Quarterly Update (Q4)

STATE INNOVATION MODEL

PATIENT CENTERED MEDICAL HOME INITIATIVE

12.14.2017

Presenters

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2017 Recap

Accomplishment Highlights
Practice Self Assessment

The PCMH Initiative Self-Assessment Tool was developed to assess Participating Practices on their current Patient Centered Medical Home capabilities and identify opportunities for the Initiative to support participants in the future. The PCMH Initiative Self-Assessment Tool also helps sites track progress toward practice transformation when completed at regular intervals.

Areas of strength:

- EHR and registry utilization to support QI activities
- Comfort and Use of standardized screening tools (such as PHQ-9)
- Patient portal implementation
- Organized visits supported by team huddles/meetings

Areas to address:

- Identifying patient risk level to support care
- Behavioral health and Substance Abuse integration
- Community-based referrals and linkages
- Patient, family and caregiver input

Accomplishment Highlights

Care Management and Coordination

In 2017 the PCMH Initiative included the Care Coordinator role as an integral part of the Care Management and Coordination team, as well as the overall care team

Areas of strength:

- 10 of 42 Participating Organizations have included Care Coordinators in their staffing model
- Mix of staffing models to support patient population
- 536 CMCC staff (366 FTE) supporting patient population

Areas to address:

- About one third of participants report CMCC vacancies
- Some participants report struggles in recruiting qualified candidates
- Not all payers (outside the Initiative) recognize the role non-licensed staff play in supporting CMCC services

Accomplishment Highlights

Practice Transformation: Clinical-Community Linkages

Highlights:

- 43% of Participants have started the screening process
- 86% of the Participants submitted a screening plan
- Most Participants will be initiating screening as part of the annual wellness exam or care management visit
- Almost 90% of Participants have a staff training approach in place
- Participants working collaboratively with CHIRs to support screening/linking processes

Opportunities

- Few Participants specifically mentioned plans for patient follow-up after the linkage is made
- Few Participants mentioned **how** they would follow up with patient after a linkage is made
- Some Participants relying solely on Care Management staff member(s) to implement CCL design as opposed to supporting team-based nature of the activities
- Some participants still unclear on the CCL requirements and ultimate purpose

Quality Improvement Activities

Screening QI Activities:

- Analyze variation in screening rates
- Compare feedback of different screening approach (paper, phone, etc.)
- Discuss where screening is more effective (who is with patient at the time of screening

Linkage QI Activities:

- Identify high volume community needs
- Plan community resource event to see if all needs are met
- Interview clinical sites to understand barriers and opportunities
- CHIR: Electronic screening and Pathways reporting

Partnership Approaches

76% of Participants have identified their partnership approach

- Meet CHW and PATHWAY organizations to optimize relationship
- Annual review and contact with community resources
- New local services are invited to present
- Regular touch base meetings
- Information contacts
- Donate funds to community organizations
- Volunteer on-site labor services such as local Soup Kitchen
- Formal MOU
- Community care management collaborative

Accomplishment Highlights
Health Information Exchange

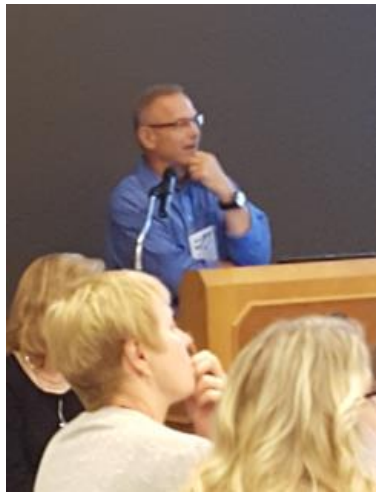
Building on Michigan's foundation in Health Information Exchange infrastructure to advance care coordination capabilities and quality measure reporting across provider groups and organizations utilizing the Relationship and Attribution Management Plan (RAMP)

