2018 SIM PCMH Initiative Regional Summit

Seamless Partnerships for Effective Patient Care

TREETOPS RESORT

3962 WILKINSON ROAD

GAYLORD, MI

Welcome - Overview

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

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

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 MDHHS SIM PCMH Initiative Summit registration web page or click here

On the SIM Summit registration page, locate the Summit date and location that you attended

Click the link titled "Evaluation"

Sign in to your Dashboard Login on the MiCMRC website

- If you don't already have one, create a Dashboard Login on the MiCMRC website www.micmrc.org

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

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

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:

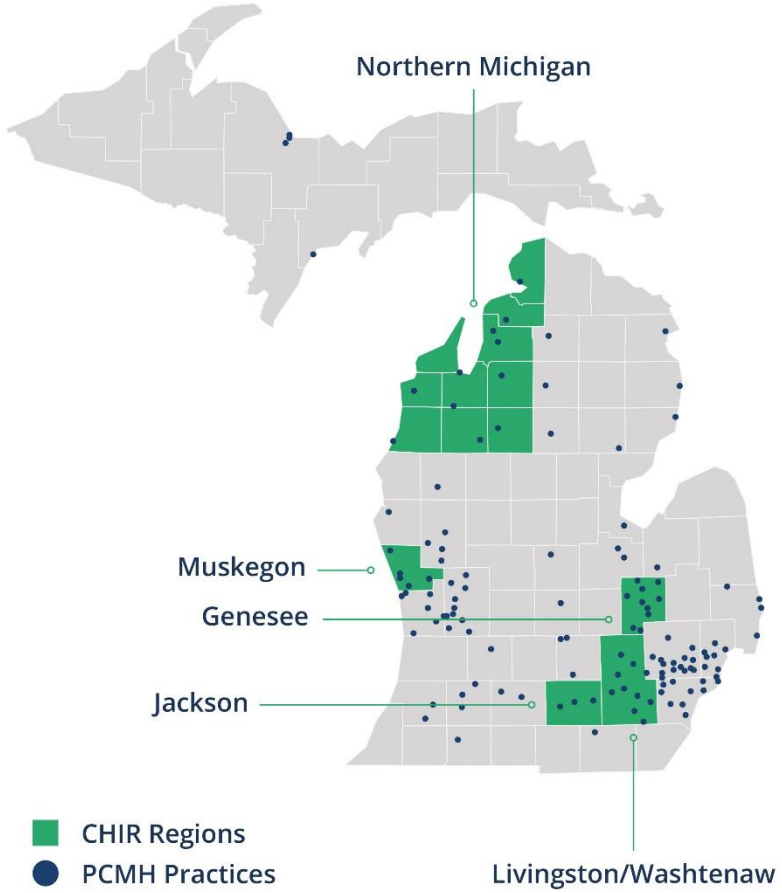
- 328 members of a Physician Organization
- 18 Federally Qualified Health Center sites
- 9 Single Practice sites

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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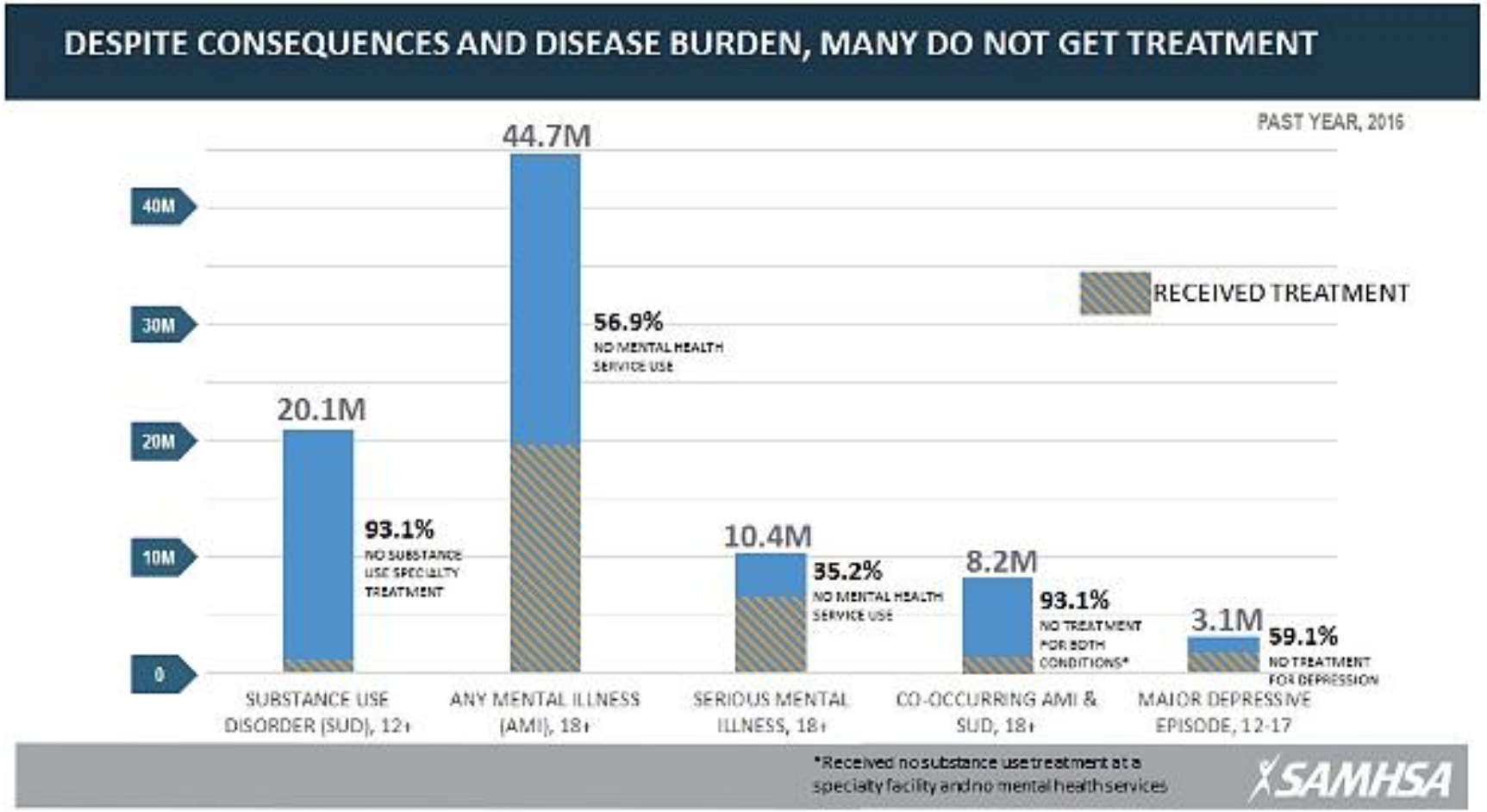
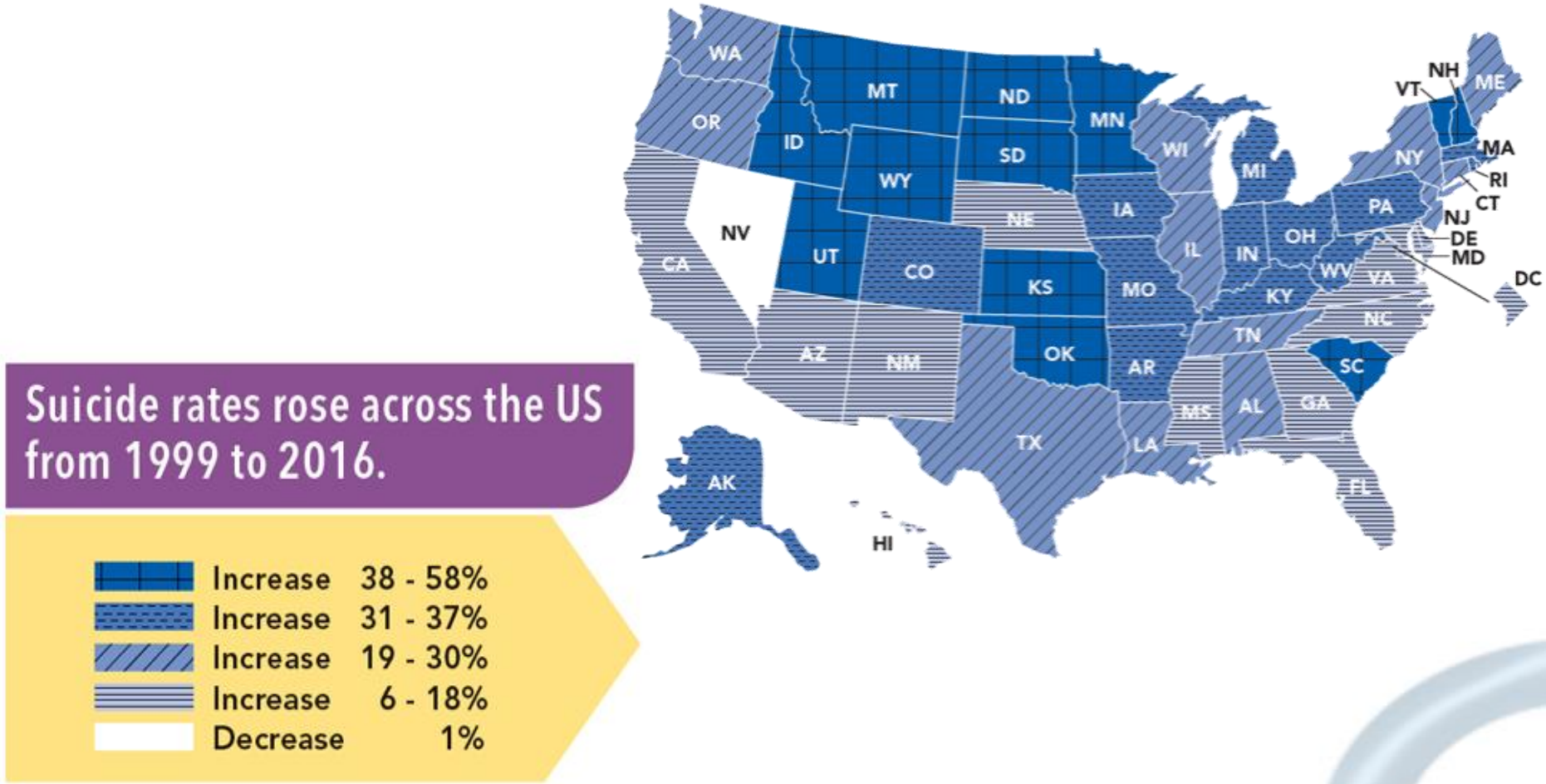
Daily Mail
No copyright infringement intended

Mental Illness is Woefully Undertreated



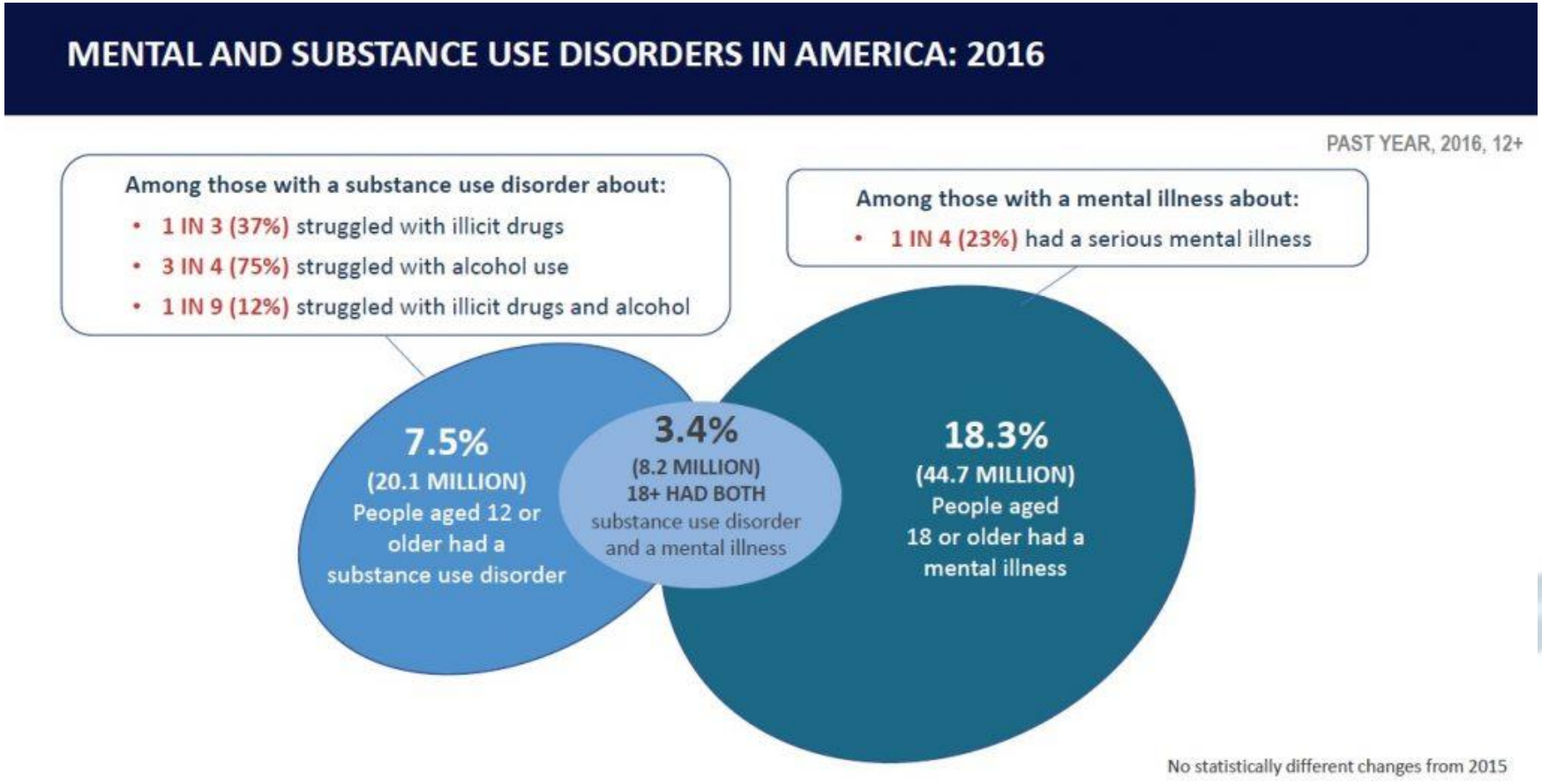
SAMSHA (2016). *SAMSHA Data Outcomes 2016.* Retrieved from: https//www.samhsa.gov/disorders

Suicide rates rose across the US from 1999 to 2016.



