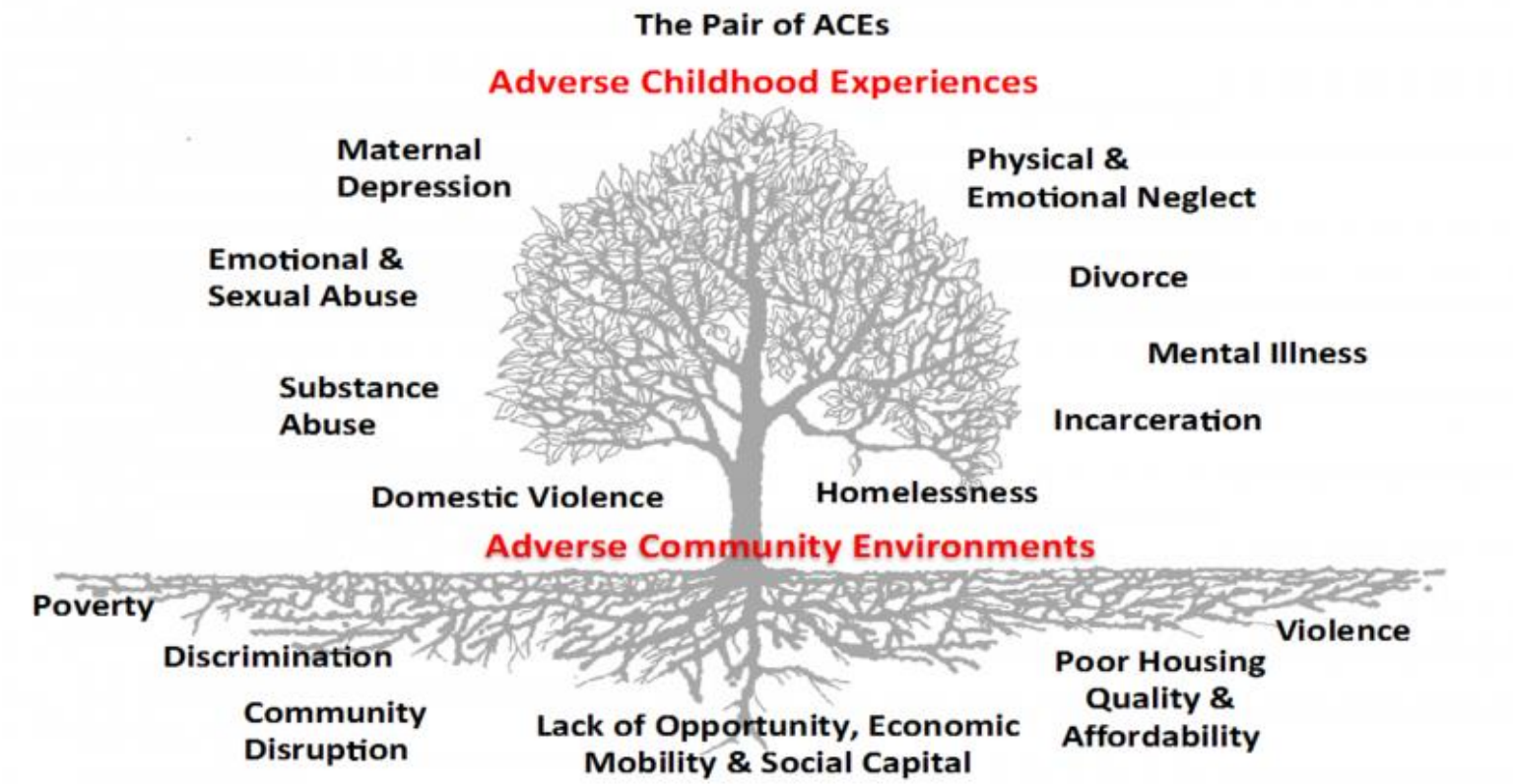
- Healthcare
  - In the past month, did poor health keep you from doing your usual activities, like work, school or a hobby?
  - In the past year, was there a time when you needed to see a doctor but could not because it cost too much?
- Food
  - In the past year, did you ever eat less than you needed to because there was not enough food?
- Employment & Income
  - Is it hard to find work or another source of income to meet your basic needs?
- Housing & Shelter
  - Are you worried that in the next few months, you may not have housing?
- Utilities
  - In the past year, have you had a hard time paying your utility company bills?

