Michigan Department of Health & Human Services

# Quarterly Update(Q1)

*State Innovation Model*

*Patient Centered Medical Home Initiative*

Webinar Recording

Note: will require you to enter registration information to access recording

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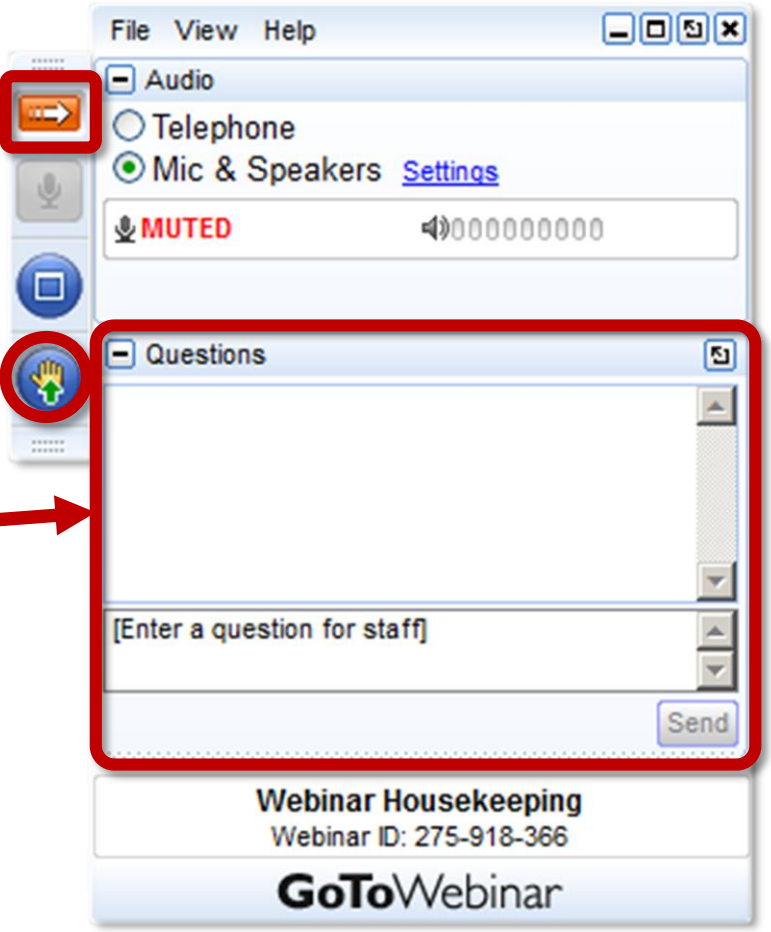
# Housekeeping: Webinar Toolbar Features