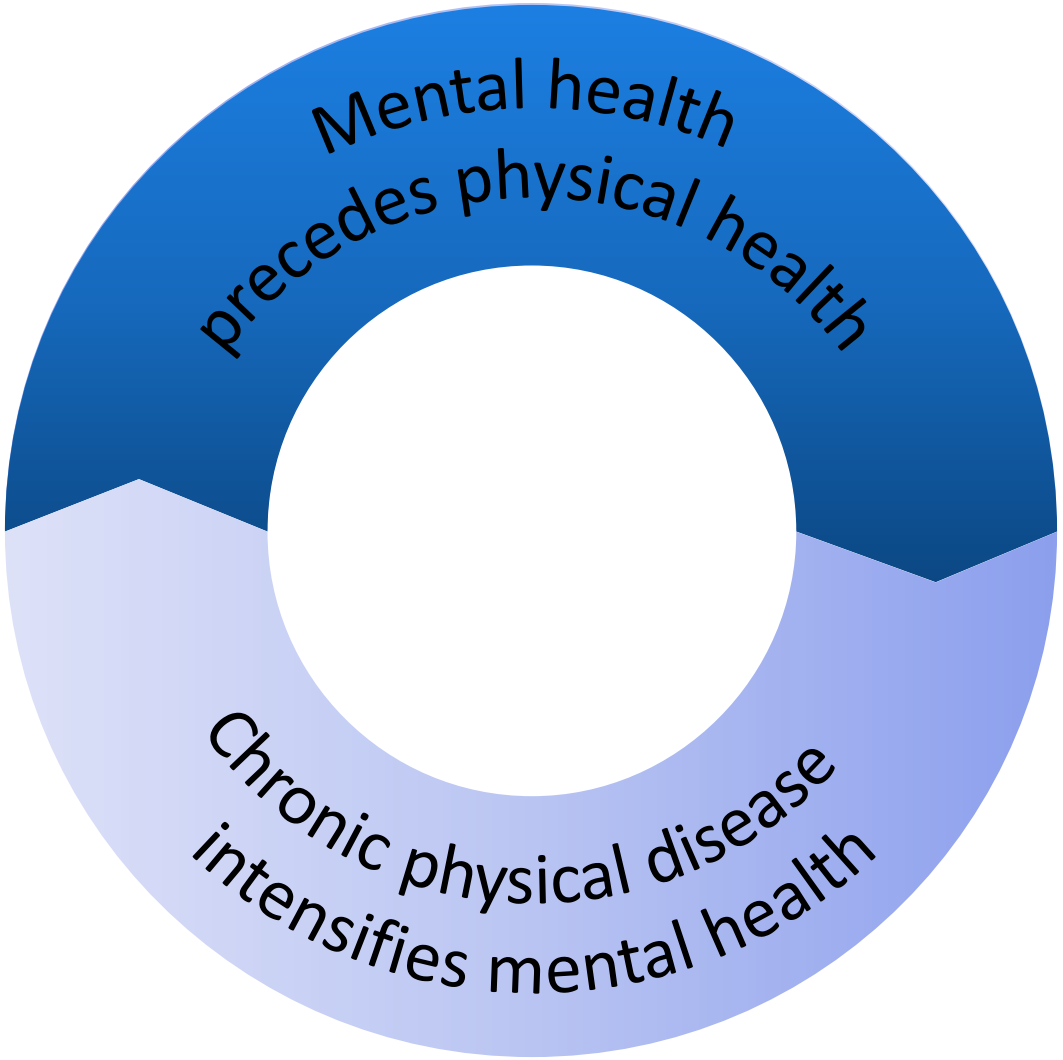
CDC Vital Signs (June 2018). *Suicide Rates Across the US*. Retrieved from: https://www.cdc.gov/vitalsigns/suicide/index.html

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

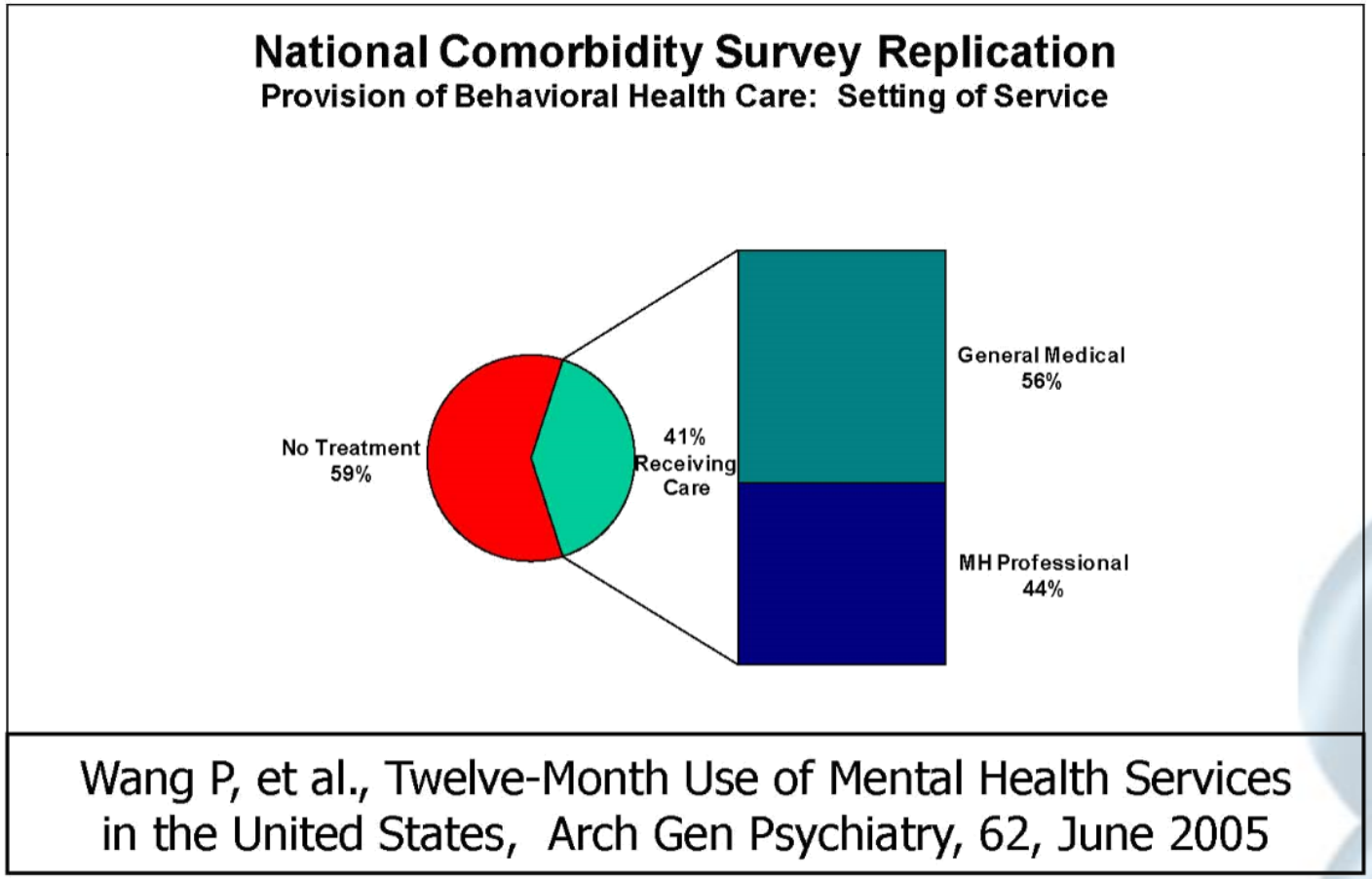
Pincus, H.A., Tanielian, T., Marcus, S., Olfson, M., Zarin, D.A., Thompson, J.W., & Zito, J.M. (1998). Prescribing trends in psychotropic medications: primary care, psychiatry, and other medical specialties. JAMA, 279 7, 526-31.

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

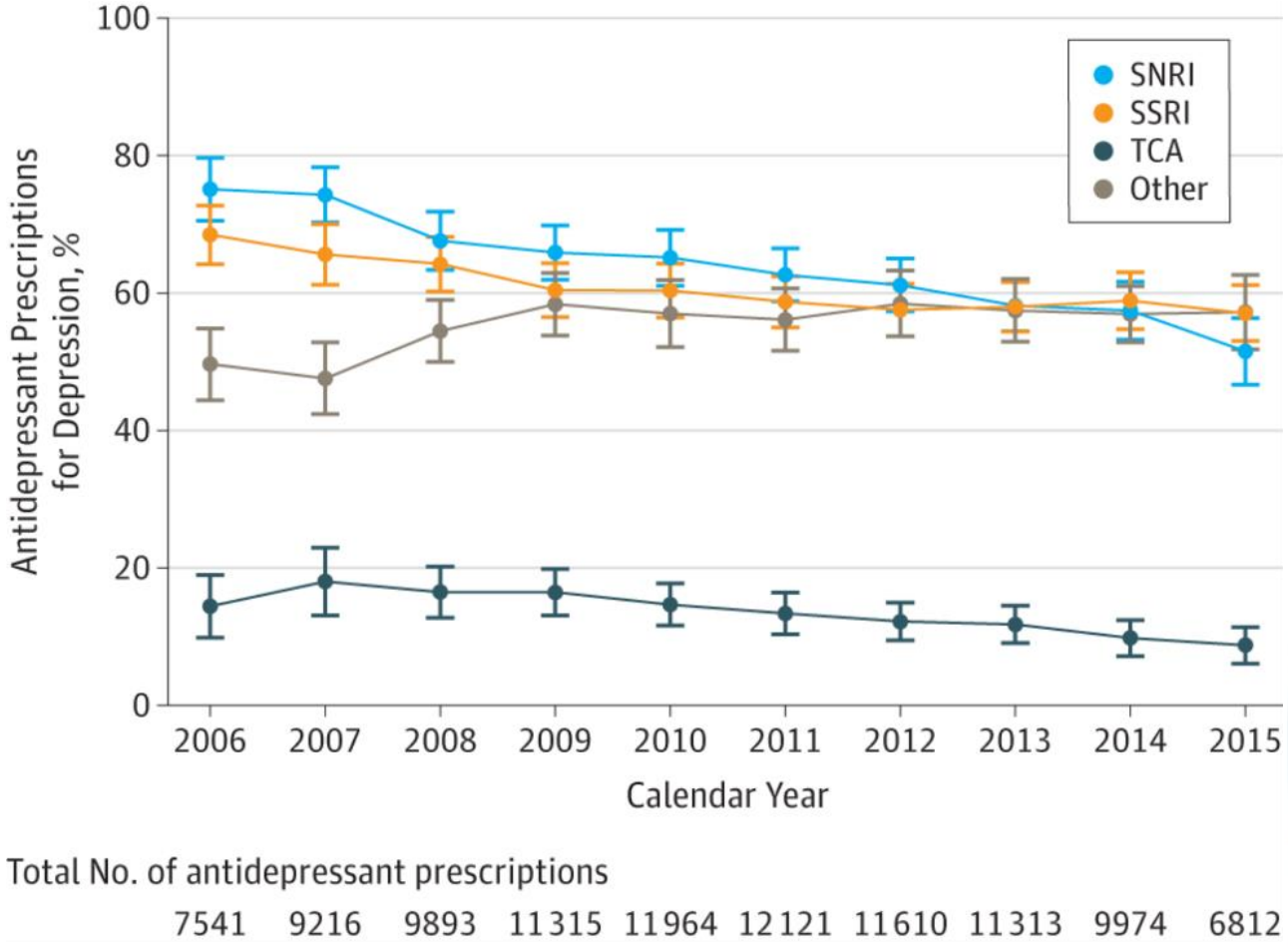
The Good the Bad and the Ugly

- 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.

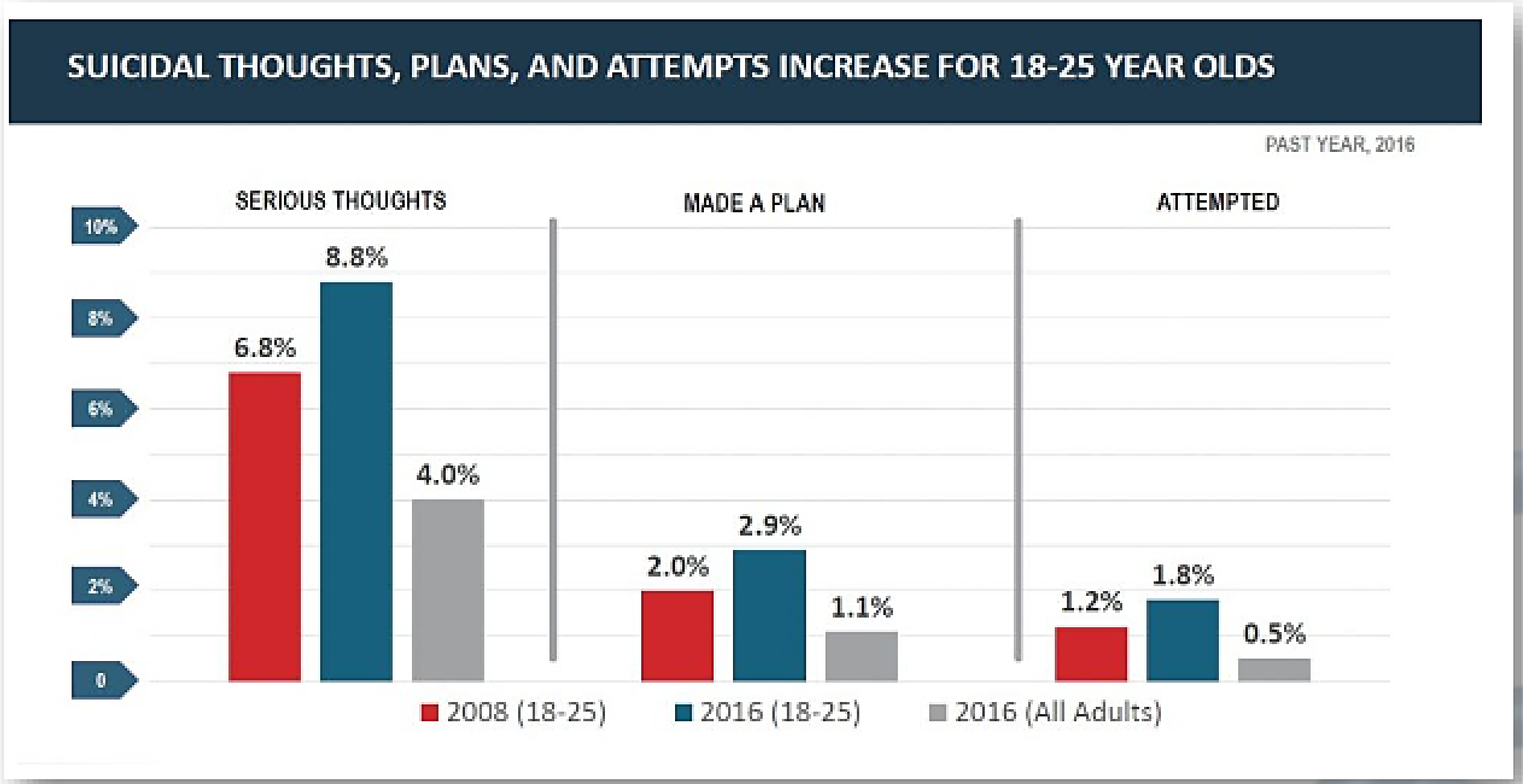
McDowell, A. K., Lineberry, T. W., & Bostwick, J. M. (2011). Practical Suicide-Risk Management for the Busy Primary Care Physician. *Mayo Clinic Proceedings*, *86*(8), 792–800. http://doi.org/10.4065/mcp.2011.0076

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)

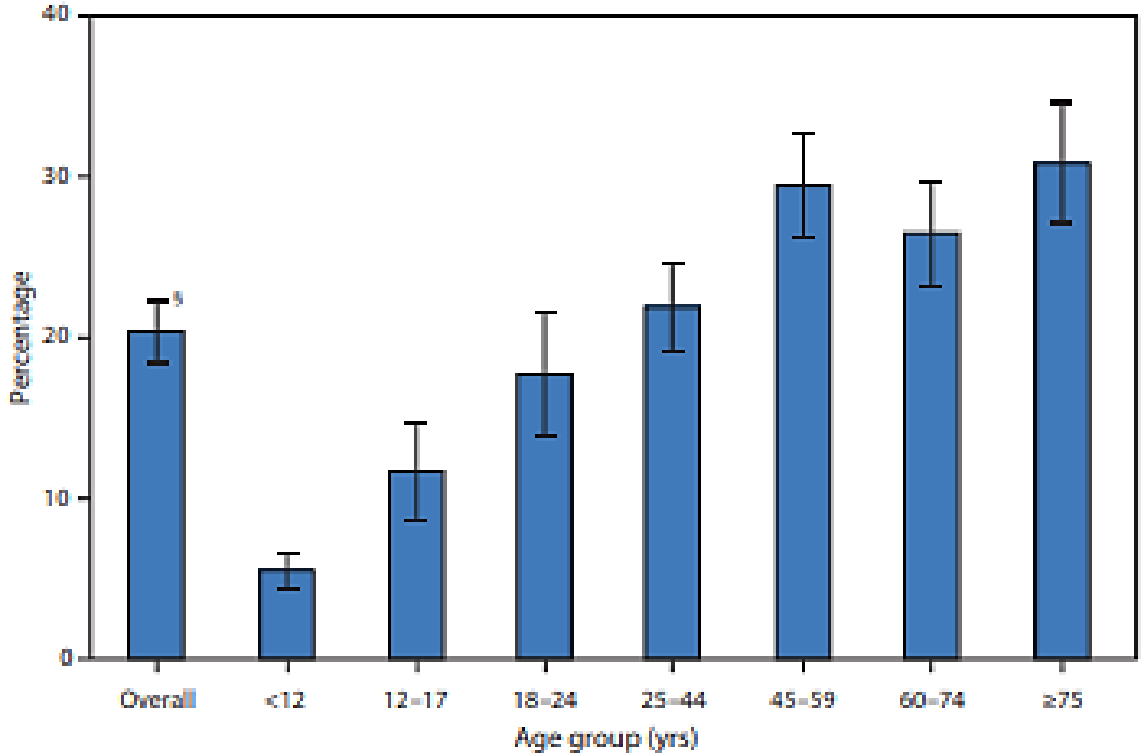


Blader, J., Suicidal Thoughts and Behaviors Increased Among Young Adults. Why?, Journal of the American Academy of Child & Adolescent Psychiatry , Volume 57 , Issue 1 , 18 - 19