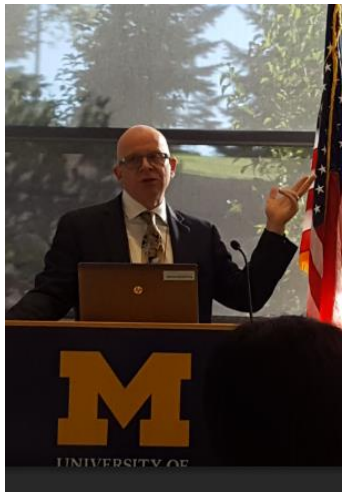
The Relationship and Attribution Management Plan was created to support the identification and capture of relationships between patients/consumers and their healthcare delivery team members, to facilitate the active exchange of necessary information between these identified individuals and organizations:

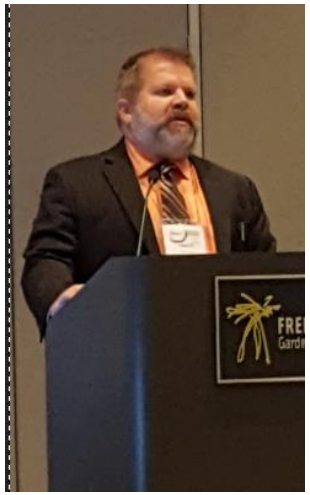
a) Active Care Relationship Service
b) Health Provider Directory Service
c) Admission-Discharge-Transfer Notifications
d) Quality Measure Information

Use Case	Total (of 42)	Percentage
HD	41	98%
ACRS	41	98%
ADT	39	93%
QMI – Submitted Initial File	38	90%
QMI – Well formed Test File	30	90%
QMI – In production/ready for production	25	60%

Three Successful 2017 Summits!







Interested in Helping to Plan the 2018 Summits?

The SIM PCMH Initiative is looking for volunteers who would like to help plan our 2018 Summit:

- This committee is for those who have a desire to shape the theme, speakers, locations and other essential parts of the Summit to make it the best it can be
- The committee meetings will occur mostly via one-hour webinar and the time commitment is envisioned to be no more than six to eight hours for the year
- If you are interested in helping to plan, please note your interest in the evaluation following this webinar or send a note with the subject “Summit 2018 Planning Committee” to MDHHS-SIMPCMH@michigan.gov.

What successes have you seen in your organization this year?

Michigan Data Collaborative

UPCOMING DELIVERABLES

MDC Upcoming Deliverables

Patient Lists/Aggregates

- December PMCH Patient List (PPL) targeted for 12/28/18
- 4Q17 Aggregate Patient Report targeted for 01/09/18
  - MDC enhanced the report to track Managing Organizations and Practices over time
  - Report will now be a sum of the members across the quarter instead of 3 monthly reports

Care Management and Coordination Reports

- September Monthly report targeted for 01/04/18
- 3Q17 Quarterly report targeted for 01/15/18

Dashboard Release 3 targeted for end of January 2018

- Ongoing reporting periods will end on a calendar quarter
- Reporting Period 10/2016 – 09/2017
- September SIM PCMH Participant Attribution
- Moving most measure to HEDIS 2018 (next slide includes more details)

HEDIS 2018 Impacts

		Low	Medium	High	No Change	Notes
Measures	Breast Cancer Screening	●				
	Cervical Cancer Screening	●				
	Chlamydia Screening in Women	●				
	Comprehensive Diabetes Care: Eye Exam (retinal) performed	●				
	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing	●				
	Comprehensive Diabetes Care: Medical Attention for Nephropathy			●		Changes to the content of the value sets that identify the numerator impact results
	Lead Screening in Children	●				
	Use of Imaging Studies for Low Back Pain					Will be removed in Release 3.0
Pediatric Measures	Adolescent Well-Care Visits	●				
	Childhood Immunization Status	●				
	Immunization Status for Adolescents	●				HEDIS 2018 includes a new break-out for immunizations plus HPV
	Immunization Status for Adolescents +HPV					
	Well-Child Visits in the First 15 Months of Life	●				
	Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	●				
Utilization Measures	All-Cause Readmissions			●		This measure will be moved to HEDIS 2018 subsequent to Release 3.0
	Emergency Department Visits	●				
	Hospital Admissions			●		This measure will be moved to HEDIS 2018 subsequent to Release 3.0
Chronic Conditions	Asthma		●			
	Hypertension	●				
	Obesity				●	This measure is not based on a HEDIS definition

Low = No Logic changes. Potentially an added exclusion or a value set change.

Medium = Minor logic and/or value set changes.

High = Major logic changes. May include value set changes.

