Michigan Department of Health & Human Services

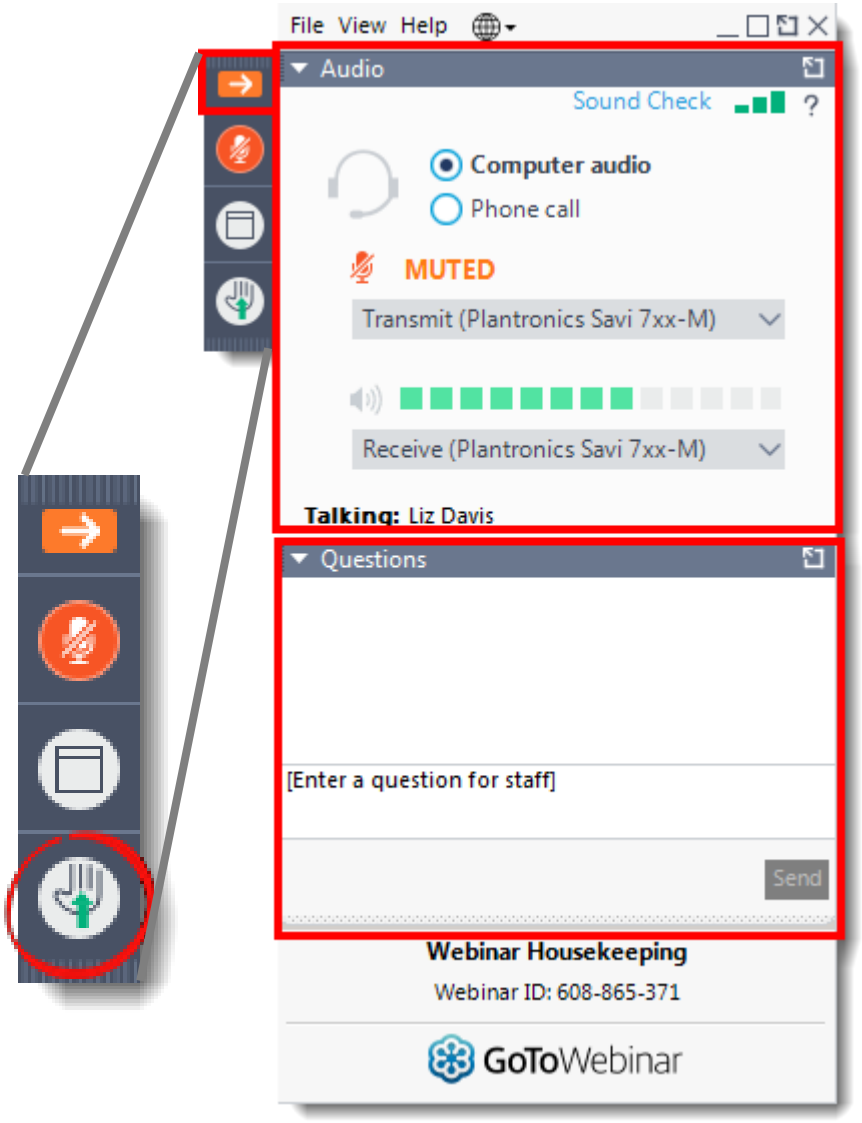
Office Hours

State Innovation Model

Patient Centered Medical Home Initiative

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

Housekeeping: Webinar Toolbar Features



Your Participation

Open and close your control panel

Join audio:

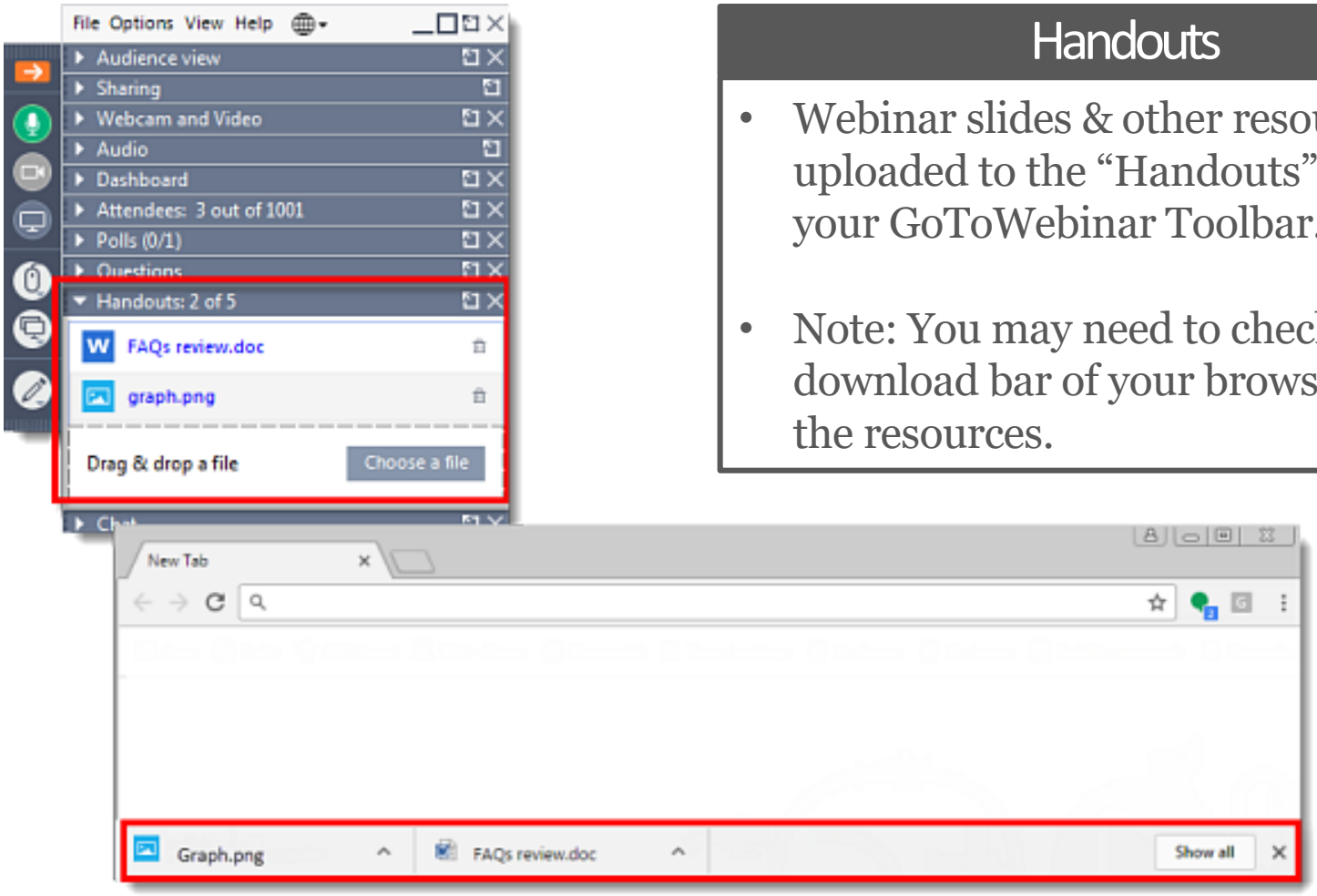
- Choose **Mic & Speakers** to use VoIP
- Choose **Telephone** and dial using the information provided

Submit questions and comments via the Questions panel

Note: If time allows, we will unmute participants to ask questions verbally.

- Please raise your hand to be unmuted for verbal questions.