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

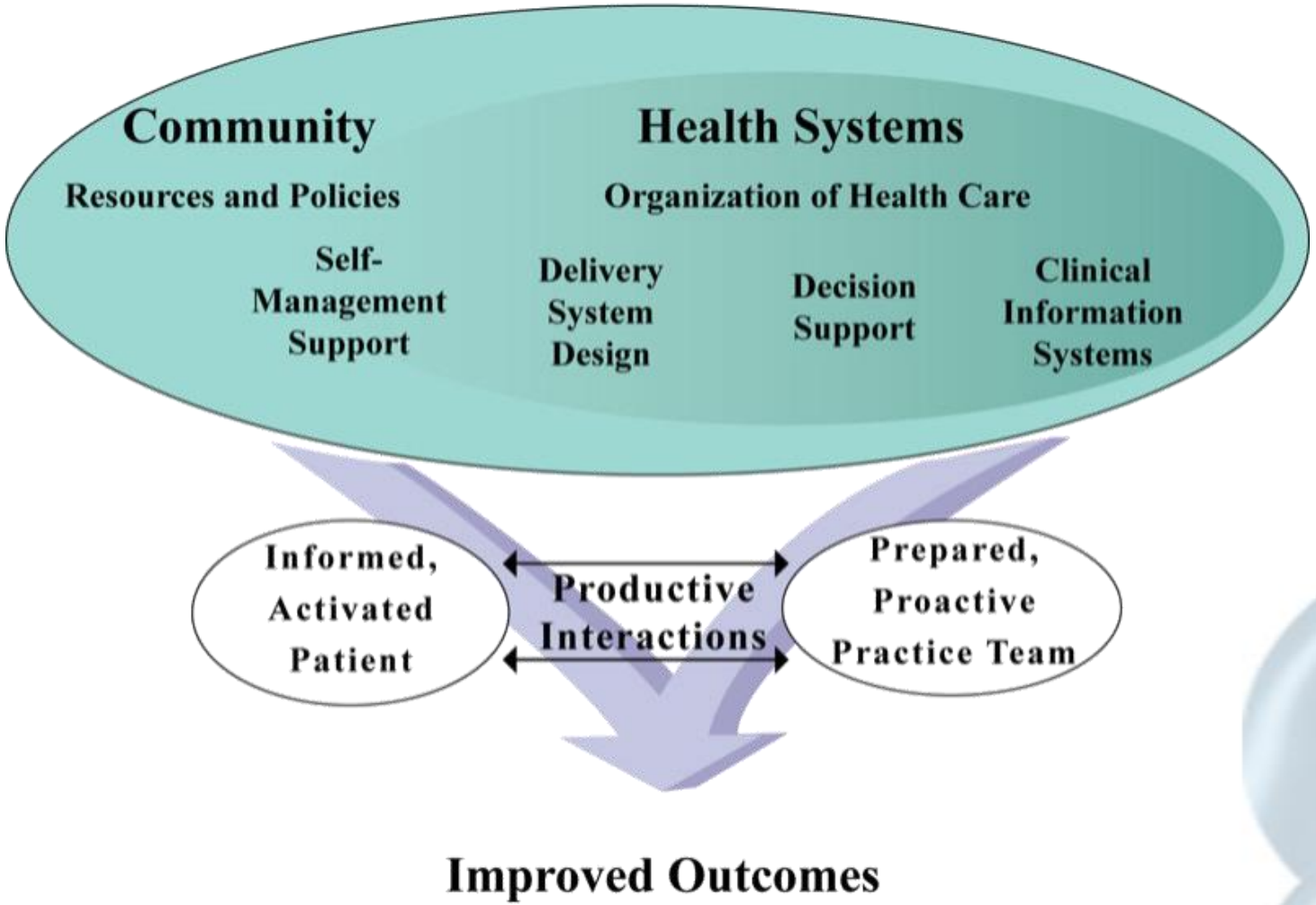
Primary Care Expectations for Panel of Patients

- 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

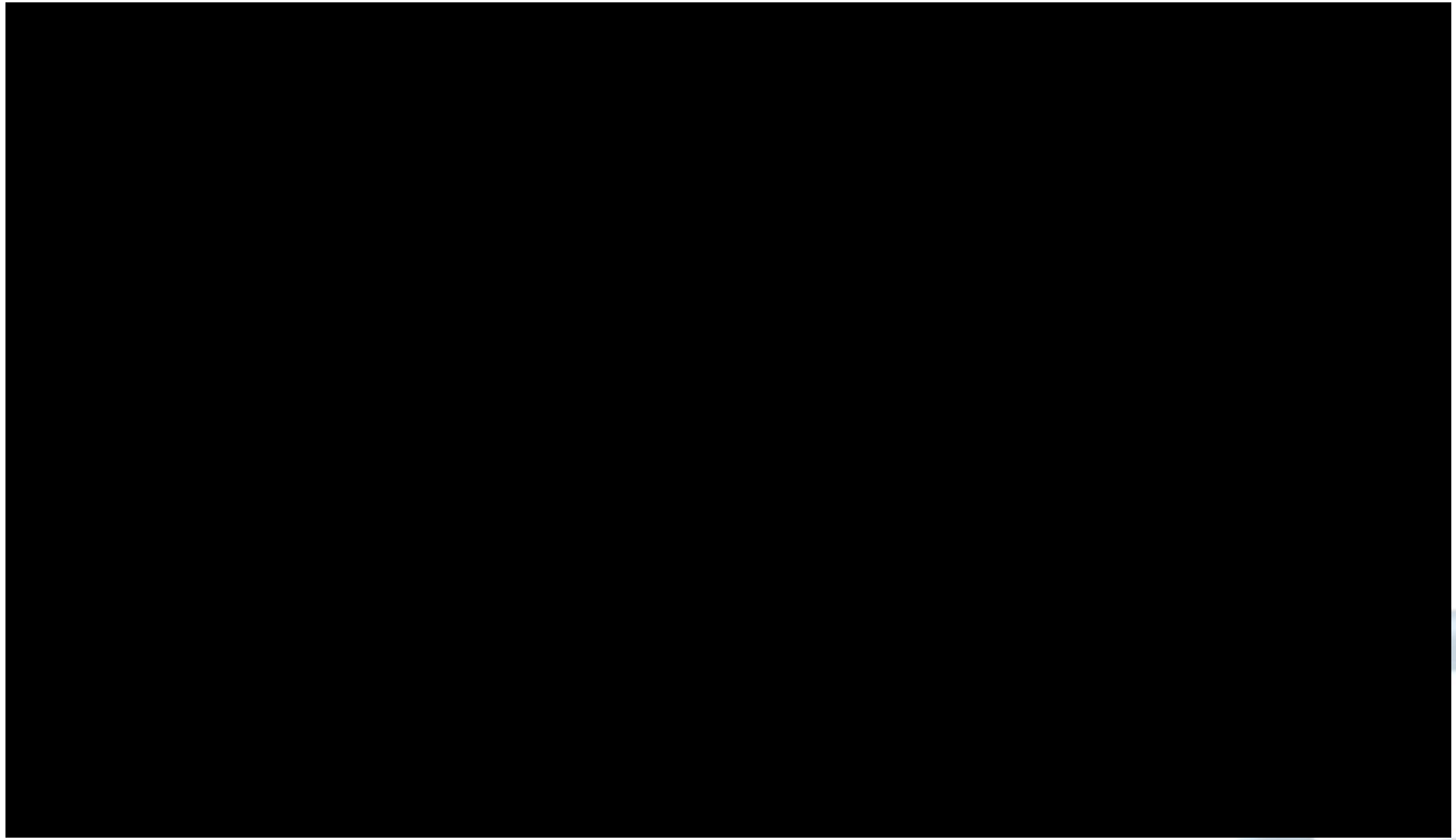
Care Management for Depression

"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

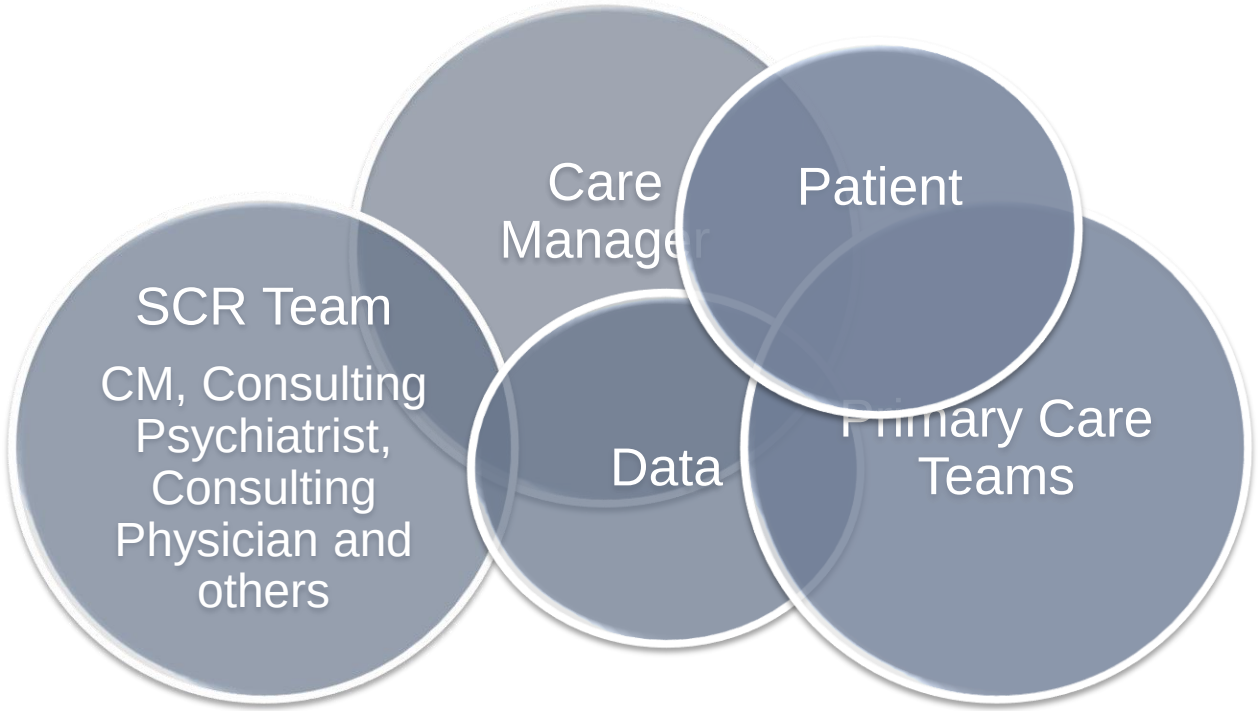
Bishop, T, Ramsay, P, et al, (March 2016). Retrieved from: https://doi.org/10.1377/hlthaff.2015.1068

