2017 SIM PCMH Initiative Quarter 4 Progress Report

Deadline for Responses: **5pm, Wednesday, January 31, 2018**

The PCMH Initiative Quarterly Progress Report is intended to assess compliance with the SIM PCMH Participant Agreement and identify opportunities for the Initiative to support participants.

The report has been divided into 3 sections. Content includes:

1. Participant information
   PO and practice contacts and champions
   Care Manager and Care Coordinator staffing information
   Medicaid Health Plan contracting information
2. Participation requirements information, updates and attestation
3. Participation experience, strengths and challenges

Respondent Information (the person who can be contacted regarding this report)

O Name _____

O Phone _____

O Email _____

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

▼ AFFINIA HEALTH NETWORK LAKESHORE (44) ... WEXFORD PHO (85)

Participant information

An Excel document with the information needing verification has been sent to the organization's primary contact. Please review and update the excel document as appropriate and save the updated document with your organization name in the following manner "OrgName_Q4" and upload in the "Participant information" section below.

There are three tabs in the file, so please make sure each spreadsheet has been reviewed and updated before submission. Below is a description of each tab: "Contact": This spreadsheet is aimed at capturing PO and/or practice contacts and champions changes. Please review and update the information in the spreadsheet entitled "Contact". "CMCC": Please review and update Care Manager and Care Coordinator staffing and training information in the spreadsheet entitled "CMCC". "MHP": Please verify the contracting information for each of the practice in the spreadsheet entitled "MHP".
Please upload the updated participant information:

Please provide the contact person information of your organization's financial service. The individual will be contacted for any payment coordination purposes by the SIM PCMH Initiative or MHPs.

- O Name _____
- O Phone _____
- O Email _____

Participation Requirements Information, Updates and Attestation

Has there been any change in provider employment or provider status within your organization's participating practice(s) since receiving the practice and provider file in November 2017?

O No

O Yes, and our organization has already reported provider change(s) using the Practice Change Form.

O Yes, and our organization will be submitting the Practice Change Form (as required) within the next seven days.

Are any care management and coordination team member positions (FTEs required to meet the 2 Care Management and Coordination staff members per 5,000 attributed patients ratio) currently vacant within your organization's participating practice(s)?

O No

O Yes - Please describe (including the number of vacant positions, how long the position has been vacant and current recruiting status

_____

Has there been any change in the PCMH designation status of your organization's participating practice(s)?

O No

O Yes - Please describe _____

Has there been any change in the Electronic Health Record (EHR) system used by your organization's participating practice(s) or the extent to which the EHR is implemented?

O No

O Yes - Please describe _____

Are there any plans to switch EHR vendors or upgrade EHRs within the NEXT (Q1 2018) quarter?

O No

O Yes - Please describe _____

Has there been any change in the Patient Registry system used by your organization's participating practice(s) or the extent to which the registry is implemented?

O No

O Yes - Please describe _____

Has there been any change in the electronic care management and coordination documentation tool(s) used by your organization's participating practice(s)?

O No

O Yes - Please describe _____

Please briefly describe your process for obtaining and utilizing shared consent with community partner organizations to support your Clinical Community Linkages. Include details about when/how consent is obtained, how often consent is required, what types of information is shared and how feedback is given.

_____

_____

_____

Participation Experience, Strengths and Challenges

Does your organization have any outstanding challenges with payment, including care management/care coordination service codes?

O No

O Yes - Please describe _____

Does your organization have any outstanding challenges in onboarding for Health Information Exchange (HIE)?

O No

O Yes - Please describe _____

Does your organization have any outstanding challenges in staffing up and training care managers and/or care coordinators?

O No

O Yes - Please describe _____