Housekeeping: Webinar Resources/Handouts



Handouts

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

Dashboard Content

- Quality and Utilization measures are included at different levels:
  - Project Level
  - PO
  - Practice
- Release 1 Dashboard
  - Visualizations and charts
  - Reporting Period: 1/2016 - 12/2016 (Baseline)
  - January 2017 Attribution
  - Medicaid eligibility, medical and drug claims as well as January attribution utilized to calculate measure results
  - Clinical/EMR data is not included in measures for this release

Dashboard Measures

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

Uses

- Evaluate overall performance
  - Quality of Care
  - Health Outcomes
  - Utilization and Cost Performance
- Compare to benchmarks and other organizations
- Identify areas for improvement
- Enable quality and process improvement
- Identify organizations for collaboration
  - Learn from high performers
  - Discuss the processes and tools that work and identify where changes in your organization may be warranted
- Evaluate performance against care management is occurring
- Determine if care management services are being billed/coded correctly

HVPA – Huron Valley Physicians Association

- Alicia Majcher, Quality Operations Director

Clinical QMI Data

- Initial measures are based on eligibility, medical and drug claims, limited to the patients and providers participating in SIM PCMH
- QMI Use case is ramping up
- MiHIN will provide clinical/EMR data to MDC for inclusion in measures
- Some measures are supplemented with clinical data
  - For example Breast Cancer Screening
  - Identify patients that have had a screening but it is not in the claims data
  - Identify patients that should be excluded because of a mastectomy that occurred years ago is captured in the EMR but not in claims
- Some measures require clinical data
  - Examples are Controlling High Blood Pressure and Poor Control in Hemoglobin A1c
  - The actual results are needed to populate the numerator and denominator
  - Blood Pressure of 140/90 or Hemoglobin A1c test value of 5.3%

Ongoing Releases and Measures Included

Target Release	Measure Name	Clinical Data X=Req S=Supplement
1	All-Cause Readmission	
1	Breast Cancer Screening	S*
1	Cervical Cancer Screening	S*
1	Chronic Condition Asthma	
1	Chronic Condition Hypertension	
1	Chronic Condition Obesity	
1	Comprehensive Diabetes Care: Eye Exam (retinal) performed	S*
1	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing (HbA1C)	S*
1	Comprehensive Diabetes Care: Medical Attention for Nephropathy	S*
1	Emergency Department Visits	
1	Hospital Admissions	
1	Use of Imaging Studies for Low Back Pain	
2	Adolescent Well-Care Visits	S*
2	Care Coordination: % attributed patients receiving care management or care coordincation services	
2	Care Coordination: % patients with timely follow up with pcp after discharge	
2	Childhood Immunization Status	
2	Chlamydia Screening in Women	S*
2	Immunization Status for Adolescents	
2	Lead Screening in Children	S*
2	Well-Child Visits in the First 15 Months of Life	S*
2	Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	S*

*Clinical Data is not expected in the first few releases. Measures will be supplemented when data is available.

Ongoing Releases and Measures Included

Target Release	Measure Name	Clinical Data X=Req S=Supplement
3	Antidepressant Medication Management	
3	Chronic Condition Diabetes	
3	Follow-Up Care for Children Prescribed ADHD Medication	
3	Prevantable ED Visits	
3	Reducing Hospitalization for Ambulatory Sensitive Conditions	
3	Standardized Per Member Per Month (PMPM) Costs	
4	Adult BMI Assessment	X
4	Comprehensive Diabetes Care: Blood Pressure Control (<140/90 mm Hg)	X
4	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	X
4	Controlling High Blood Pressure	X
4	Depression Screening	X
4	Prenatal & Postpartum Care: Timeliness of Prenatal Care (PPC)	S
4	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	X
4	Tobacco Screen	X
4	Utilization of the PHQ-9 to Monitor Depression Symptoms or Adolescents and Adults (DMS)	X
4	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	X

Documentation

- Measures are described in the SIM PCMH Measures Technical Guide available on the MDC web site
- Link to MDC Site
- Additional information include dashboard release notes, user guide, and timeline