**Collapse Toolbar**

**Raise Your Hand**

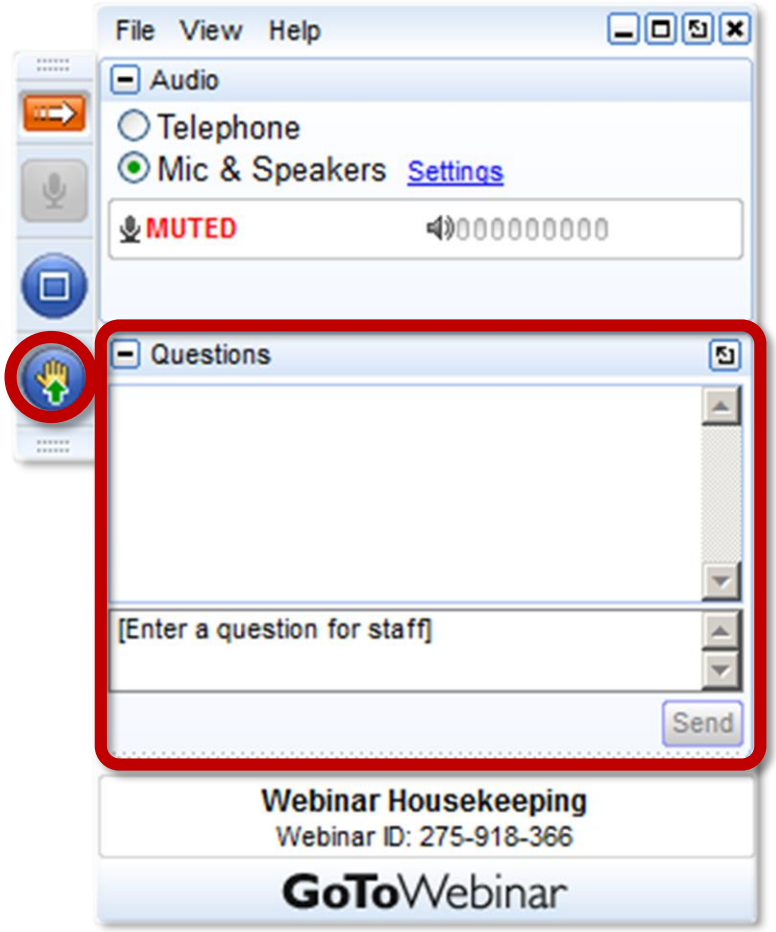
**Ask a Question**



# Housekeeping: Time for Questions

## Your Participation

- Please continue to submit your text questions and comments using the Questions Panel
- Please raise your hand to be unmuted for verbal questions.




Michigan Department of Health & Human Services

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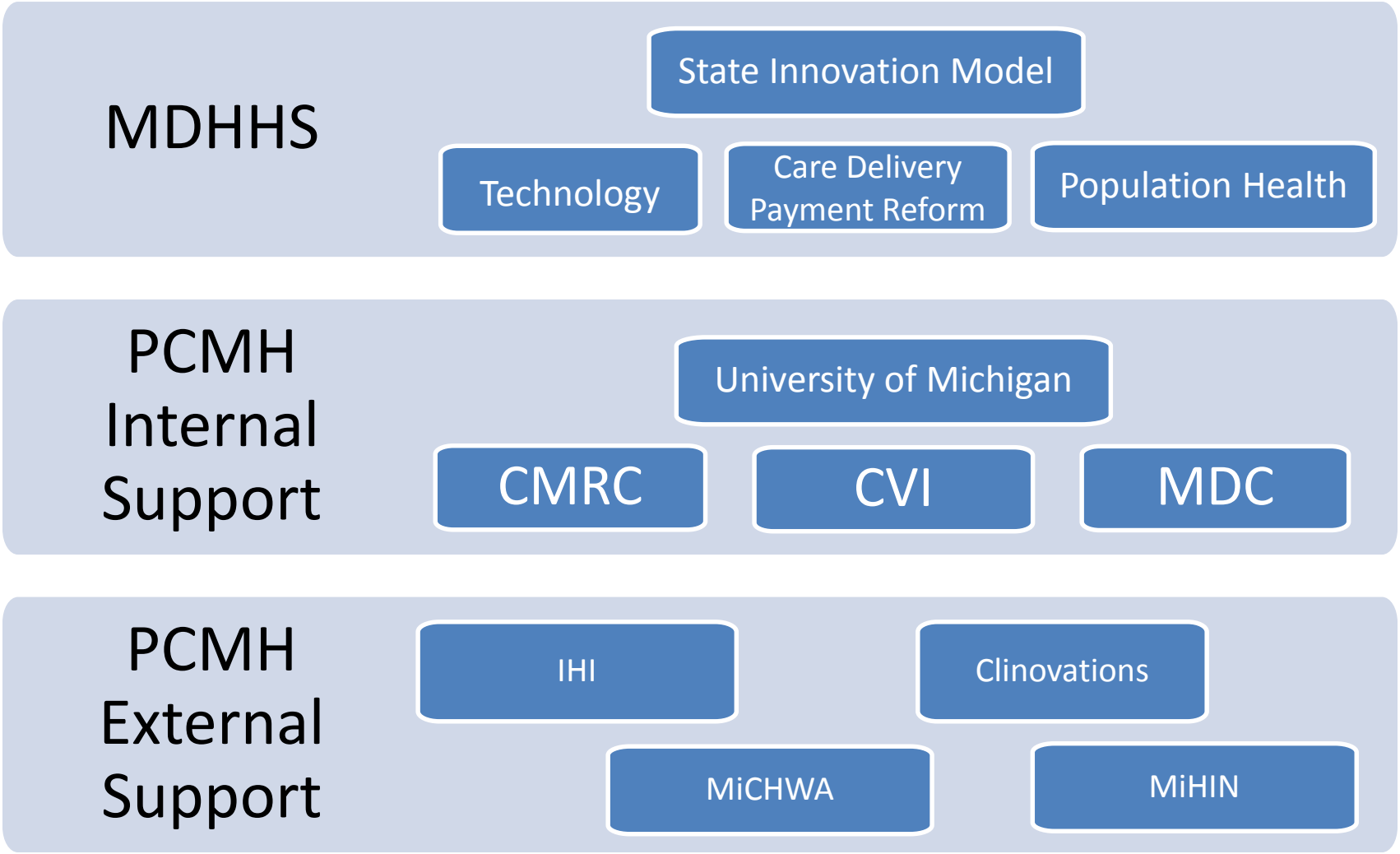
# A look at the State Innovation Model