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

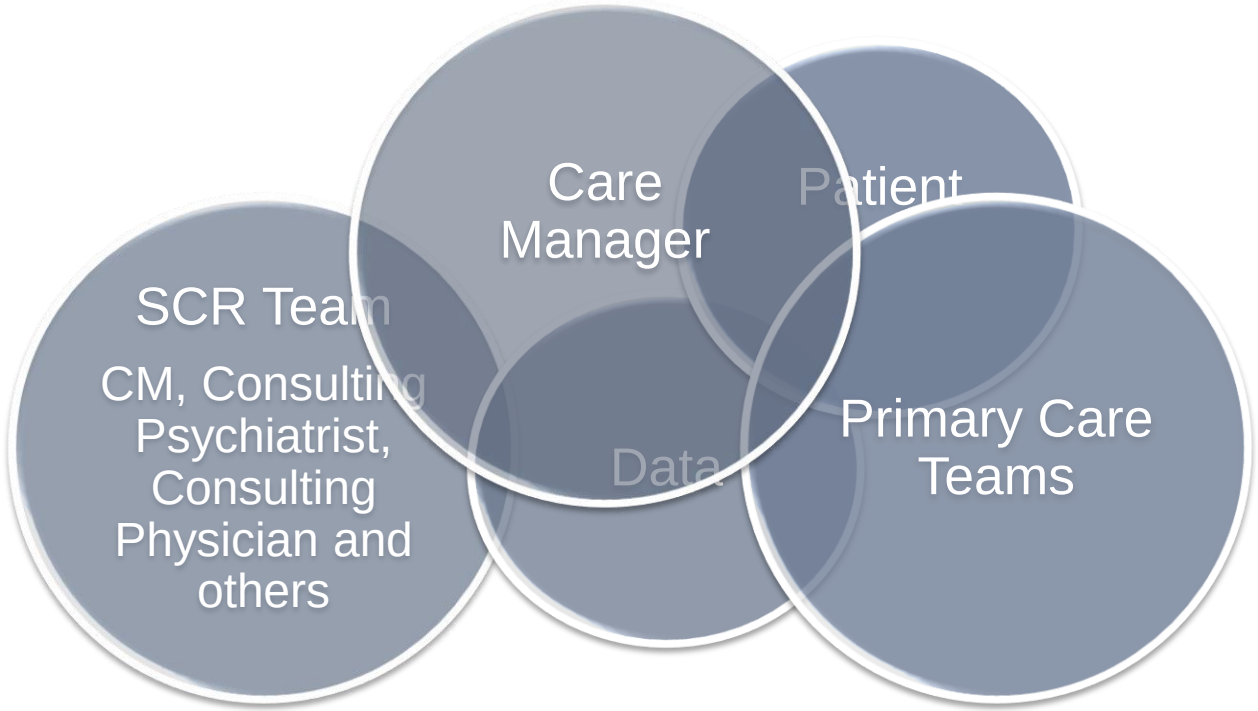


Patient

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

Collaborative Care

Roles and Responsibilities

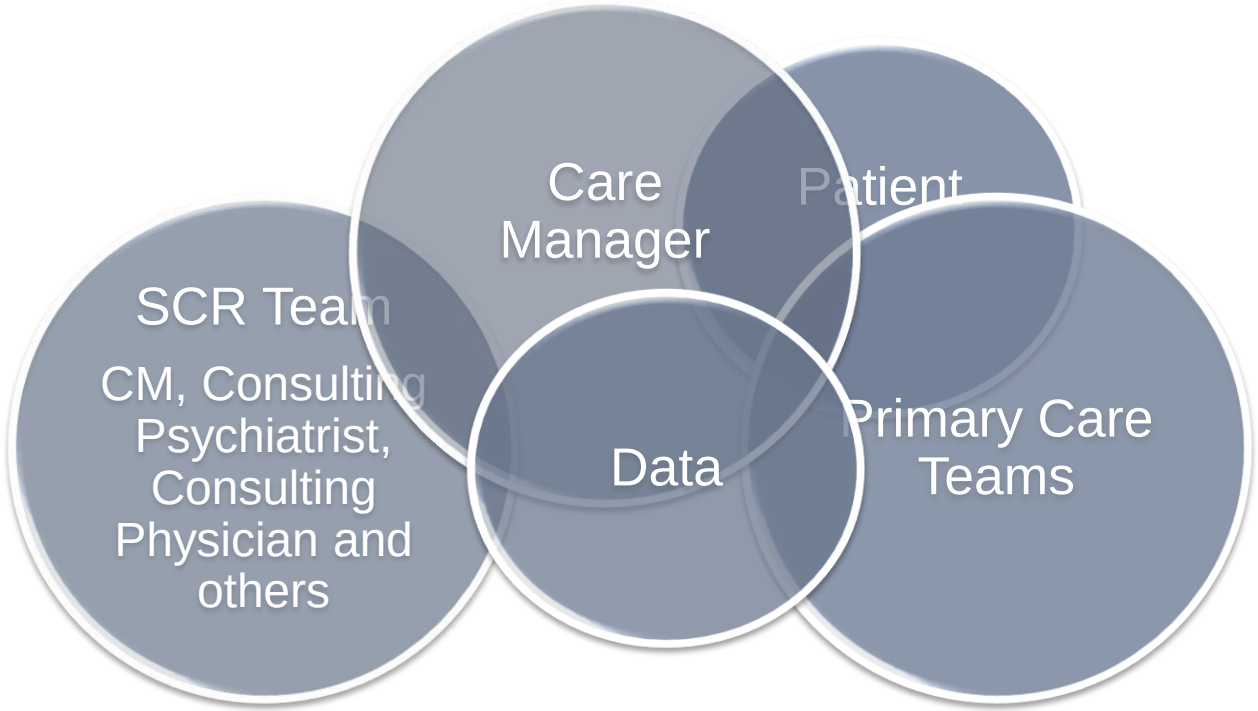


Care Manager

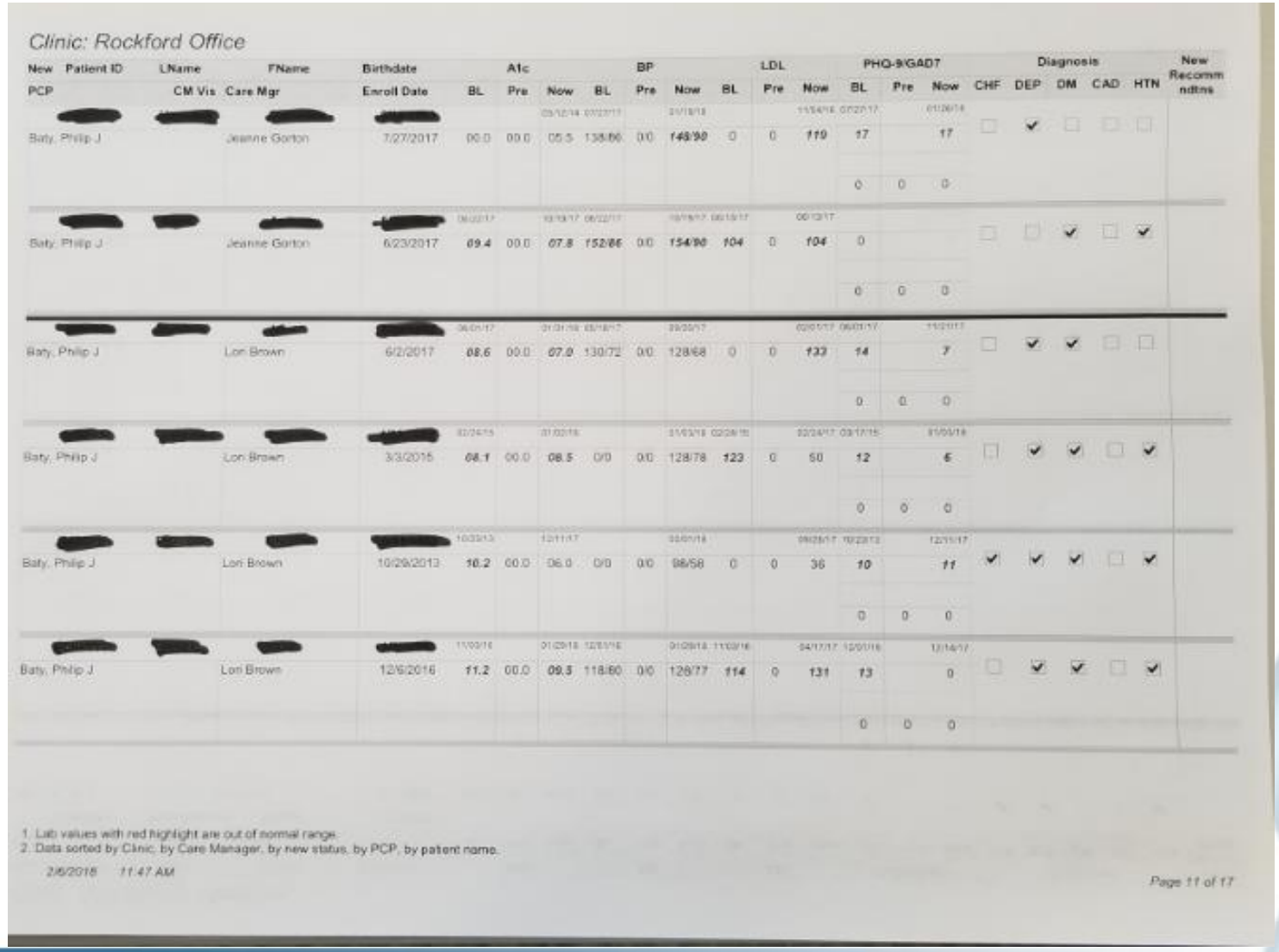
- Care Coordination
  - PCP and team
  - Systematic case review team
  - Patient
  - Ancillary staff (MSW, pharmacist)

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	A1c BL	BP Pre	BP Now	BP 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 Recommndtns
Baty, Philip J	[redacted]	[redacted]	Jeanne Gorton	7/27/2017	00.0	00.0	05.5	138/86	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	152/86	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	☐	✓	✓	☐	✓	
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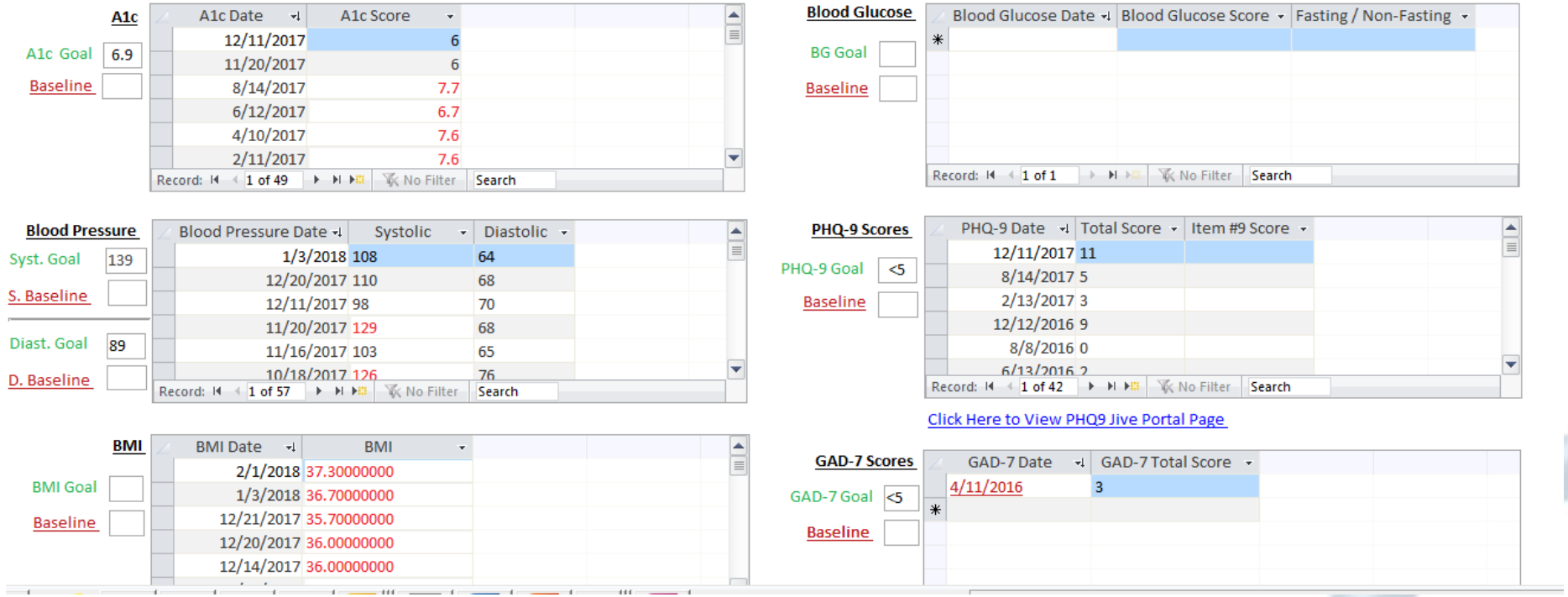
Baty, Philip J	[redacted]	[redacted]	Lori Brown	10/29/2013	10.2	00.0	06.0	0/0	0/0	98/58	0	0	36	10		11	✓	✓	✓	☐	✓	
														0	0	0						
Baty, Philip J	[redacted]	[redacted]	Lori Brown	12/6/2016	11.2	00.0	09.5	118/80	0/0	128/77	114	0	131	13		0	☐	✓	✓	☐	✓	
														0	0	0						

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

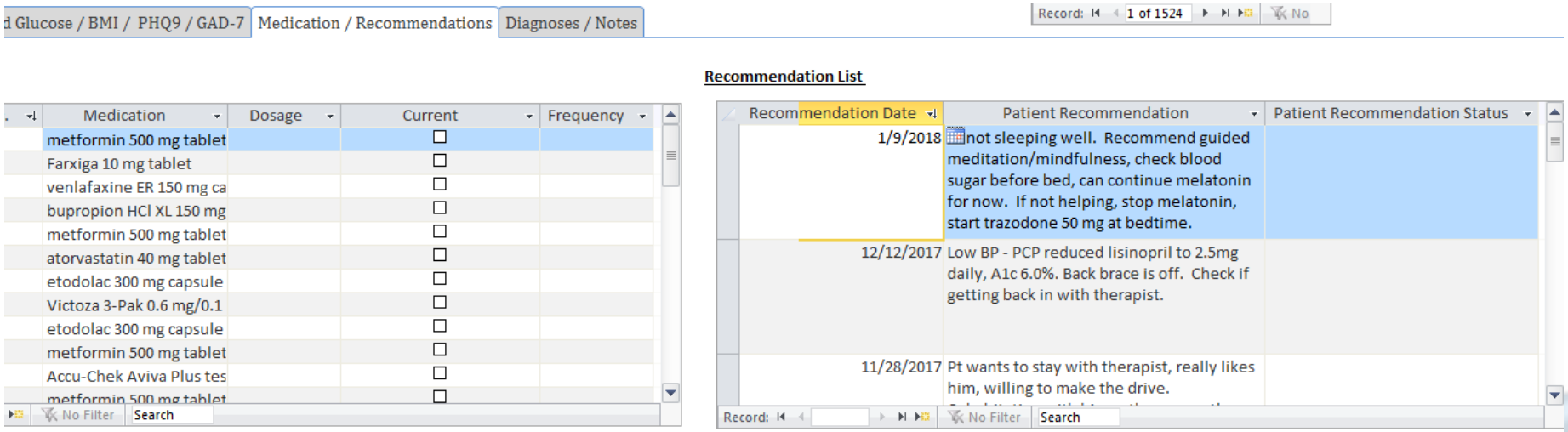
GAD-7 Scores

GAD-7 Goal <5

Baseline

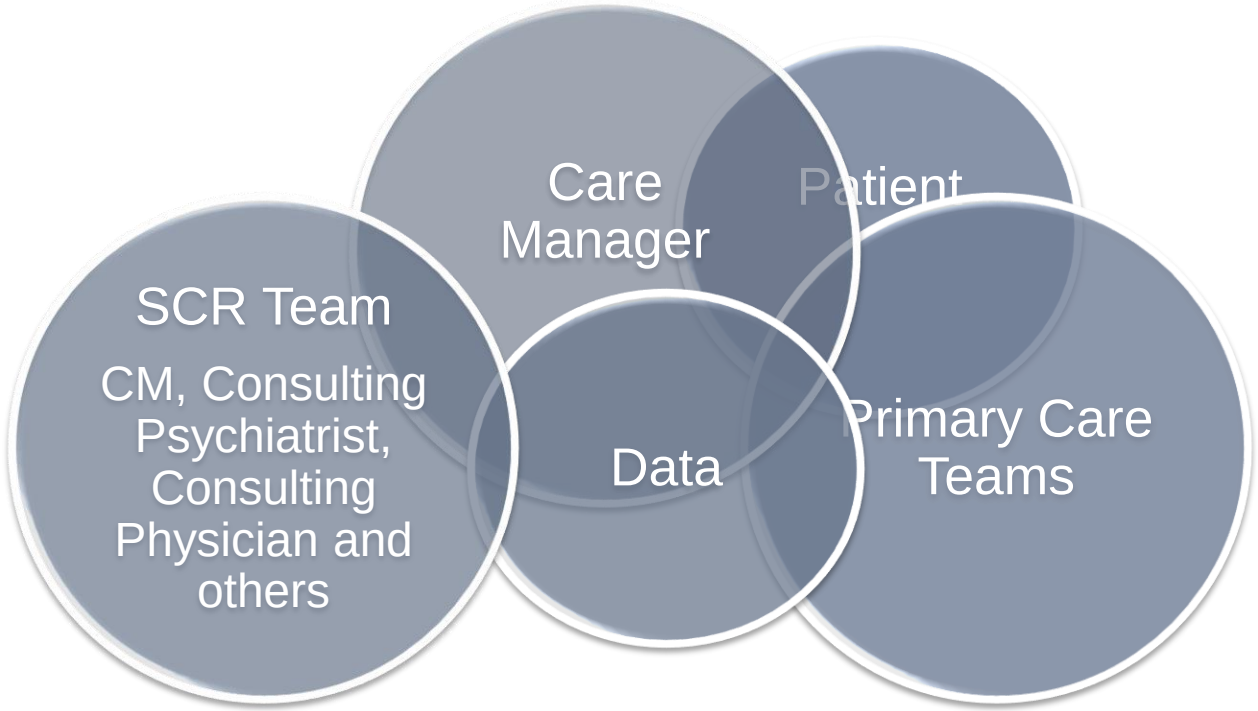
GAD-7 Date	GAD-7 Total Score
4/11/2016	3