Social Determinants of Health, Cont'd

- 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.
- Education
  - Do you want help with school or job training, like finishing a GED, going to college, or learning a trade?
- Transportation
  - Do you ever have trouble getting to school, work, or the store because you don't have a way to get there?
- Personal and Environmental Safety
  - Do you ever feel unsafe in your home or neighborhood?
- 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

Pair of ACEs



Ellis, W., Dietz, W. (2017) A New Framework for Addressing Adverse Childhood and Community Experiences: The Building Community Resilience (BCR) Model. Academic Pediatrics. 17 (2017) pp. S86-S93. DOI information: 10.1016/j.acap.2016.12.011

Screening Tools Used For Behavioral Health In Primary Care Settings

PHQ-9 Initial Depression Screening Tool

KADS-Depression Screening Tool

MDQ-Bipolar Screening Tool

SCARED-Anxiety Screening Tool

Suicide Lethality Screening Tool

MCHAT-R Screening Tool for Autism

AQ-10 Child Screening Tool for Autism (Age 4-11)

AQ-10 Adolescent Screening Tool for Autism (Age 12-15)

Screening Tools Used For Behavioral Health In Primary Care Settings, Cont'd

GAD-7 Anxiety Screening Tool for Adults

Edinburgh Postnatal Depression Scale

AUDIT-Alcohol Use Disorders Identification Test

CAGE AID- Screens for drug and alcohol use

Columbia-Suicide Severity Rating Scale (C-SSRS)

Life Event Checklist-Screens for potentially traumatic events during lifetime

ACEs-Adverse Childhood Experiences

Commonly Identified Behavioral Health Needs In The Primary Care Setting

- ADHD/ADD and Autism
  - Both pediatric and adult
  - Evaluation and treatment options
- General Behavioral Concerns
- Social Pragmatic Communication Disorder

Commonly Identified Behavioral Health Needs In The Primary Care Setting, Cont'd

- Mental Health
  - Depression
  - Anxiety
  - Suicidality
  - Bipolar
  - Need for acute hospitalization
- Delays In Development
  - Referral and treatment options
- Fatigue, Stress from Chronic Conditions

Meeting The Patient's Needs: Behavior Health and Care Management

Care Management and Coordination

- Medication Management
  - PCP vs. Psychiatry written, oversight
- Transportation Needs
  - Community support and coordination
- Appointment Coordination
- Collaborative Communication
  - Internal AND external
  - Team Huddles, coordination and communication with specialists
- Additional Services and Needs
  - Referrals, coordination, and collaboration

Meeting The Patient's Needs: Behavior Health and Care Management, Cont'd

Behavioral Health Needs

- Psychiatry Needs
  - Referral, medication management and oversight
- Counseling Needs
  - Internal referral vs. external referral
- Additional Services and Need
  - Referrals, coordination, and collaboration

Patient Referrals: Differentiating Care Management and Behavioral Health

- Care Management Referrals
  - Completed by care manager, billing G Codes, Phone Codes, and S Code
    - Chronic Disease Management
    - Patient Education
    - Self Management
- Behavioral Health Referrals
  - Completed by mental health specialist credentialed with health insurance provider, billing behavioral health codes
    - Individual, family, group, and crisis behavioral health needs
    - May be referred internally or to external providers

Care Management Coordination of Behavioral Health Needs

Services completed by any trained care manager:

(1) G9001 Assessment and (2) G9002 Face to Face Visits:

- Completed by approved, trained care manager

G9001 – Comprehensive Assessment and Care Plan*
Education: Assessment-G9001

- Include patient and care giver assessment, discussion and collaboration:
  - Beliefs about diagnosis
  - Basic education about diagnosis
  - Dispel myths
  - Provide hope
  - Collaborate with Psychiatrist, PCP

*For details see the SIM Care Management and Coordination Tracking Quick Reference Guide

Care Management Coordination of Behavioral Health Needs, Cont'd

Prevention-G9002 Face to Face Visit

- SIM face to face criteria must be met
  - Triggers
  - Identify and highlight strengths
  - Identify barriers and ways to overcome barriers
  - Collaborate with Psychiatrist, PCP
  - Modify care plan

Management and Rescue-G9002 Face to Face Visit

- SIM face to face criteria must be met
  - Daily treatment
  - Develop rescue, crisis plan
  - Collaborate with Psychiatrist, PCP
  - Modify care plan