Michigan received a State Innovation Model grant from Centers for Medicaid and Medicare Services (CMS) to test delivery and payment system changes. SIM will facilitate the development and testing of new multi-payer health care payment and services delivery models in Michigan.

- Strategies focus on moving towards cost-effective use of healthcare dollars overall in terms of patient experience and quality outcomes.
- System that coordinates care within the medical system to improve disease management and utilization; and out into the community to address social determinants of health.

**Vision:** A person-centered system that is coordinating care across medical settings, as well as with community organizations to address social determinants of health, improve health outcomes; and pursue community-centered solutions to upstream factors of poor health outcomes.

# Introduction to the PCMH Initiative Team

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# The MDHHS PCMH Initiative Team

**Katie Commey, MPH**
PCMH Initiative Coordinator

**Phillip Bergquist**
Policy & Strategic Initiatives Manager

**Justin Meese**
Sr. Business Analyst

# The PCMH Initiative Internal Support Team

**Amanda First**
CVI Analyst

**Diane Marriott**
CVI Director

**Veralyn Klink**
CVI Administrator

**Marie Beisel, MSN, RN, CPHQ**
Sr. Project Manager - CMRC

**Lauren Yaroch, RN**
Project Manager - CMRC

**Susan Stephan**
Sr. System Analyst - MDC

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# The PCMH Initiative Focus

| Support Scale for What's Working | Encourage the "Next Step" for Advancement | Test Promising Practices Where Opportunities Exist |
|---|---|---|
| **PCMH Recognition as a Foundation** | **Team-Based Care Practices** | **Clinical-Community Linkages** |
| **Advanced Access** (24/7, Open Access, Non-Traditional Hours) | **Integrative Treatment Planning** | **Health Literacy and Social Determinants Perspectives** |
| **Electronic Health Record and Registry Base Technology** | Provider Collaboration and Integration | Patient-Reported Outcomes |
| Structured Quality Improvement Processes | **Robust Care Management and Coordination** | Referral Decision Supports |
| | Patient Education and Self-Care | |
| | Caregiver Engagement | |
| | **Transitions of Care** | |
| | Managing Total Cost of Care | |
| | **Health Information Exchange Use Cases** | |
| | **Patient Experience Perspectives** | |
| | **Population Health Strategies** | |

Bolded items represent current areas of direct focus.

# Participant Requirements: Supporting What's Working

- PCMH accreditation from an Initiative approved recognizing body
- Implementation of an ONC certified Electronic Health Record (EHR)
- Advanced patient access (e.g. 24/7 access to clinician, open access slots, extended hours)
- A relationship with specialty and behavioral health providers in addition to one or more hospitals which accept patient referrals and cooperate with PCMH coordination activities
- Enrollment as a Michigan Medicaid provider in compliance with all provider policies
- Embedded care management / coordination staff meeting standards set by the Initiative
- A patient registry or EHR registry functionality

# Participant Requirements: Encouraging the Next Step

- Practice Transformation Objectives were selected by each Participating Organization to support advancements
  - Refer to the 2017 Participation Agreement or PCMH Initiative Participant Guide for a full list of objectives
- PCMHs to meet the following practice requirements during the first 6-12 months of participation:
  - Connection to a Health Information Exchange (HIE) Qualified Organization (QO), also known as sub-state HIEs
  - Participation in MiHIN use cases applicable to SIM (e.g. HPD, ACRS, ADT, QMI)
  - Stage 1 / modified Stage 2 Meaningful Use achievement
- Participating Organizations must maintain a Care Management and Coordination ratio of 2 staff per 5,000 attributed beneficiaries
  - Addition of the role of Care Coordinator as a critical part of the care team
  - Model for Reimbursement supports effort/level of support needed to provide robust care management services to patients of varying needs

# Participant Requirements: Testing Promising Practices

**Clinical Community Linkages:**

- Develop documented partnerships between a Practice (or PO on behalf of multiple Practices) and community-based organizations which provide services and resources that address significant socioeconomic needs of the Practice's population following the process below:

    - Assess patients' social determinants of health (SDoH) to better understand socioeconomic barriers using a brief screening tool with all attributed patients.
    - Provide linkages to community-based organizations that support patient needs identified through brief screening, including tracking and monitoring the initiation, follow-up, and outcomes of referrals made.
    - As part of the Practice's ongoing population health and quality improvement activities, periodically review the most common linkages made and the outcome of those linkages to determine the effectiveness of the community partnership and opportunities for process improvement and partnership expansion."