Upcoming Compliance

DECEMBER/JANUARY

Upcoming Compliance: Semiannual Practice Transformation Report

Release date: Monday, November 13, 2017

Report link has been distributed to the primary contact of each organization by email. Directions for completing the report can be downloaded here.

Deadline: **Friday, December 22, 2017**

Contents:

1. Clinical-Community Linkages (CCL): fully developed and finalized information
   - Assessing social determinants of health
   - Linkage methodology
   - Quality improvement activities

2. Practice Transformation Objective(PTO) identified by POs
   - How to realign the current transformation objective with improving performance on population health objectives

Upcoming Compliance: Quarterly Progress Report (Q4)

Release: December 21, 2017

Due: January 31, 2018

Content:

- PO contacts and clinical champion, practice contacts and clinical champions
- Care Manager and Coordinator information
- MHP contracting information
- Infrastructure, practice, provider changes
- Participation Experience, Strengths and Challenges

Note:

Report will be formatted so that the PO can complete on behalf of all participating practices

Participant Key Contact will receive an email with supplemental excel document (similar to Q3 report)

Upcoming Compliance: Annual Practice Self-Assessment

Release: January 9, 2018

Due: February 9, 2018

Content:

- Similar to 2017 self assessment so that results can be tracked over time
- Covering:

Leadership	CM/CC Sustainability	Quality Improvement	Medical Neighborhood
Integrated Behavioral Health Care	Population Health	Team Based Care	Patient and Family Care Giver Engagement
Shared Decision Making	Clinical-Community Linkages	Health Literacy	

Note:

A self-assessment must be completed for each practice.

Gearing up for 2018

2018 PCMH Initiative Participation Agreement

The 2018 Participation Agreement is now available!

Generic Agreements (which do not list participating organizations/practices) have been sent to the individual who completed the Intent to Continue Participation and/or key contact.

A resource has been developed to support review of the 2018 agreement.

NEXT STEPS:

MDHHS Bureau of Purchasing (BOP) will send the formal agreement to appropriate individuals (as listed in the ItCP) for signature and execution of the agreement.

Signed agreements must be returned electronically (to MDHHS BOP) by 1/19/2018

Care Management and Coordination Metrics

2018 BENCHMARK

Any patient who has had a claim with one of the applicable codes during the reporting period / Eligible Population	3.0%
Any patient who sees a PCP, within 14 days of the last discharge date on a room and board claim in the measurement period. / Eligible Population with an inpatient claim*	40.0%

*Excludes any member who had an inpatient stay in a psychiatric facility, or inpatient stay related to pregnancy/birth

Will be measured quarterly at a practice level (via MDC Quarterly CMCC reports, available on the dashboard). More details to come with the release of the 2018 Compliance Plan (anticipated in February 2018).

2018 Participant Guide Release

The 2018 Participation Guide will be released on: **December 19, 2017**

This guide is meant to be a companion to the 2018 Participation Agreement and to provide further detail on participation requirements for participating Practices/Physician Organizations.

This is an iterative document, therefore PCMH Initiative team will be updating the guide on a regular basis beginning early 2018 and will send communication when those updates occur.

Version 1 includes the following content:

2018 Payment Model	Clinical-Community Linkages Guidance	Population Health Management	Models of Care Management and Coordination
CMCC Training Information	Health Information Exchange Participation	Michigan Data Collaborative Dashboards and Reports	Participant Reporting Structure
Support and Learning Activities Information	Initiative Communications	Updated CMCC Billing and Coding Quick Guide	2018 Calendar

2018 Self-Management Training Options

To provide additional flexibility and convenience for SIM PCMH Initiative participants, three organizations will be available for self-management training for Care Managers and Coordinators who have not been trained:

- Integrated Health partners (IHP)
- Michigan Center for Clinical Systems Improvement (MiCCSI)
- Practice Transformation Institute (PTI)

If self-management training is completed through one of these vendors, the PCMH Initiative will cover the cost of the course. (Travel and any other related expenses are the responsibility of the attendee or their organization.)

Trainees must attest that they have not been previously been trained in self-management. (Those who completed self-management training with a CMRC-approved vendor with MiPCT or another initiative do not need to be retrained).