Beyond Care Management

Care management may not be enough

- Chronic disease management leads to fatigue, which leads to mood, behavioral concerns
- Services may be limited due to care manager's licensure

Other services that may be necessary

- Behavioral health counseling
- Medication management
- Specialist for further evaluation and treatment

Behavioral Health Services: Internal and External

External behavioral health services

- Psychiatrist, Psychologist, Neuro Psychologist, Physician Assistant, Nurse Practitioner
- Counseling services
- Inpatient, outpatient behavioral health services

Internal behavioral health services

- Psychiatrist, Psychologist, Neuro Psychologist, Physician Assistant, Nurse Practitioner
- Counseling services

LMSW Behavioral Health Billing Opportunities

Behavioral Health Codes

- Becoming Credentialed
  - Coordinate and credential through participating health insurance providers
  - Will be necessary to gain an understanding of contract rules, accepting providers, limitations, billing procedures
- Billing Procedures
  - Develop procedures and policies
  - Develop confident understanding of billing practices
  - Collaborate with other practicing professionals
    - NASW
    - SIM BCBSM collaborative efforts

Behavioral Health Treatment-Internal LMSW Specific Treatment Methods

- Motivational Interviewing
- Cognitive Behavioral Therapy
- Dialectical Behavior Therapy
- Trauma Focused Cognitive Behavior Therapy
- Applied Behavioral Therapy
- Forensic Interviewing

SIM/Behavioral Health Coding Algorithm

Please refer to hand out

Behavioral Health Coding 101 – Commercial Codes

Behavioral Health Coding 101 – Commercial Codes

Assessment-1+ visits, Annual, Significant changes			90791
Face to face visit per minutes	16-37		90832
	38-52		90834
	53+		90837
	60-89		90837,99354
	Each 30+ minutes		90837, 99354, 99355 (#)
Group Therapy 2+ Non-family group			90853
Crisis Visit Per Minutes	30-74	90839	Each 30+ minutes 90840

Behavioral Health Coding 101, Cont'd

Family therapy (27-59 minutes) with patient	90846
Family therapy (27-59 minutes) without patient	90847
Family therapy of 2+ family members	90849
60-89 minutes	99354
60-89 minutes, each 30+ minutes	99354, 99355
Report not for court purposes	90889
Interactive complexity present	90785*

*Interactive Complexity can be added to all behavioral health visits

Behavioral Health Coding 101, Cont'd

Referral and Intake Process

Benefits, Coding and Billing

- Very important to determine benefits of patient BEFORE visits begin
- Submit prior authorizations as required BEFORE visits begin
- Select appropriate coding and bill accurately with each visit

Diagnosis

- Select most specific and appropriate diagnosis with each visit

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2:00 - 2:15 PM

BREAK

SIM
MDHHS State
Innovation Model

5:00

Plenary: Sustainability Post-SIM

Katherine Commey, MPH
SIM Care Delivery Lead
Policy, Planning, and Legislative Services Administration
Michigan Department of Health and Human Services

Learning Objective

Explain strategies to optimize practice resources, to invest in the future state for sustainability of Clinical-Community Linkages and team-based delivery of care in the primary care setting

Looking Back

Strengths Going Into SIM PCMH Initiative

- Primary Care Transformation Experience
- Committed Payer Partnership
- Clinical Care Management Competency
- Team-Based Care
- Learnings from Accountable Care
- Significant Health Coverage Gains
- Working Demonstration Models for Community Connections
- Physician Organization (provider network) Expertise in Supporting Transformation
- Health IT Infrastructure (including multi-payer data)

Challenges Going Into SIM PCMH Initiative

- Underuse of HIT and HIE Technology in MAPCP
- Mixed Outcome/Utilization Evaluation Results from MAPCP
- Costs/Capacity Constraints Associated with Practice Transformation (i.e. “easy” transformation was already complete)
- Historically Clinically Focused Care Management Infrastructure
- Inconsistent Financing of Care Management Infrastructure
- Multiple Transformational Initiatives and Funding Streams Operating Simultaneously
- Lack of Medicare Financial Participation
- Limited Medicaid Budget Available to Fund Care Delivery Initiative Payments

The PCMH Initiative

SIM PCMH Initiative Participants:

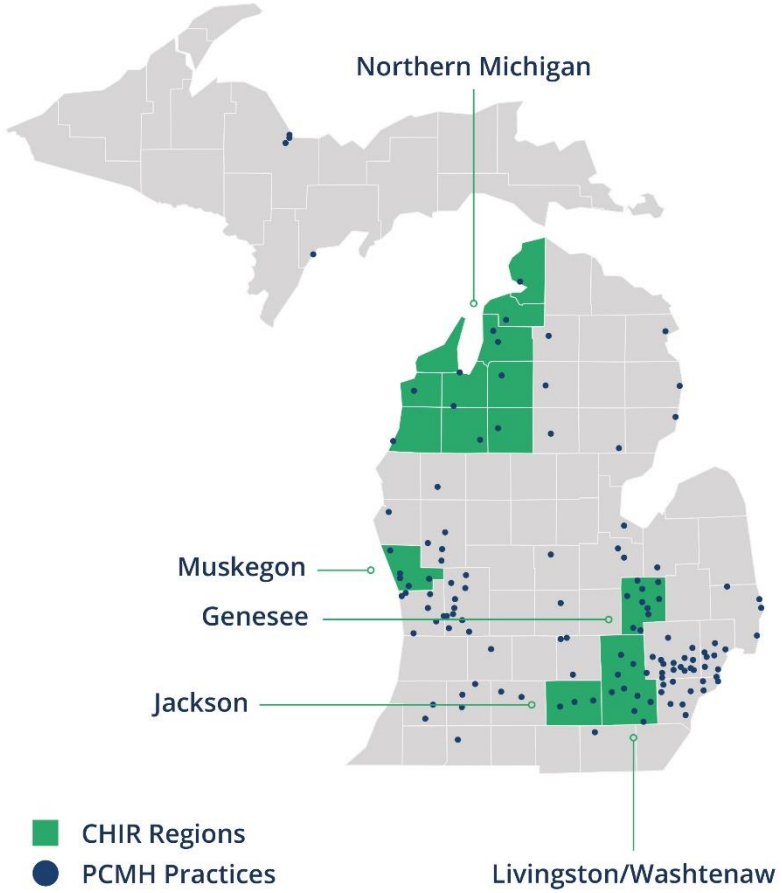
355 practices:

- 328 members of a Physician Organization
- 18 Federally Qualified Health Center sites
- 9 Single Practice sites

238 previous MiPCT participants

125+ CPC+ (track 1 & 2) participants

- 206 within a SIM Test Region
- 150 outside of a SIM Test Region



Looking to the Future

Maintain, Sustain, Expand?

- The service delivery model established in MiPCT and further refined through the support of the SIM PCMH Initiative, is valuable to MDHHS and Medicaid Beneficiaries.
- The need for provider delivered care management and coordination is not going away.
- The need to address patients in a comprehensive, whole-person oriented manner, inclusive of their social needs, is not going away.

What can SIM PCMH Initiative Participants Expect Going Forward?

1. There is no simple solution.
2. No one entity can do this alone - It will take coordination and collaboration between MDHHS, Medicaid Health Plans, Physician Organizations, Providers…

Important Factors for Post-SIM Transition

Provider Community	Medicaid Health Plans	MDHHS Medical Services Administration	Centers for Medicare & Medicaid Services
Care Managers	Quality Strategy	Care Managers/Coordinators	Care Management Services
Risk Stratification	Risk Stratification	Focus on Quality	Focus on Quality
Payment Mechanism for Care Management and Coordination	Evidence-based Model of Care	Access to Needed Services for Beneficiaries	Cost Neutral or Reduction
Incentive Alignment	Reduced Administrative Burden		Alternative Payment Models

Today's Landscape

Michigan's State Innovation Model demonstration comes to an end in January 2020

- Funding for the PCMH Initiative is secure through December 31, 2019

<u>Considerations:</u>

- State:
  - Coordination of Physical and Behavioral Health Pilot (Section 298, Public Act 207 of 2018)
  - Medicaid Work Requirements (Senate Bill 0897) Implementation
  - Healthy Michigan Plan Health Risk Assessment (HRA) (1115 Medicaid Waiver); Healthy Behavior Selection
- National:
  - CPC+ demonstration operating in MI
  - Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) and the Quality Payment Program
  - New funding announcements from Centers for Medicare and Medicaid Services (CMS)