Access Database



Collaborative Care

Roles and Responsibilities

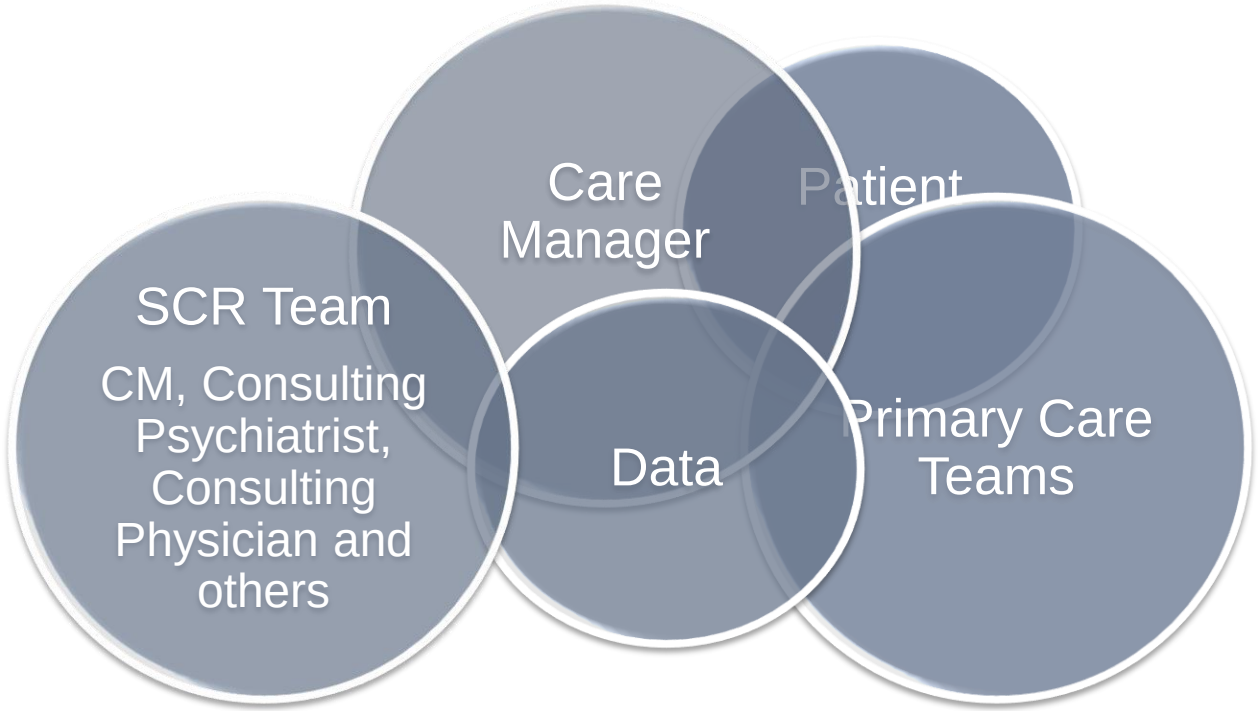


Psychiatrist Role

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

Collaborative Care

Roles and Responsibilities

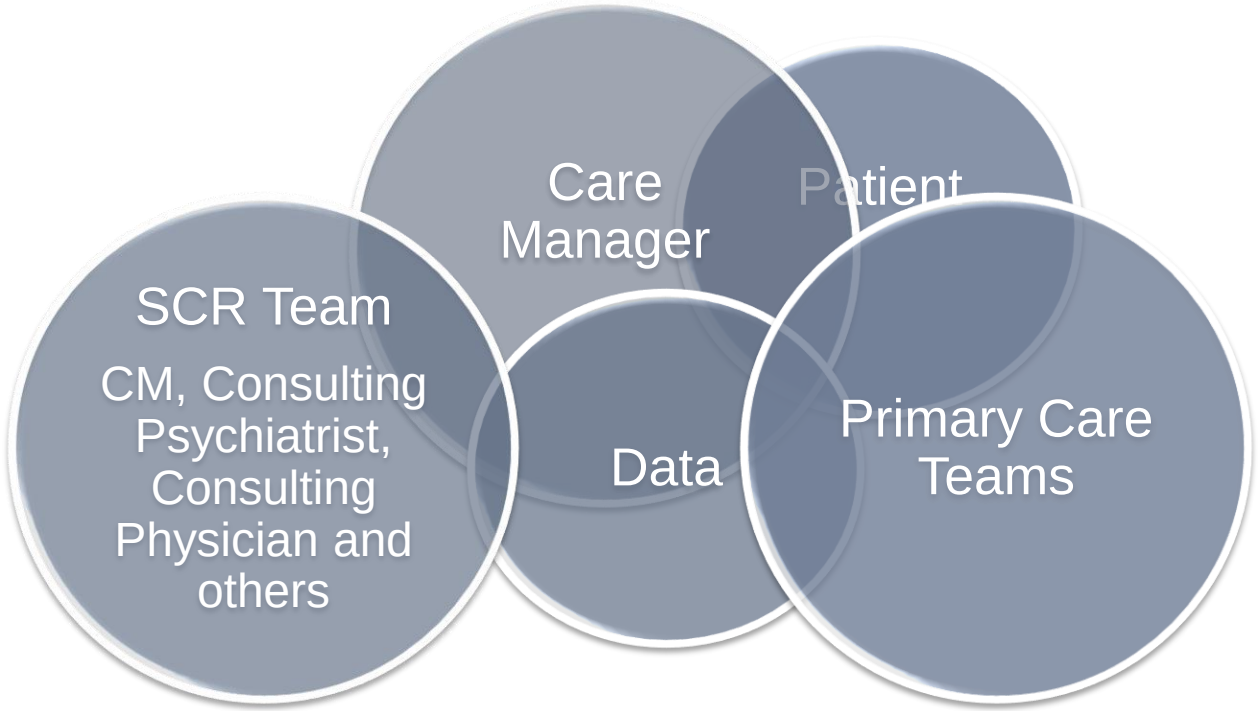


Medical Consultant

- 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



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

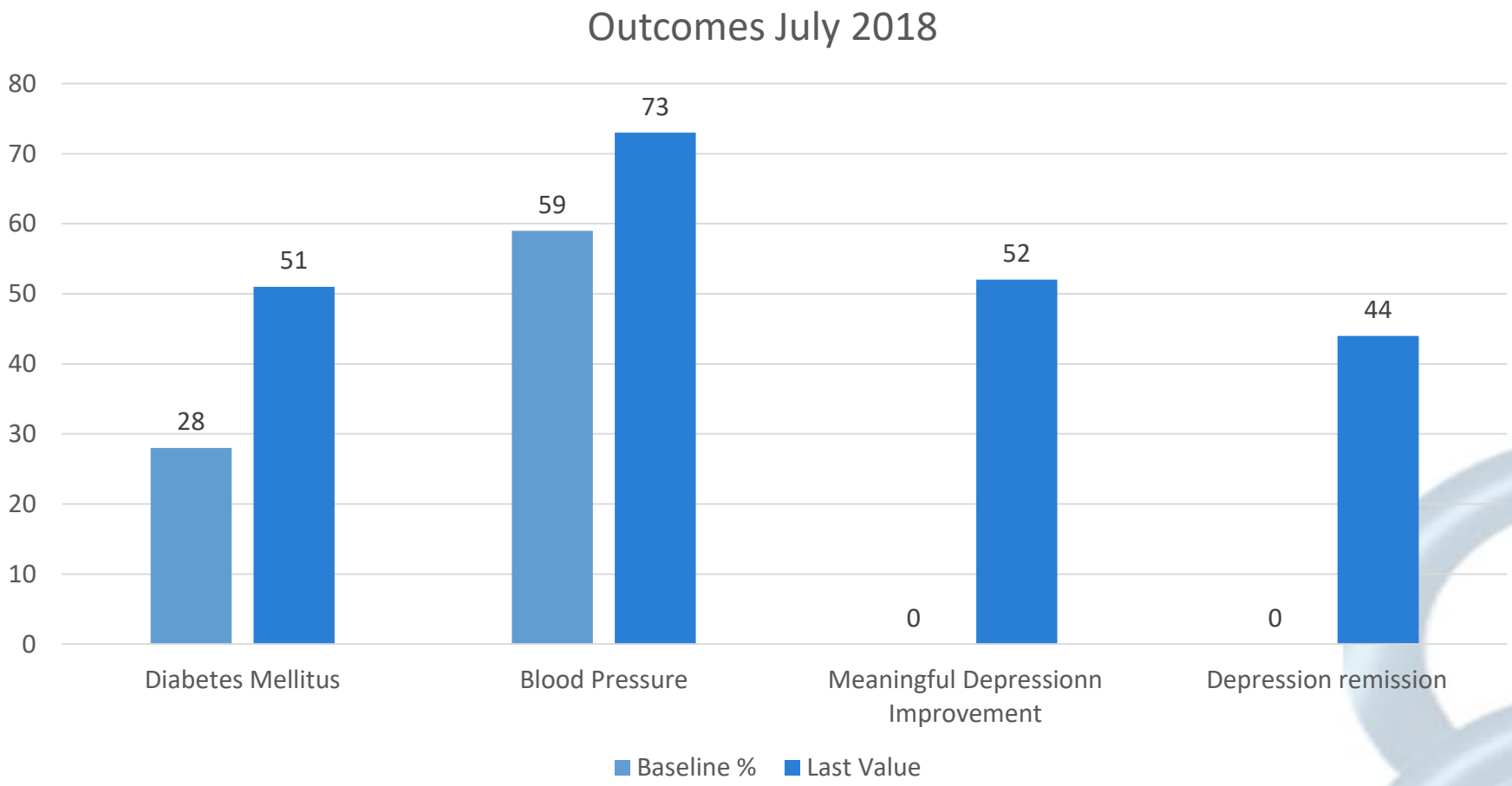
	Number of Deaths by Suicide	Rate per 100,000 Population	State Rank
Michigan	**1,364**	**13.27**	**34**
Nationally	44,695	13.42	

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

afsp.org/StateFacts

American Foundation for Suicide Prevention

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 SettingA 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

Primary Care Team

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

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

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.

"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

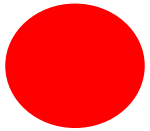
Bethany Oberhaus, RN, BSN, MBA
Lisa Nicolaou, RN, MSNI

Yellow Dot

Michigan Breakout Room

Medicaid Tracking Codes

Theresa Landfair

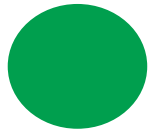


Red Dot

Superior Breakout Room

Behavioral Health

Laurisa Cummings, LMSW



Green Dot

Huron Breakout Room

Note: The colored dot on the right side of your name badge indicates the morning breakout session that you will be participating in.

Social Determinants of Health & Community Resources

Lisa Nicolaou MSNI, RN
Northern Physicians Organization
Project Manager/ Process Analyst

Beth Oberhaus MBA, RN, PMP
Wexford Physician hospital organization
Clinical Operations Director

Learning Objectives:

A look at approaches to screening, engaging patients and building strong Clinical-Community Linkages

SIM
MDHHS State Innovation Model

- Outline successful strategies for
  - SDoH screening
  - engaging patients and family
  - follow up of the linkages with community resources
- Summarize key steps for:
  - SDoH screening
  - assessing high priority needs of your practice's patient population
  - building community clinical linkages

1. Brief review of SIM structure
2. Historical barriers and Northern Michigan plan to overcome
3. Key steps and strategies for SDoH screening
4. Strategies for building Clinical-Community Linkages
5. Reinforce skills for successful change
6. How this work impacts our patients

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This will not be:

A prescribed how-to discussion

A ready made solution to be dropped into a practice

Easy

Quick

State Innovation Model (SIM)

Community Collective Action/Integration
Entire Community Health Innovation Region with shared community level goals, mutually reinforcing activities and shared accountability.

Community Sector by Social Determinant
Cross-sector and individual-sector alignment to build the infrastructure to meet the complex needs of individuals and families. *E.g. collaborative bodies, health improvement group and continuum of care.*

Organization/Agency/Provider
Organizations are effectively screening the holistic needs of all individuals and have adopted a continuous improvement work culture to remain flexible to respond to the community needs. *E.g. Schools, health department and hub.*

Individual/family
There is a Clinical Community Linkages (CCLs) framework that is coordinated across the community to screen and link individuals and families to organizations regardless of where the screening takes place.

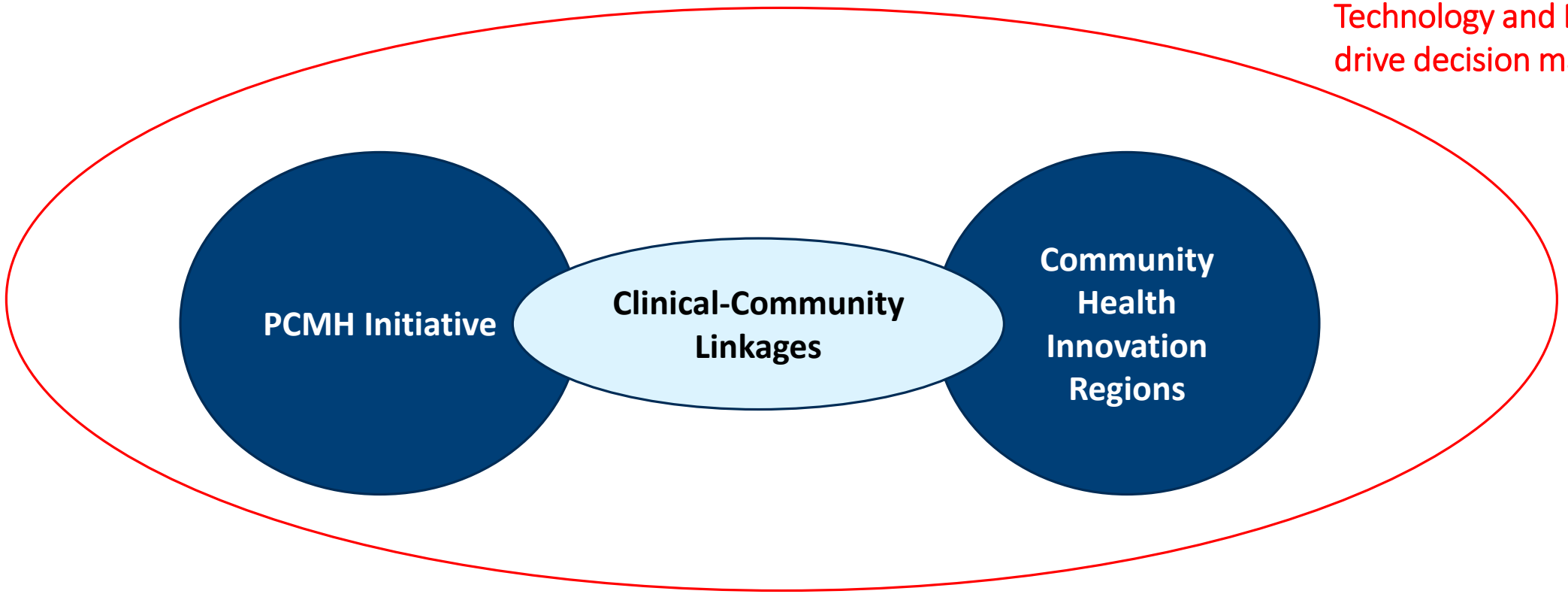
The Social Determinants of Health (SDOH) are the conditions in which people are born, grow, work, live and age, and the wider set of forces and systems shaping the condition of daily life.

Overlapping work in the Clinical-Community Linkages

Social Determinants of Health

The Social Determinants of Health are the conditions in which people are born, grow, work, live and age and the wider set of force and systems shaping the conditions of daily living.

State Innovation Model (SIM)

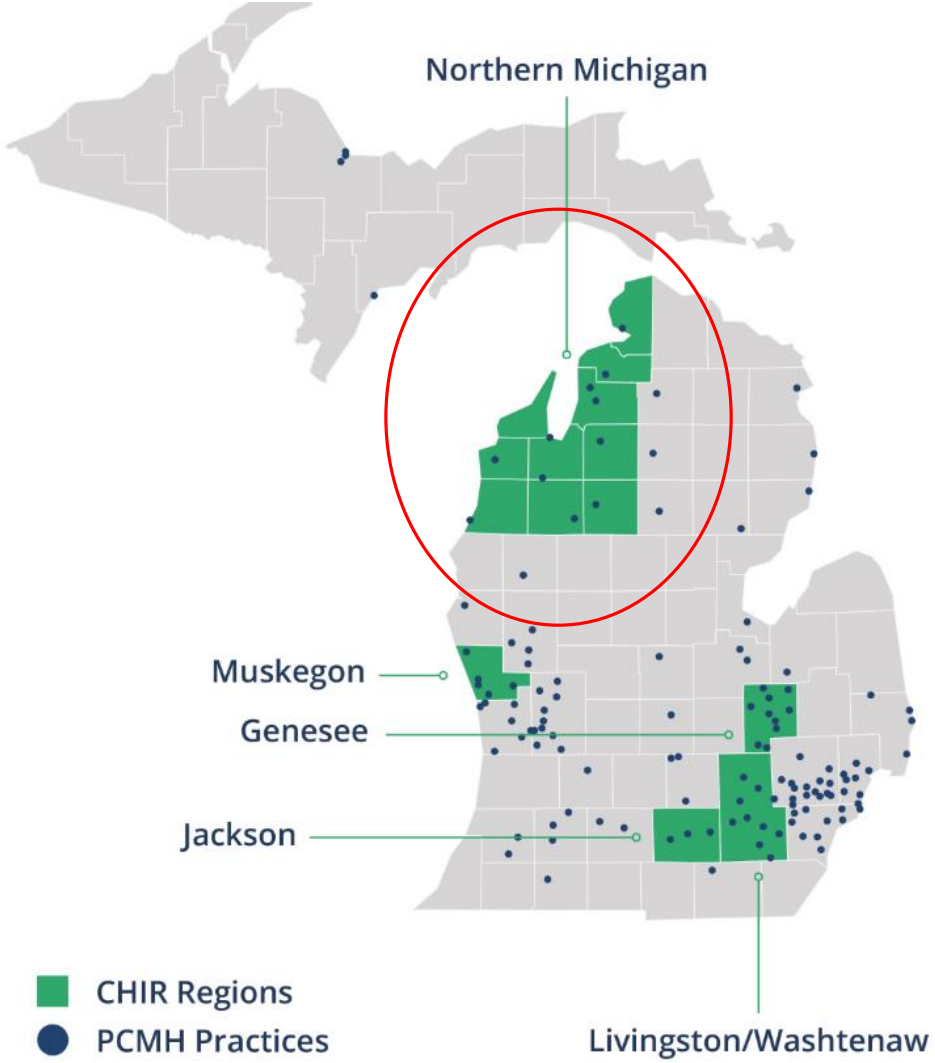


Overlapping work in the Clinical-Community Linkages

Community Health Innovation Region (CHIR)

A broad partnership of community organizations, local government agencies, business entities, healthcare providers, payers, and community members that come together to identify and implement strategies that address community priorities.

A primary goal of the CHIR initiative is to address nonmedical factors that affect health, such as housing and food insecurity, by supporting connections between primary care practices and community service providers, often referred to as clinical-community linkages.