# Deep Dive: PCMH Initiative CCL Objective

## *Assessing Patients' Social Determinants of Health*

| Domain | Question | Response | |
|---|---|---|---|
| ***Healthcare*** | In the past month, did poor physical or mental health keep you from doing your usual activities, like work, school or a hobby? | Yes | No |
| | In the past year, was there a time when you needed to see a doctor but could not because it cost too much? | Yes | No |
| ***Food*** | Do you ever eat less than you feel you should because there is not enough food? | Yes | No |
| ***Employment & Income*** | Do you have a job or other steady source of income? | Yes | No |
| ***Housing & Shelter*** | Are you worried that in the next few months, you may not have safe housing that you own, rent, or share? | Yes | No |
| ***Utilities*** | In the past year, have you had a hard time paying your utility company bills? | Yes | No |
| ***Childcare*** | Does getting child care make it hard for you to work, go to school or study? | Yes | No |
| ***Education*** | Do you think completing more education or training, like finishing a GED, going to college, or learning a trade, would be helpful for you? | Yes | No |
| ***Transportation*** | Do you have a dependable way to get to work or school and your appointments? | Yes | No |
| ***Clothing & Household*** | Do you have enough household supplies? For example, clothing, shoes, blankets, mattresses, diapers, toothpaste, and shampoo. | Yes | No |
| ***General*** | Would you like to receive assistance with any of these needs? | Yes | No |
| | Are any of your needs urgent? | Yes | No |

# Initiative Payment Model

- Initiative participants receive two per member per month (PMPM) based payments, one for practice transformation (PT) and one for care management and coordination (CM/CC), which are paid on a quarterly basis by all Medicaid health plans (MHP)
  - PT payment is a fixed rate, CM/CC payment is variable
  - Participating organizations (in most cases a PO) must have a payment arrangement in place with each MHP that has members in your attributed population
  - Participants can anticipate the first quarterly payment to be made around April 28th (+ or – a few business days is possible)
- Payments are made for all Medicaid beneficiaries in a practice's attributed Initiative population (the patients on your monthly PCMH Patient List)
  - The Initiative attribution process and beneficiary inclusion criteria are posted online for reference
  - The accuracy of MHP primary care provider assignment records is critical in this process, we encourage participants to work with patients to update the PCP or record as needed with MHPs

# Initiative Payment Model

- Initiative participants should be billing care management and coordination tracking codes to Medicaid health plans for patients attributed by the Initiative
  - These tracking codes "report" the CM/CC services being provided by participating organizations' care teams to the Initiative
  - The codes are inclusive of comprehensive assessment, in-person and phone-based based CM/CC services, care transitions support and team conferences
  - With the exception of two care transitions codes, most are for tracking/reporting purposes only (MHPs most often pay a FFS amount for care transition services in addition to the Initiative using them for tracking)
  - Please note that even though most codes are used for tracking purposes only, a charge (e.g. $0.01) generally has to be included on the claim for the claim to be adjudicated
  - Detailed tracking code guidance and billing instructions are posted online for reference

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# Participant Engagement Opportunities

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# PCMH Initiative Live Office Hours

- What are Live Office Hours
  - Provide Participants to hear about a specific aspect of participation in the Initiative in detail and ask questions in real time
  - Key Partners are brought in as applicable

- What is the value in the PCMH Initiative Live Office Hours
  - The schedule of topics of the Live Office Hours are driven by Participant feedback and questions received through the listserv
  - Provides a real time opportunity to engage with leadership, key partners, understand further details about the Initiative and expectations for participants

- How to Engage in this opportunity:
  - Offered approximately once a month, announced a few weeks in advance, posted on website and sent in GovDelivery communications