2018 Self-Management Training Options, cont.

Class availability and the number of training slots may vary at each organization. If classes with a particular vendor are full, you will be put on a wait list or can explore availability at the other organizations.

The links for each organization are:

- Integrated Health Partners (IHP) - based in Battle Creek
  - http://www.integratedhealthpartners.net/events
  - Note: this is a 2 part series and participants must attend both session dates
  - To be placed on a wait list, contact: Emily Moe | moee@integratedhealthpartners.net | Phone: 269-425-7138.
- Michigan Center for Clinical Systems Improvement (Mi-CCSI) - based in Grand Rapids
  - https://www.miccsi.org/training/upcoming-events/
  - To be placed on a wait list, contact: Amy Wales | amy.wales@miccsi.org | Phone: 616-551-0795 ext. 11
- Practice Transformation Institute (PTI) - based in Southfield
  - http://www.transformcoach.org/care-manager-training/
  - To be placed on a wait list, contact: Yang Yang | yyang@transformcoach.org | Phone: 248-475-483

Upcoming Events

Upcoming Events – January 2018

2018 Initiative Kick-off webinar
January 9, 2018
12:00 – 1:00pm
Initiative Staff
REGISTER HERE

Topics:

- Recap of 2017, an
- Overview of 2018,
- Reporting requirements including the 2018 Practice Self-Assessment

January Office Hours: Integrated Service Delivery
January 17, 2018
11:30am -12:30pm
Phillip Bergquist
REGISTER HERE

Topics:

- Overview of Integrated Service Delivery Model
- Pilot and launch statewide

2018 Office Hours will be scheduled for the 3rd Wednesday of the month (except holidays), between the hours of 11:30am and 1:30pm

2018 Care Coordination Collaborative

Purpose: Through collaboration, the SIM PCMH Initiative Medicaid Health Plans, POs, Practices and CHIRs will identify and test strategies to improve care coordination to optimally address the needs of shared patients.

- The care coordination strategies will involve the Medicaid Health Plans (MHPs), and POs, practices, including CHIRS.

Events: A series of events will be held throughout 2018 to support this coordination between SIM participating MHPs, practices/POs, and CHIRs.

Attendees: Participation is voluntary:

The Care Coordination Collaborative event(s) will be held for State Innovation Model participants, including: POs, interested practice team members, Medicaid Health Plans and Community Health Innovation Regions (CHIRs).

Note: Interested practice team members, are individuals closest to direct work with patient coordination between MHP Care Manager, practice Care Manager, and other community resource coordinators.

Care Coordination Collaborative Surveys

Example of Survey Focus areas:

What issues are most challenging for your organization in coordinating care with Medicaid Health Plans?

Have you experienced success in coordination with Medicaid Health Plans? If so, what did that look like and are there shared lessons for other practices?

Purpose of Surveys

- Prioritize and understand topics of interest: perspective from the MHP, CHIR and PO, Practice
- Gather information about current state
- Logistic preferences – meeting modalities in person and virtual, cadence
- Responses from this survey will be used to inform planning for these Care Coordination Collaborative

Surveys will be distributed to:

- CHIRs
- Medicaid Health Plans
- PO Leaders and Independent Practice Leaders

Surveys will be distributed to PO and practice leaders this week and will be open until January 12th

Interested in Helping to Plan the 2018 Care Coordination Collaborative Events?

The SIM PCMH Initiative is looking for volunteers who would like to help plan our 2018 Care Coordination Collaborative:

- This Committee is for those actively involved in the Care Management and Coordination processes within their organization and interested in shaping connections between others involved in the State Innovation Model and Care Coordination (Medicaid Health Plans, POs and practices, Community Health Innovation Regions)
- The committee meetings will occur mostly via one-hour webinar and the time commitment is envisioned to be no more than six to eight hours for the year
- If you are interested in helping to plan, please note your interest in the evaluation following this webinar or send a note with the subject “Care Coordination Collaborative Committee” to MDHHS-SIMPCMH@michigan.gov.

Time for Questions

Questions and Additional Resources

MDHHS-SIMPCMH@michigan.gov

SIM
MDHHS State Innovation Model

Thank you for joining us today!

www.michigan.gov/SIM

(SIM Comprehensive Summary; Newsletters; Operational Plan, CHIR info., PCMH, etc.)