Northern Michigan Community Health Innovation Region

Public Health Alliance acting as the Back Bone Organization

Geographic, socioeconomic and cultural diversity

Started collaborative work prior to the start of SIM

Foundation in successful elements in from the Northern region

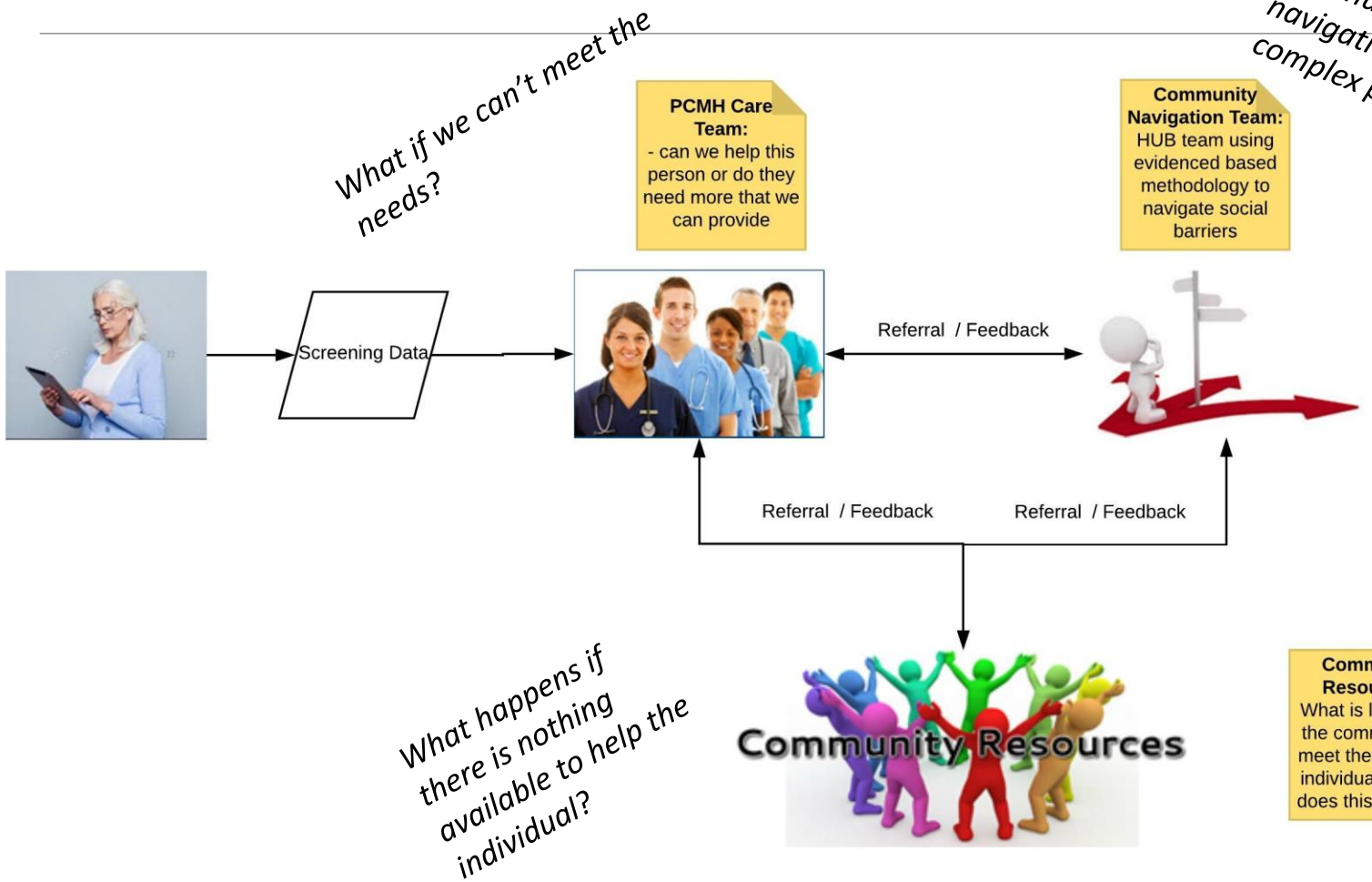
NORTHERN MICHIGAN PUBLIC HEALTH ALLIANCE

Identified barriers to addressing SDoH:

- Difficult to aggregate data
- Administrative burden overload
- No one source of truth about what community resources were available
- Required significant collaboration
- No standardized way to screen for needs
- Lack of feedback to primary care

The NMCHIR response to these barriers was to develop a regional approach based on the strengths and weaknesses identified through community discussion.

Could we find a way too…..



- Decrease administrative burden
- Promote data aggregation and use for decision making
- Not reinvent the wheel (use existing resources)
- Driven by end users
- Evidenced based navigation of complex individuals
- Move towards a standardized process without enforcing a specific process

Navigation

Some individuals will be able to successfully resolve their unmet needs independently while others will need assistance to navigate the complex web of social services

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PCMH Team Navigation:

- Care Manager, Care Coordinator
- Other staff who assist patients to locate community resources
- Work was being done in many practices before SIM
- Some practices opted to continue to screen and refer independently

Community Navigation Team:

- 5 person team (RN, SW, CHW, Coordinator, intake worker)
- Evidenced based practice using the CHAP / Pathways model
- This existed in the community on a smaller scale prior to SIM but SIM allowed the resource to expand and move towards self-sustainability
- Available to patients regardless of the way in which they were identified as having needs

Web Enabled Screening and Referral

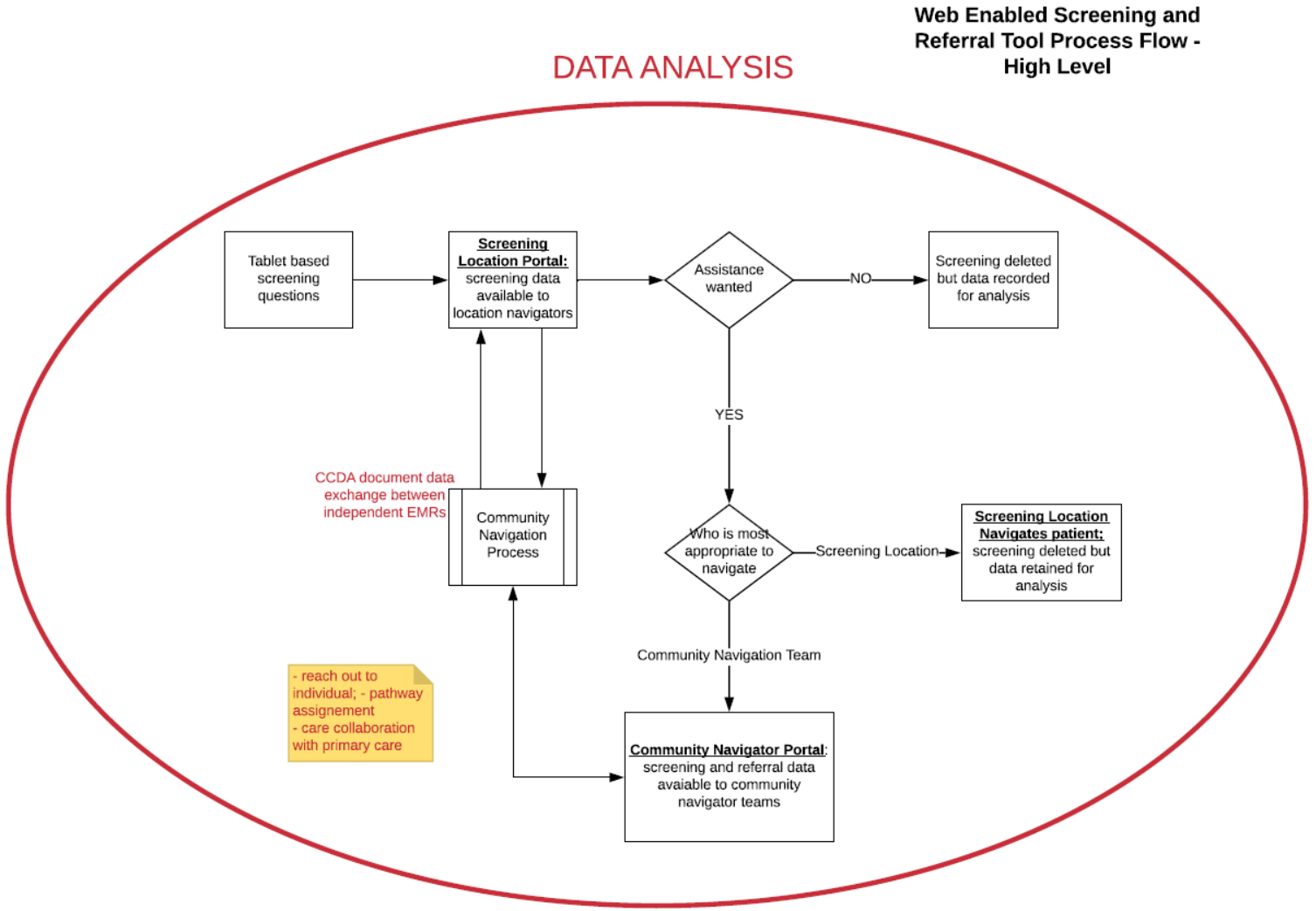
Phased approach to building the technology:

- Phased development and use of the tool
- Understand barriers from all perspectives
- End users invested in the development of the tool
- Decreased administrative burden; proactive vs. responsive

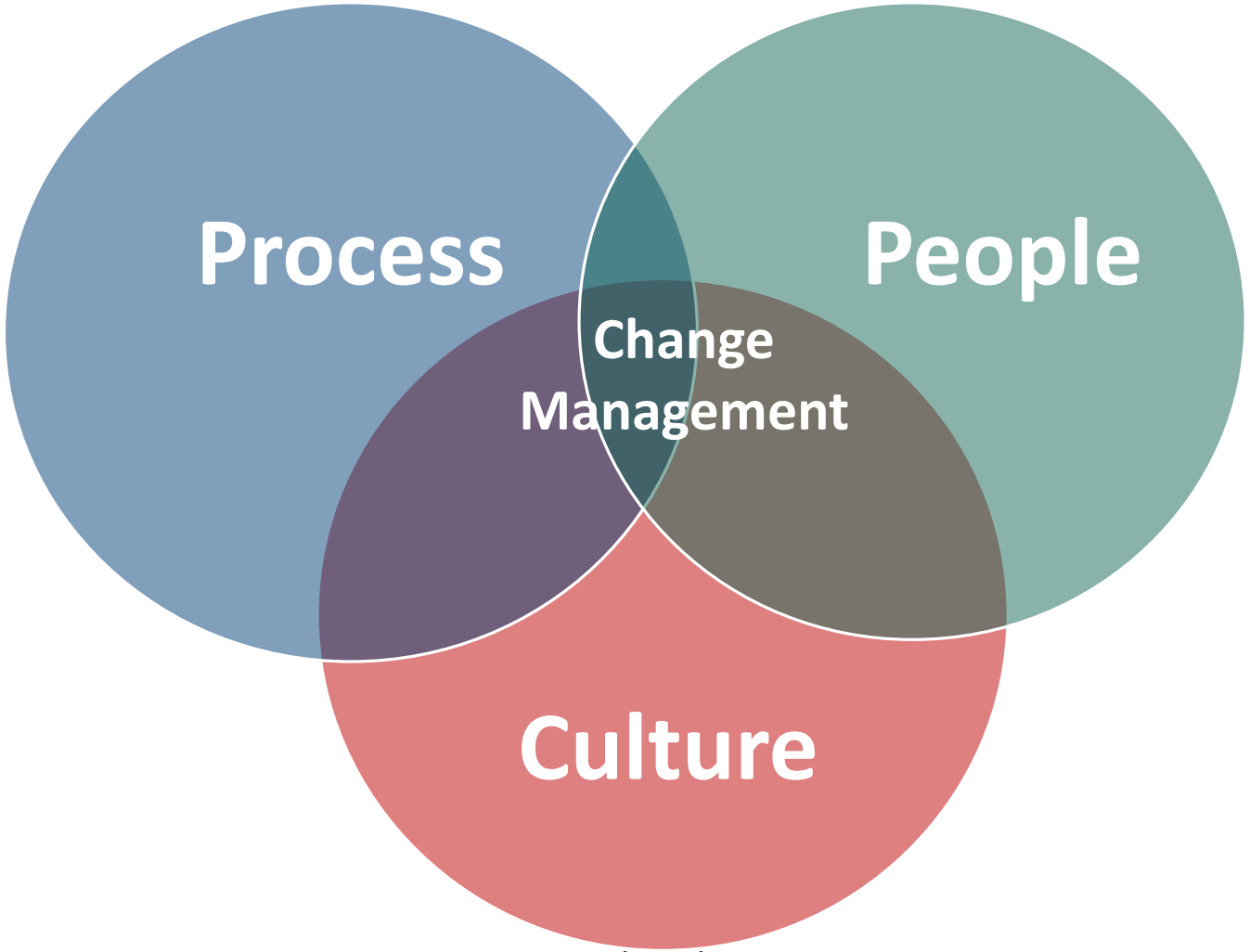
Once we know that the screenings are happening; what about care collaboration?

- Whaaaat….another separate site to log into?
  - CCDA documents (data exchange with an EMR)

Visual of NMCHIR screening process



Remember Change is Hard



Rural Approach: What separates this CHIR approach from others?

Standardized screening questions
- Improved ability to analyze and exchange data

NMCHIR convenes collaborative partners
- Create capacity for an effective regional approach
- Shared vision, collaborative/ complimentary processes

Web enabled screening process
- Easier data aggregation and analysis
- Built to accommodate growth
- SIM is a test; state looking for well developed tools to use in broader context

LEAN methodology for improvement

The Good and the Bad

PRO

- Collaborative approach to connecting to community resources
- Regional data aggregation
  - Tells the story in data; measurable
- Decreased administrative burden at the community and practice levels
  - Changes are made once and carried through the system
- Evidenced based approach to navigation

CON

- Less local control
  - Always easier to input information into an individual EMR
- Not quick to get that level of collaboration
- Large projects often have challenges in coordinating lead agencies
  - (CHIR & PCMH Initiative)
- Process improvement knowledge in the PCP offices is fundamental; building a process with outside partners
- Requires dedicated time; huddles, meetings, investment by teams

Practice Based Approach

- Why would a practice choose not to participate with the Web enabled tool?
  - Not in the CHIR region
  - Pre-existing process/ team in place
  - EMR systems and data aggregation already in place
- Questions directly in the EMR or paper based
- Screening analysis at the practice level
- First line of triage at the practice level
  - Sent on to community resources directly
  - Sent on to navigation assistance at the community level
  - Kept in practice

The Good and the Bad

PRO

- Fastest to implement
- Does not require agreement among community partners on content or process……faster
- Data resides locally
  - Changes made locally
- Full control

CON

- Data resides locally
  - Difficult to extract community data
  - Requires manipulation at the PCMH level
- Not just input but how to get data back in a meaningful way
- When changes are necessary must occur across all sites
- Easy to have other priorities distract
- Multiple communication pathways with different community resources which constantly change
- Requires constant updates to community resource information…great if 211…not great if 211 not available

Lessons Learned

"Lessons in life will be repeated until they are learned"

Frank Sonnenberg

SIM
MDHHS State Innovation Model

- One size does not fit all
- Multi dimensional problem… collaborative solution
- Who's driving the bus???
  - Need champion and change management skills to be effective long term
- Any change process requires flexibility
  - Set the expectations early and frequently
    - Build capacity for change
- Learning to manage change effectively is a huge win

Time to Think Outside the Box

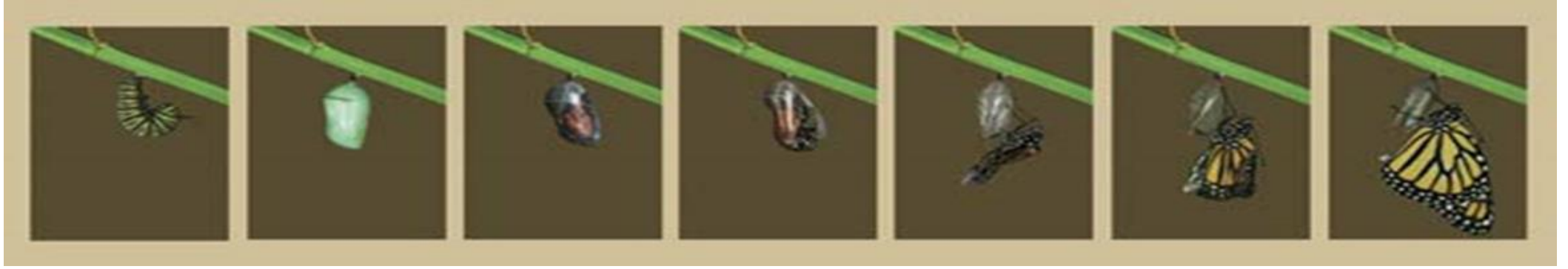
Process Improvement Principles

14 principles of the Toyota Way (Great book)

Lean Principle #4 Respect for People:

- *Standardized Work is a consistent method for performing a process developed by the people that know the processes best*
- *Have a Champion of the work (do you sense a theme here)*

Liker, J. K. (2004).



Lean Principle #5: Strive for perfection through continuous improvement:

- Standardized Work is the foundation for Continuous Improvement
  - There are many benefits of Standardized Work
  - All roads in Lean lead to Standardized Work
- Frequent short communication touchpoints (huddles) ongoing
- Support for a long while (30, 60, 90 days are basic process improvement timelines)
- Small changes not sweeping

Liker, J. K. (2004).

Best Practices for SDoH screening: Process Improvement Concepts continued

- Remember to not over analyze
  - It is going to change: decisions are good enough
- Think ahead to how you are going to measure improvement
  - Build that into the process
- Provide analytics from the beginning
  - Screening rates
  - Conversion rates
- Takes time to understand what other organizations in the process bring to the table (regional work)
  - These community partners have not always worked together
  - May not understand what each other really do

TIPS:

Improvement strategies for PCMH staff

- Introduction/ Scripting
  - Key understanding of why assessing these needs relates to the practice of health care
  - How identifying these needs can assist people in becoming healthier
- Screening via tablet or paper? Pick one
  - Be open to the other
- Follow up on the screenings at the time of the visit
  - Takes time to make this happen
  - Widening the team
  - Slow steady changes that are managed vs. abrupt change process
- Assess PCMH practice's experience with locating and making clinical community linkages
  - Recognize and identify areas in which community resources are not in place to meet the needs of patients. It takes time, resources and community changes to address areas of unmet need

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TIPS:

Engaging Patients and Families

- Patients understand why screenings are happening at the practice level
  - Team needs to understand not just what to do but why
  - Shared value
- Layers of decision making
  - Clear role definition at all levels
- Motivational Interviewing skill
  - Scripting
  - See clear roles
- Standardized processes
  - Documented process
- Team attention to drive the project forward
  - Must have clear leadership and support of the providers

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TIPS: Follow-up on Community Linkages

Is there a perfect world?