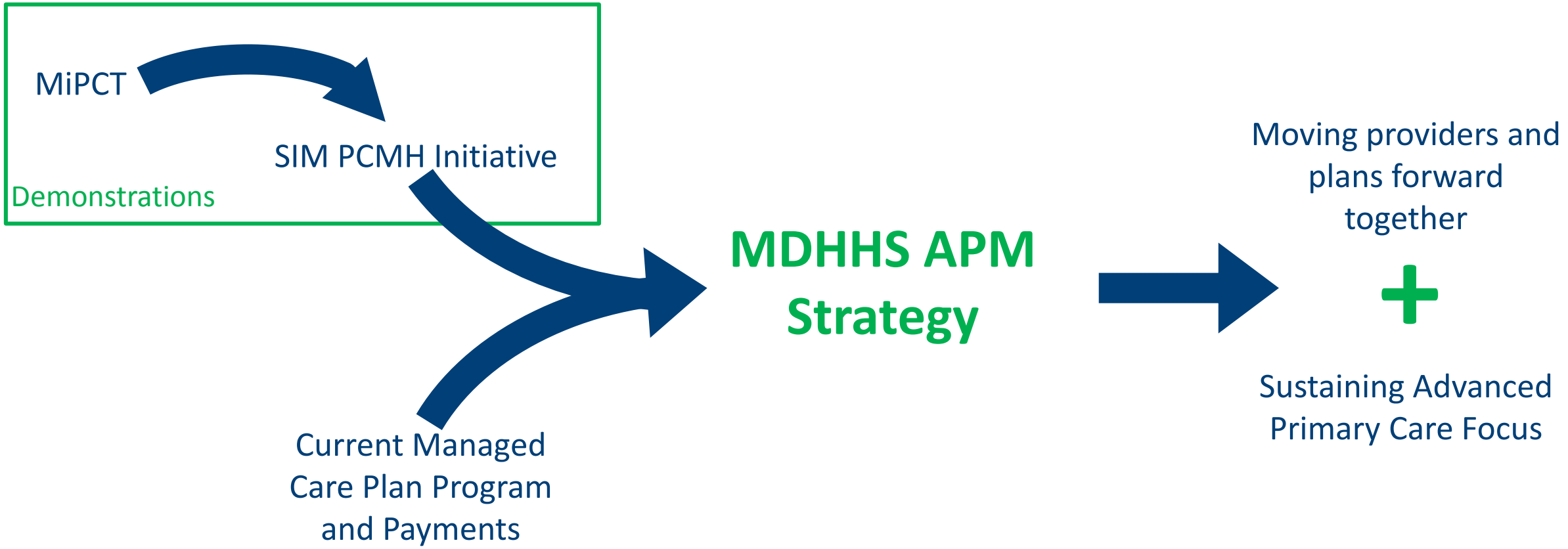
Available Levers

- Medicaid:
  - Health Plan Contract
    - Contract Language (Requirements)
    - Withhold/Bonus
  - Policy

Current Efforts

SUSTAINING THE MOMENTUM

Driving Change Through Payment



MDHHS APM Strategy

GOAL:

sustainability, effectiveness, and consistency

- Components:
  - Preferred Models: Supporting priority areas through advanced payment models
    1. Behavioral & Physical Health Integration
    2. Patient Centered Medical Home – Care Management and Coordination
  - Quality Measure Alignment: regionalized measure sets to support consistency

Plan for Improving Population Health

Purpose:

The Plan for Improving Population Health (**PIPH**) will describe how Michigan is creating health, equity, and well being through clinical and community based prevention strategies that address the social determinants of health.

Plan Components

- ***Overall health burden*** in the state & priority health concerns
- ***Current capacity*** to improve population health (major initiatives & infrastructure, key stakeholders)
- ***Plan for improving health***, including goals, objectives, strategies, & supports for effective implementation

The Plan Should:

- Use evidence-based, preventive, population focused interventions that address social determinants of health; policy, systems, and environmental change; and the health care delivery system (including innovative models of health care delivery)
- Address health disparities and work toward health equity
- Include strategies led by both governmental & non-governmental partners

Proposal For Change

What is a Proposal for Change (PFC)?

- A mechanism to identify priorities for funding across state government

How does it work/what is the process:

- Within each state agency, each administration has the opportunity to submit a limited number of PFCs, the Agency Director then identifies which of the PFCs to prioritize and submit for budget processing:

Areas for Further Development

Maximize the experience we have gained:

- Care Management and Coordination Policy Development
- Social Determinants of Health Data Collection and Sharing
- Health Information Exchange Optimization
- Exploration of Attribution Barriers

Wrap Up and Closing

THANK YOU!

SIM
MDHHS State Innovation Model