# Practice Transformation Collaborative

- What is the Practice Transformation Collaborative
  - Collaborative Learning Network that supports "going beyond" Patient Centered Medical Home, sustaining change, and continuous quality improvement
- Key Partner: Institute for Healthcare Improvement
- What is the value in the Practice Transformation Collaborative
  - Focus on supporting practices in implementing Practice Transformation requirements (CCLs and selected objective)
  - Access to IHI Open School
- How to Engage in this opportunity:
  - Action Period Coaching Calls: virtual learning opportunities geared towards preparing for Learning Sessions
  - Learning Sessions: face to face engagements centered on practice team building, working through practice transformation requirements collectively, and networking
  - Peer Coaching Calls: Four occurrences per month, facilitated sessions to support learning promising practices and sharing amongst participants

# Practice Transformation Collaborative, CONT.

- Who Should Participate:
  - Participating Practice and Physician Organization (PO) teams
  - Participation will be most effective if it is as part of a team, and includes key members representing:
    - Clinical Leadership
    - Administrative Leadership
    - Providers, including Care Managers/Coordinators
    - Practice Coaches/Consultants
    - Patient Representative
    - Other key staff in achieving practice change

- It is important to keep in mind that an ideal team will include both key decision makers, and "boots on the ground" staff members.

*Note*:

- *It will be important to have the same core team members attend all Learning Sessions.*
- *PO teams are encouraged to include a few member practice representatives for face-to-face sessions, while virtual sessions could benefit from broader member practice participation.*

# Affinity Groups

- What is an Affinity Group?
  - An affinity group is a collection of people joined for a common purpose
  - Affinity groups can be helpful to exchange best practices, advance goals through a structured framework and also serve as helpful networking and support forums
  - Any good affinity group is organized around a purpose and has a charter (e.g., Billing and Coding Affinity Group Charter).

- How Will Affinity Groups Function in the SIM PCMH Initiative
  - Affinity groups will be formed around areas of common interest to participants and stakeholders that advance the work of the SIM PCMH Initiative.
  - The groups will be structured around formats agreed upon by participants.
  - Each group will have a lead convener but the participants in the group are the focus of the work – it is the members who will make a group successful and purposeful.

# Billing and Coding Collaborative

- What is the Opportunity?
  - A series of six webinars about the Medicare CMS Care Management codes and their requirements, and live "office hours" address participant pre-submitted questions and case examples

- Key Partners: Clinovations/The Advisory Board (for Medicare Care Mgt G/CPT Codes) and Medicaid (for Medicaid Tracking Codes)

- What Is the Value in the Opportunity?
  - Of the six webinars, three are Initiative-selected and three will be based on participant needs
  - For the first three months, the topics will be:
    - TCM codes;
    - Complex Chronic Care Management and Chronic Care Management codes;
    - Strategies to overcome patient engagement challenges related to CMS' incorporation of patient financial liability
  - Participants will provide input on the topics for the remaining three webinars (e.g., a potential topics could include FQHC and RHC implications; integrated behavioral health care codes, etc. )

# Billing and Coding Collaborative

- How Will This Help Me?
  - Will provide education and practice insights into billing the CMS care management G and CPT codes for Medicare patients and Medicaid Tracking Codes
  - Counts toward Practice Learning Credit requirement (one Practice Learning Credit per hour of participation, up to 4 hours)

- How Do Participants Engage?
  - **Save the Dates** for Our First Three Proposed Webinars (Office Hours would be held the week following each session):
    - Transitional Care Mgt Code – Thursday, May 23 (11:30-12:30)
    - Complex Chronic Care Management and Chronic Care Management codes – Tuesday, June 20 (11:30-12:30)
    - Strategies to overcome patient engagement challenges related to CMS' incorporation of patient financial liability – Wednesday, July 25 (11:30-12:30)

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# Participant Requirements and Compliance

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# Quarterly Report

- Released today, March 23, 2017
- **Due April 30, 2017**
- Content:
  - PO contacts and clinical champion, practice contacts and clinical champions
  - Care Manager and Coordinator information
  - Infrastructure, practice, provider changes
  - Participation Experience, Strengths and Challenges
  - Practice Transformation
- Access the Quarterly Report HERE

# PO and Practice Changes

- Attribution is run once a month
- Changes made by the **25th** will be incorporated the next month
- **CRITICAL** that provider changes and accurate Tax IDs are provided in a timely manner to ensure accurate attribution and payment
- Current process: Submit practice change form to **SIM mailbox** simpcmh@mail.mihealth.org
- The change form can be used for PO name and Tax ID changes, practice participation and Tax ID changes, practice mergers, provider additions and terminations
- Change form can be found on the PCMH Initiative Website, and directly linked here for your convenience