Plato

SIM
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- Navigation at the PCMH
  - Established well rounded teams
  - CHW, MSW, RN, teams established to deal with the complex patient needs internally (FQHC, RHC)
- Minimal resources currently available in practice
  - Depending on CM / Care coordination teams (RN, LPN, MA)
  - Likely full panels of patients looking more at TOC, Chronic disease, ACP, Multiple complex diseases – more medical need vs. SDoH needs
  - Learning curve much higher when SDoH is not primary focus
- Navigation by partner navigators
  - Whether you participate with the HUB teams or not, PCMH can't do this alone
- In a perfect world
  - Shared roles and communication (housing issue)

TIPS:

Assessing High Priority Needs of Populations

- You know your patient population best
  - What needs are highest and impact care most
- What about the patients that your practice rarely sees
  - How to close the gap
  - Bring patients back to primary care foundation
- Annual visits but then expanding
  - TOC visits
  - Care management appointments
  - Follow up chronic disease visit
  - New diagnosis visits
  - Has to be a plan to how to assess

SIM
MDHHS State Innovation Model


SUCCESS
Because you too can own this face of pure accomplishment

References:

Kub, J.E., Kulbok, P.A., Miner, S. & Merrill, J.A. (2017, September - October). Increasing the capacity of public health nursing to strengthen the public health infrastructure and to promote and protect the health of communities and populations. *Nursing Outlook*, 65(5), 661-664.

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Liker, J. K. (2004). *The Toyota Way: 14 Management Principles from the World's Greatest Manufacturer*. Madison, Wisconsin: CWL Publishing Enterprises

Reid, R.J, & Larson, E.B. (2012, July 27). Improvement happens: Doctors talk about the medical home, an interview with Charles Mayer, MD, MPH and Eric Seaver, MD. *Journal of General Internal Medicine*, 27(7), 871-875.

Suneja, A., & Suneja, C. (2010). *Lean Doctors: A Bold and Practical Guide to Using Lean Principles to Transform Healthcare Systems, One Doctor at a Time.* Milwaukee, Wisconsin: Quality Press

Medicaid Tracking Codes

THERESA LANDFAIR
PROGRAM SPECIALIST
MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES (MDHHS)

Care Management and Coordination:
2018 Tracking Codes

- The PCMH Initiative requires all participating practices to track Care Management and Coordination Service provision using a designated set of Healthcare Common Procedure Coding System (HCPCS) and the American Medical Association's Current Procedural Terminology (CPT) codes.

New codes added for 2018:
Could bill these codes as of 1/1/2018

Code	Quick Description
G9001	Comprehensive Assessment
G9002	In-person Encounter
98966, 98967, 98968	Telephone Services
99495, 99496	Care Transition
G9007	Team Conference
G9008	Physician Coordinated Care Oversight Services
98961, 98962	Group Education and Training
S0257	End of Life Counseling

SIM PCMH Initiative:
Why do we use the CMCC Tracking Codes

1. Submission of the Care Management and Coordination service claims supports one of the SIM PCMH Initiative Care Management and Coordination Metrics:

$$\frac{\text{Any patient who has had a claim with one of the applicable codes during the reporting period}}{\text{Eligible Population}}$$

2. Regular claims submission supports more than the SIM PCMH Initiative!
   - Shows the value of a Patient Centered Medical Home to Medicaid beneficiaries
   - Shows the value of provider delivered care management and coordination to Medicaid beneficiaries

SIM PCMH Initiative:
General Conditions for Tracking Code Use

For SIM PCMH Initiative Care Management and Coordination services to be tracked within the Initiative, the following applies:

- The patient must be within the SIM PCMH Initiative Eligible Population.
- Services must ordered by a Primary Care Provider within the approved practice; a note indicating these services were ordered must be in the medical record.
- Services performed must be based on patient need
- Service is performed by the appropriate qualified, non-physician health care professional employed or contracted with the approved practice or PO
- Billed to participating Medicaid Managed Care Organizations in accordance with Medicaid billing guidelines
- **There is no cost share (copay, coinsurance or deductible) for Care Management and Coordination services.**

SIM PCMH Initiative:
Eligible Patient Population

A Medicaid beneficiary must have full Medicaid coverage and be served through a Medicaid managed care organization (Medicaid Health Plan) to be attributed to a participating practice and provider within the SIM PCMH Initiative:

Included Benefit Plans:	
BMP	Benefits Monitoring Program
MA-HMP-MC	Healthy Michigan Plan – Managed Care
MA-MC	Medicaid – Managed Care
TCMF	Targeted Care Management Flint

A patient's eligibility can be verified on both the PCMH Patient Lists produced by the Michigan Data Collaborative on a monthly basis, or by checking the Community Health Automated Medicaid Processing System (CHAMPS).

Care Management and Coordination:

General Service Documentation Requirements

All Services rendered should be documented in electronic Care Management and Coordination Documentations Tools (either a stand alone product or component of EHR), with information accessible to all care team members at the point of care.

Documentation should, at a minimum, include the following:

- Date of Contact*
- Duration of Contact
- Method of Contact
- Name(s) of Care Team Member(s) Involved in Service
- Nature of the discussion and pertinent details regarding updates on patient's condition, needs, progress related to care plan with goals and target dates

** Date of service reported should be the date the care management and coordination service took place. In some cases, a service may take place over the course of more than one day, in such an event the date of service reported should be the date the service was completed*

Current Status Update

As of October 2018, all PO's and practices should be submitting the tracking codes to the Medicaid health plans.

Here are some helpful hints for when problems arise:

- What to do when patient lists do not match the population you are treating.
- Who to contact when your claims aren't reflected in CHAMPS.
- When to contact the SIM Initiative for assistance.

What to do when patient lists do not match the population you are treating

We have had concerns expressed by providers that patient lists do correctly reflect the patient panel of their practice.

- It has taken considerable effort to correct the inaccuracies.
- We are now requesting that you immediately contact the health plan when discrepancies are noticed to ensure corrections are made immediately.
- For that reason, the lists need to be checked monthly by the practice.

Who to contact when your claims aren't reflected in CHAMPS

If after 60 days past the date of your clean claim adjudication you are unable to see your claim in CHAMPS, contact your health plan representative.

When to contact the SIM initiative for assistance

When issues arise regarding your patient lists or tracking claims are not resolved in a timely fashion, contact the SIM Initiative and state staff will contact the practice and health plan.

Additional Questions and Resources

MDHHS-SIMPCMH@michigan.gov

SIM Care Delivery Webpage

SIM
MDHHS State Innovation Model

Theresa Landfair,
Specialist, Managed Care Plan Division
Medical Services Administration

Katie Commey, MPH
SIM Care Delivery Lead
Policy, Planning, and Legislative Services Administration

Laura Kilfoyle, MPA
SIM Care Delivery Coordinator
Policy, Planning, and Legislative Services Administration

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

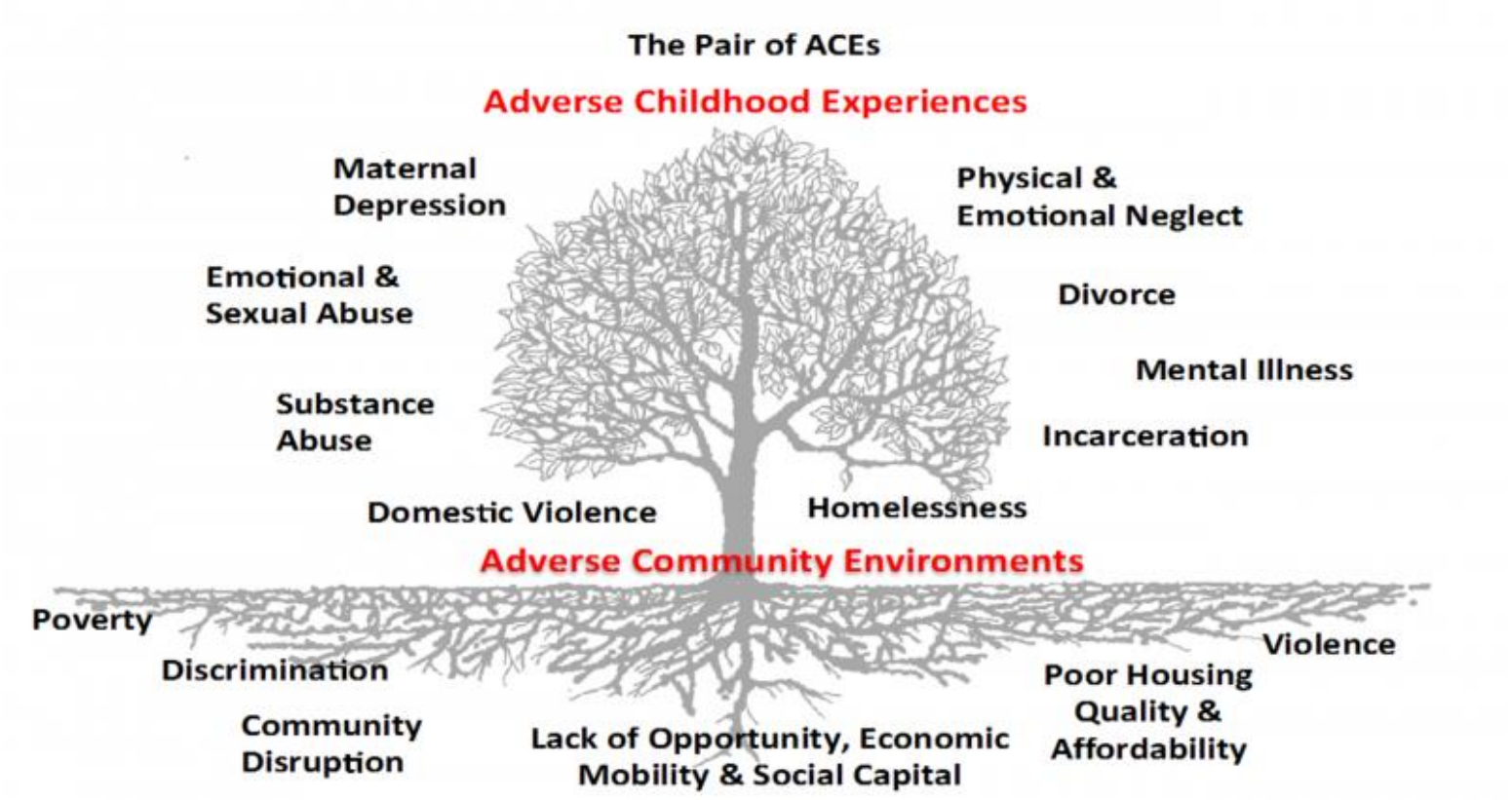
- Healthcare
  - In the past month, did poor health keep you from doing your usual activities, like work, school or a hobby?
  - In the past year, was there a time when you needed to see a doctor but could not because it cost too much?
- Food
  - In the past year, did you ever eat less than you needed 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

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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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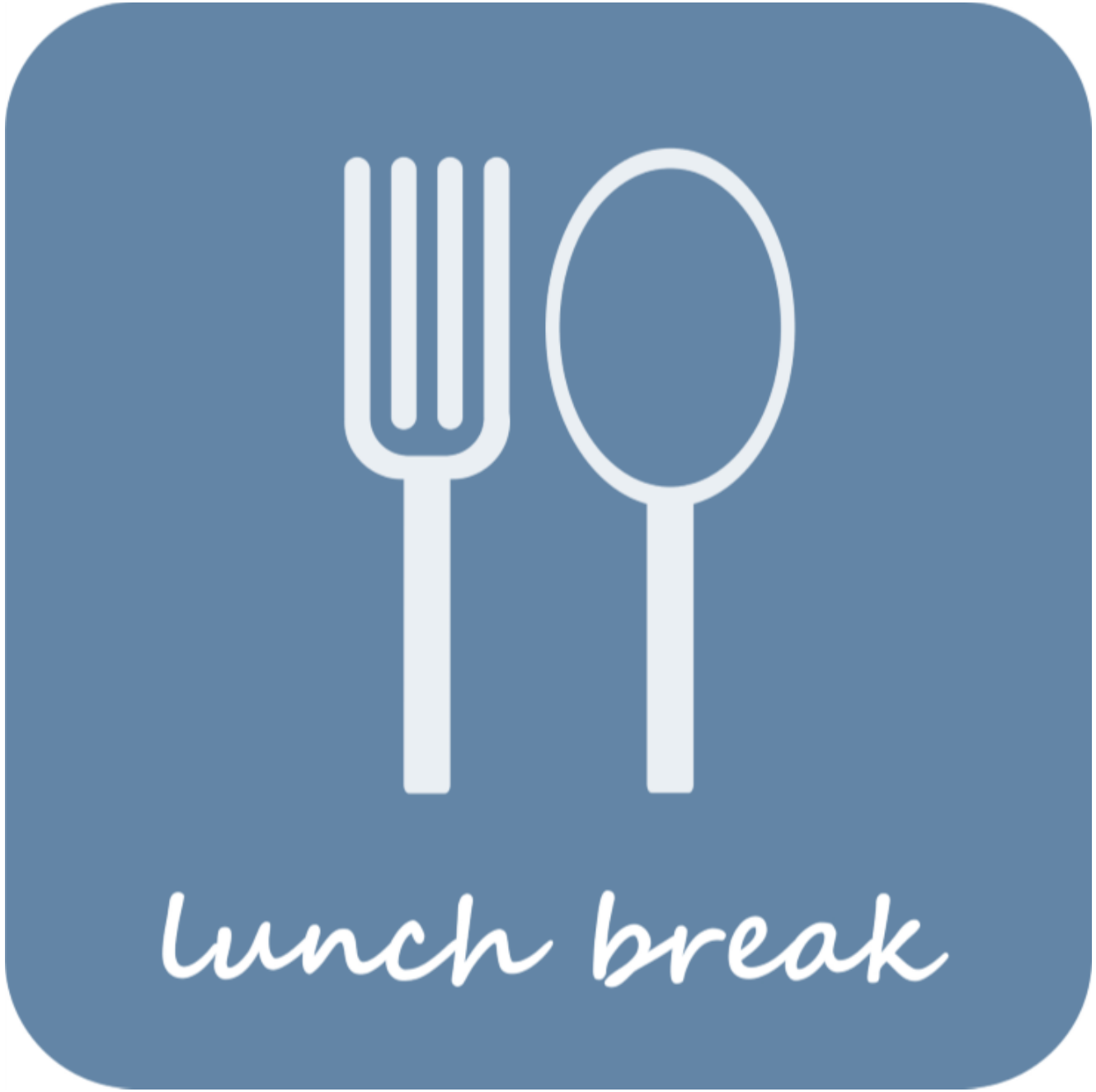
12:00 - 12:45 PM

LUNCH

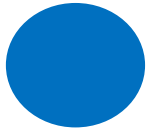
SIM
MDHHS State
Innovation Model



5:00

Concurrent Breakout Sessions
12:45 - 2:00

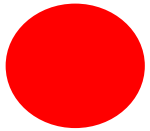
Practice Workflow for Target Populations
Bethany Oberhaus, RN, BSN, MBA
Matthew Hutchinson BSN, RN, PCCN
Lisa White MHA, MSN, RN



Blue Dot

Michigan Breakout Room

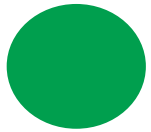
Medicaid Tracking Codes
Theresa Landfair



Red Dot

Superior Breakout Room

Behavioral Health
Laurisa Cummings, LMSW



Green Dot

Huron Breakout Room

Note: The colored dot on the left side of your name badge indicates the afternoon breakout session that you will be participating in.

Practice Workflow for Target Populations

MATTHEW HUTCHINSON BSN, RN, PCCN
DIABETES EDUCATION PROGRAM LEAD
MUNSON HEALTHCARE CADILLAC

BETHANY OBERHAUS MBA, RN
CLINICAL OPERATIONS DIRECTOR
WEXFORD CRAWFORD PHYSICIAN HOSPITAL ORGANIZATION

LISA WHITE MHA, MSN, RN
DIRECTOR OF HOME CARE
MUNSON HEALTHCARE

Learning Objective

Describe workflow for a specific patient population, using standing orders, standard activity guides, and/or protocols for two or more team members

Agenda

Describe work flow for a specific patient population

Discuss key community partners and out of the box thinking

Explain utilization of standard orders, standard education pathways across different team members outside the walls of the PCMH

Community Partners are Vital

- Expands expertise
- Gets the right care to the right patient at the right time
- We are better together

Patient Focused Approach to Diabetes Education

THE PERFECT STORM

History

Traditional Diabetic Education program

Group focus

Small number of patients touched

- 5-7% of DM access their DSME benefit

One learning style

Sustainability issues

Care Management developing

Motivational interviewing

Capacity issues

- PCMH CM are busy seeing the most complex patients
- Need support to better manage “moderate” patients with DM

Physician Hospital Organization - Hospital Diabetes Education Partnership

- Planning process
  - Community committee
  - New Certified Diabetes Educator (CDE) - grow our own
    - Partnership with Munson
- Collaboration with PCP care managers and office staff
  - Pilot with 2 practices
  - CDE dual role as Complex Care Manager
  - Billing issues with FQHC and RHC added complexity
  - Separating facility from CM codes
    - Partnership with Physician Hospital Organization to allow deeper development with PCP and CM
  - Shared Care Plan
    - Real time engagement with PCP
- Addition of tele-health
  - More patient centered
  - 5-7% of DM access their Diabetes Self Management Education benefit

Process

- All patients receive initial Face to face
  - Develop patient center care plan (review to maximize insurance options)
    - Referral form changed to give CDE flexibility without needed additions process for provider
    - Increased bi-directional communication with PCP
- Success Story

Key Concepts

- Diabetes Self-Management Education and Support (the new S is for Support)
  - Support and relationship is the driving focus
  - In the relationship is where change happens
    - Understanding patients goals and barriers and finding creative solutions to engagement
- These are key concepts in CM now being applied to Diabetes Self-Management Education and Support
  - This points to on going changes to how Diabetes education programs will be developing and reimbursed for

Next Steps: Technology

- Allows for increased engagement
- Meeting patients where they are at
  - Less time off work
- In the future text reminders and questionnaires so we reach out when patients need it

Partnership Approach to Chronic Obstructive Pulmonary Disease (COPD)

TAKING TECHNOLOGY TO THE NEXT LEVEL

History

- Developed partnership with Home Care and Physician Hospital Organization
- Shared data drivers
  - Readmission rates for COPD patients were poor
- Care Managers in community maxed out with complex patients
  - No need for competition on who was going to manage patients

Collaborative Approach

- Home Care
- Hospital Discharge planning
- Transitions of Care Nurse
- Physician Hospital Organization
- Pulmonary Rehab
- Hospitalists
- Palliative Care Physician

Build Rescue Kit

- Started with PCP (several years ago)
  - Without a lot of buy in
- Reintroduced with support from Home Care and Palliative Care Provider
  - Brought to Hospitalists
  - Orders to start from IP discharge

Add Technology

- Home Care pilot in Cadillac
- Utilize data to identify core group of patients based on
  - Home care utilization
  - Number of hospital stays
  - Access to Physician Hospital Organization CM

Lessons Learned

- Implement LEAN process improvement
- Follow up regularly to keep project going
- Get provider feed back
- Don’t give up
- Still learning…

References

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Medicaid Tracking Codes

THERESA LANDFAIR
PROGRAM SPECIALIST
MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES (MDHHS)

Care Management and Coordination:
2018 Tracking Codes

- The PCMH Initiative requires all participating practices to track Care Management and Coordination Service provision using a designated set of Healthcare Common Procedure Coding System (HCPCS) and the American Medical Association's Current Procedural Terminology (CPT) codes.

New codes added for 2018:
Could bill these codes as of 1/1/2018

Code	Quick Description
G9001	Comprehensive Assessment
G9002	In-person Encounter
98966, 98967, 98968	Telephone Services
99495, 99496	Care Transition
G9007	Team Conference
G9008	Physician Coordinated Care Oversight Services
98961, 98962	Group Education and Training
S0257	End of Life Counseling

SIM PCMH Initiative:
Why do we use the CMCC Tracking Codes

1. Submission of the Care Management and Coordination service claims supports one of the SIM PCMH Initiative Care Management and Coordination Metrics:

$$\frac{\text{Any patient who has had a claim with one of the applicable codes during the reporting period}}{\text{Eligible Population}}$$

2. Regular claims submission supports more than the SIM PCMH Initiative!
   - Shows the value of a Patient Centered Medical Home to Medicaid beneficiaries
   - Shows the value of provider delivered care management and coordination to Medicaid beneficiaries

SIM PCMH Initiative:
General Conditions for Tracking Code Use

For SIM PCMH Initiative Care Management and Coordination services to be tracked within the Initiative, the following applies:

- The patient must be within the SIM PCMH Initiative Eligible Population.
- Services must ordered by a Primary Care Provider within the approved practice; a note indicating these services were ordered must be in the medical record.
- Services performed must be based on patient need
- Service is performed by the appropriate qualified, non-physician health care professional employed or contracted with the approved practice or PO
- Billed to participating Medicaid Managed Care Organizations in accordance with Medicaid billing guidelines
- **There is no cost share (copay, coinsurance or deductible) for Care Management and Coordination services.**

SIM PCMH Initiative:
Eligible Patient Population

A Medicaid beneficiary must have full Medicaid coverage and be served through a Medicaid managed care organization (Medicaid Health Plan) to be attributed to a participating practice and provider within the SIM PCMH Initiative:

Included Benefit Plans:	
BMP	Benefits Monitoring Program
MA-HMP-MC	Healthy Michigan Plan – Managed Care
MA-MC	Medicaid – Managed Care
TCMF	Targeted Care Management Flint

A patient's eligibility can be verified on both the PCMH Patient Lists produced by the Michigan Data Collaborative on a monthly basis, or by checking the Community Health Automated Medicaid Processing System (CHAMPS).

Care Management and Coordination:

General Service Documentation Requirements

All Services rendered should be documented in electronic Care Management and Coordination Documentations Tools (either a stand alone product or component of EHR), with information accessible to all care team members at the point of care.

Documentation should, at a minimum, include the following:

- Date of Contact*
- Duration of Contact
- Method of Contact
- Name(s) of Care Team Member(s) Involved in Service
- Nature of the discussion and pertinent details regarding updates on patient's condition, needs, progress related to care plan with goals and target dates

** Date of service reported should be the date the care management and coordination service took place. In some cases, a service may take place over the course of more than one day, in such an event the date of service reported should be the date the service was completed*

Current Status Update

As of October 2018, all PO's and practices should be submitting the tracking codes to the Medicaid health plans.

Here are some helpful hints for when problems arise:

- What to do when patient lists do not match the population you are treating.
- Who to contact when your claims aren't reflected in CHAMPS.
- When to contact the SIM Initiative for assistance.

What to do when patient lists do not match the population you are treating

We have had concerns expressed by providers that patient lists do correctly reflect the patient panel of their practice.

- It has taken considerable effort to correct the inaccuracies.
- We are now requesting that you immediately contact the health plan when discrepancies are noticed to ensure corrections are made immediately.
- For that reason, the lists need to be checked monthly by the practice.

Who to contact when your claims aren't reflected in CHAMPS

If after 60 days past the date of your clean claim adjudication you are unable to see your claim in CHAMPS, contact your health plan representative.

When to contact the SIM initiative for assistance

When issues arise regarding your patient lists or tracking claims are not resolved in a timely fashion, contact the SIM Initiative and state staff will contact the practice and health plan.

Additional Questions and Resources

MDHHS-SIMPCMH@michigan.gov

SIM Care Delivery Webpage

SIM
MDHHS State Innovation Model

Theresa Landfair,
Specialist, Managed Care Plan Division
Medical Services Administration

Katie Commey, MPH
SIM Care Delivery Lead
Policy, Planning, and Legislative Services Administration

Laura Kilfoyle, MPA
SIM Care Delivery Coordinator
Policy, Planning, and Legislative Services Administration

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

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  - 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.
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  - Do you want help with school or job training, like finishing a GED, going to college, or learning a trade?
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  - 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

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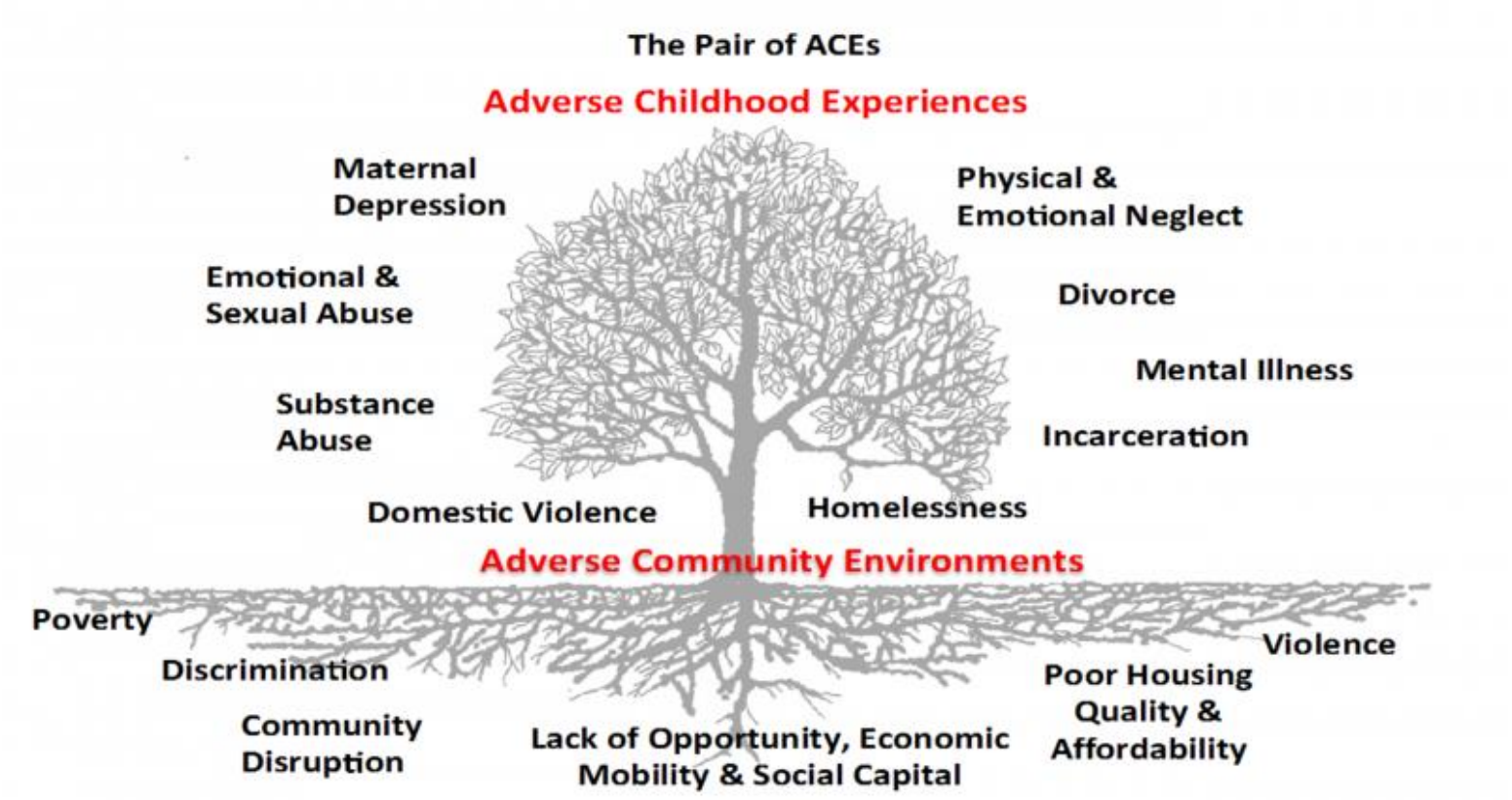

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- Delays In Development
  - Referral and treatment options
- Fatigue, Stress from Chronic Conditions

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:

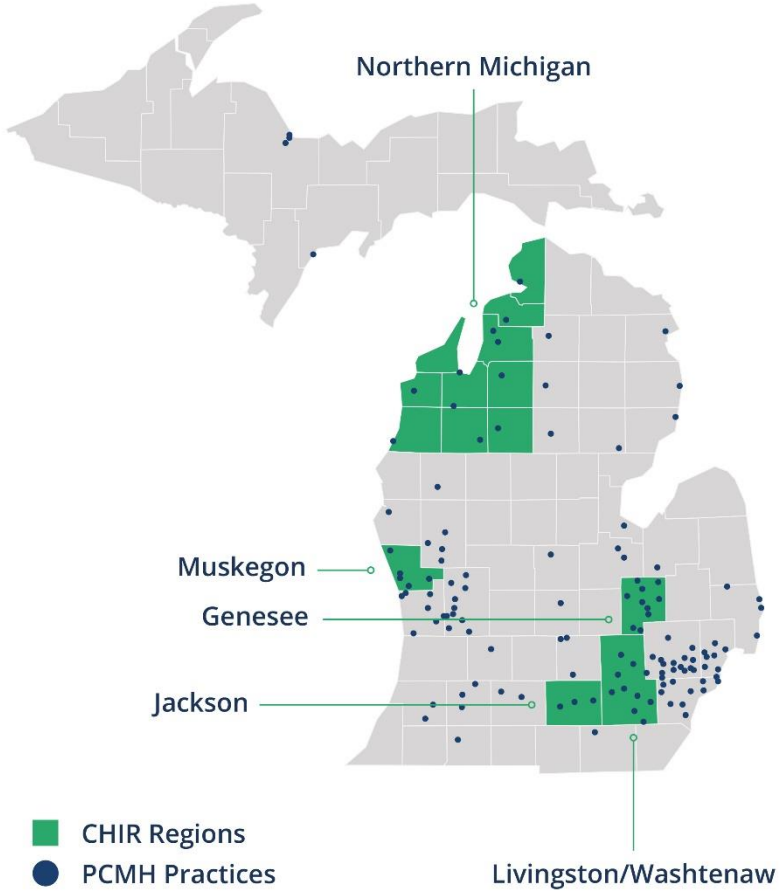
355 practices:

- 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

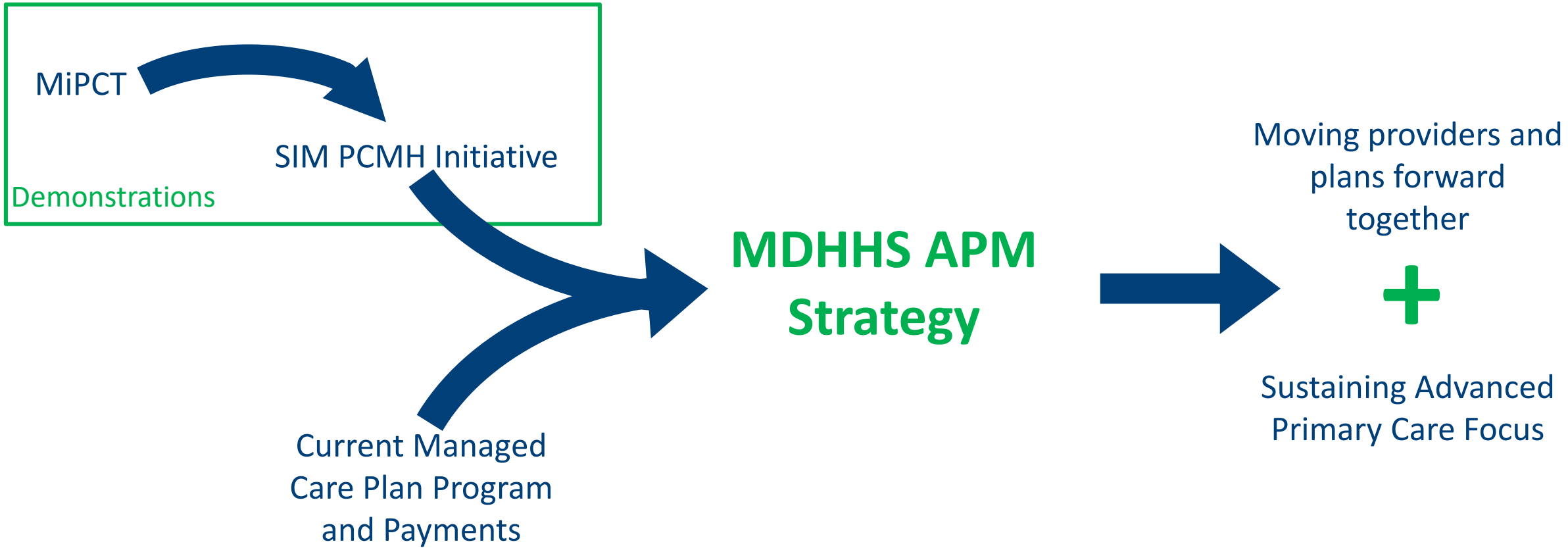
Michigan's State Innovation Model demonstration comes to an end in January 2020

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

<u>Considerations:</u>

- 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)
- Impending administration change
- 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)

Driving Change



MDHHS APM Strategy

GOAL:

sustainability, effectiveness, and consistency

- State Preferred PCMH Model:
  - Supporting a shared care delivery model within the Patient Centered Medical Home setting across the state
- Quality Measure Alignment:
  - Regionalized (based on Michigan's prosperity regions) measures for Medicaid Health Plans

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