# 2017 PATIENT CENTERED MEDICAL HOME INITIATIVE

## PROVIDER & PRACTICE CHANGE REQUEST FORM

Please complete one form for each Provider or Practice Unit that requires a change.
Submit request by email to simpcmh@mail.mihealth.org

| | |
|---|---|
| **Submitter Information (Must Complete):** | |
| **Submitter Name:** Click here to enter text. | **Date of Request:** Click here to enter a date. |
| **Phone:** Click here to enter text. | |
| ☐ **Provider Organization Change:** | |
| **Name:** Click here to enter text. | **PO Tax ID:** Click here to enter text. |
| **Physical Address:** Click here to enter text. | **Billing Address:** Click here to enter text. |
| ☐ **New Provider Request:** | |
| **Name:** Click here to enter text. | **Individual NPI:** Click here to enter text. |
| **Practice:** Click here to enter text. | **Date Joined Practice:** Click here to enter date |
| ☐ **Departing Provider:** | |
| **Name:** Click here to enter text. | **Individual NPI:** Click here to enter text. |
| **Practice:** Click here to enter text. | **Date Left Practice:** Click here to enter text. |
| **New Practice (If Known):** Click here to enter text. | |
| ☐ **Practice Change (Complete each field you would like to update):** | |
| **Practice Termination (Enter Date and Explain Why Practice is Terminating):** Click here to enter text. | |
| **Practice Departing PO (Enter Effective Date, and New PO, if Known):** Click here to enter text. | |
| **Demographic or Billing Changes (Update All That Apply):** | |
| **Practice Name:** Click here to enter text. | **Practice Tax ID:** Click here to enter text. |
| **Physical Address:** Click here to enter text. | **Billing Address:** Click here to enter text. |
| **Lead Contact Name:** Click here to enter text. | **Lead Contact Email:** Click here to enter text. |
| **Lead Contact Phone Number:** Click here to enter text. | |
| **Attained or lost FQHC, RHC or CAH status (If yes, Part A Number):** Click here to enter text. | |
| **Practice Merger* (Please Explain):** Click here to enter text. | |
| **Practice Divestiture/Spin-off* (Please Explain):** Click here to enter text. | |
| **Practice Addition* (Enter Date and any Additional Details):** Click here to enter text. | |
| **Other* (Please Explain):** Click here to enter text. | |
| **FOR SIM PCMH INITIATIVE USE ONLY** | |
| **Date Received:** Click here to enter a date. | **Date Reviewed:** Click here to enter a date. |
| **Date Updated:** Click here to enter a date. | **Date Response Sent:** Click here to enter a date. |
| **Additional Comments:** Click here to enter a date. | |

- May require SIM PCMH Initiative Leadership Review

# Participant Compliance

- Developing a comprehensive guide and timeline based on the Participation Agreement
- General process: Warning, Corrective Action Plan, Resolution
- Resolutions include continuing participation, care management payment sanction, practice transformation payment sanction, and termination
- Requirements can be grouped into 5 categories:
  - Care Management
  - Learning Requirements
  - PCMH Status and Infrastructure
  - Practice Transformation
  - Technology
- Coming up:
  - ACRS and HPD Use Case (due 3/1), Quarterly Report (due 4/30), ADT Use Case (due 5/1)

# Participant Compliance

| | PO Reporting | Verification | Failure to comply results in: |
|---|---|---|---|
| Care Management | All quarterly reports | Care Management Training Records | Warning, CAP, care management payment sanction |
| Learning Requirements | 4th quarter report | Attendance records | Warning, CAP, termination |
| PCMH Status and Infrastructure | Application, Quarterly Reports | BCBSM, NCQA and AAAHC database; random practice calls to verify hours, appointments available, access to decision-makers. Random requests for care management documentation. | Warning, CAP, termination |
| Practice Transformation | Semi-annual Reports | Documentation will be requested in the semi-annual reports | Warning, CAP, practice transformation payment sanction, termination |
| Technology | None for Use Cases, 2nd Quarterly Report for Decision Support Prompts and Registry Utilization | MiHIN use case progress reports, MDC patient list download activity reports | Warning, CAP, termination |

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# PCMH Patient List and Participant Dashboard

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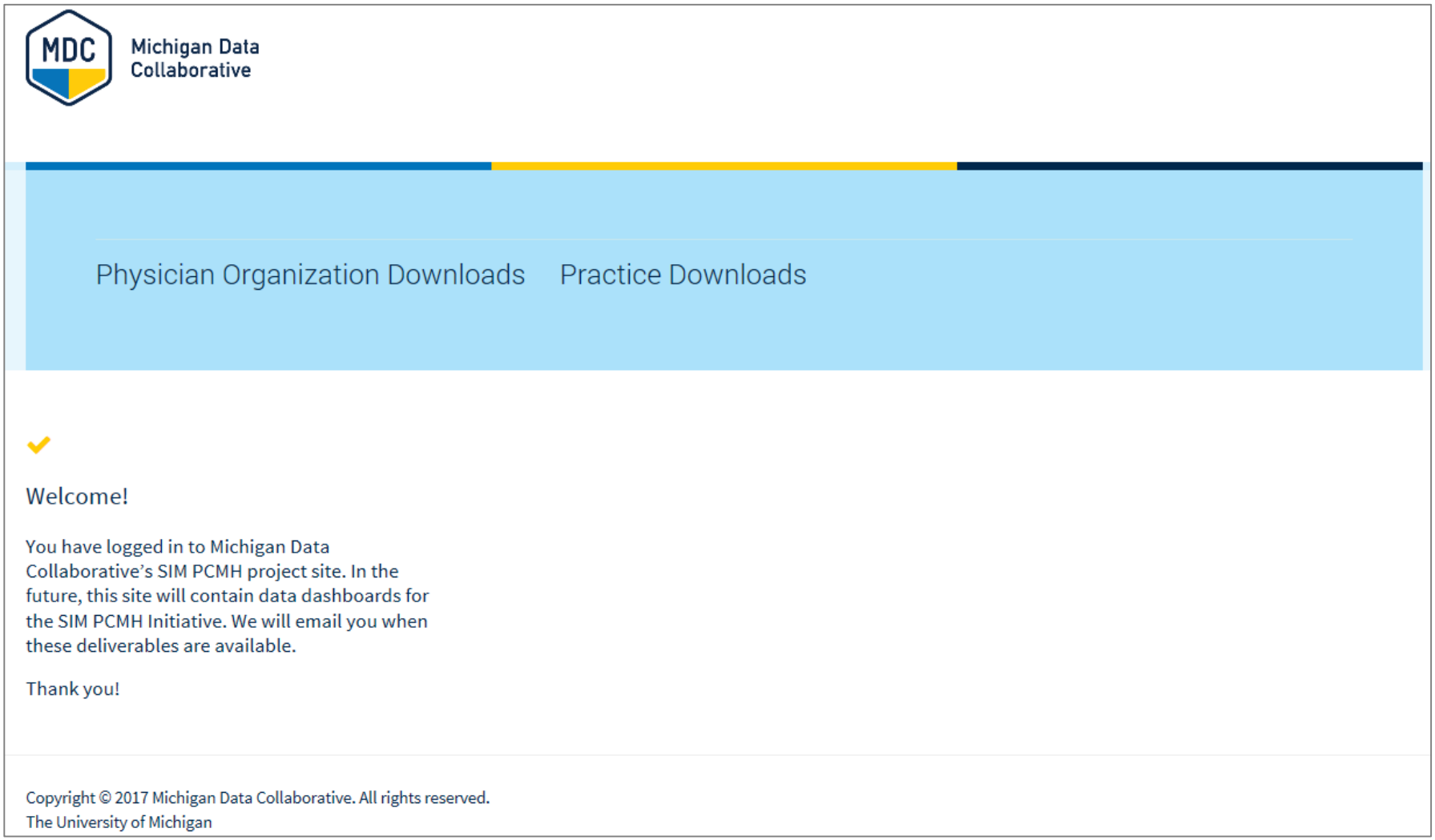
# MDC PCMH Patient Lists

- PCMH Patient List (PPL) Schedule
  - March PPL provided on 3/16/17
  - April PPL scheduled for 4/13/17
  - May PPL scheduled for 5/11/17
- If you are having difficulty accessing the portal, MDC can provide the PPLs via secure file transfer
  - Contact us at MichiganDataCollaborative@med.umich.edu
- There are still a few organizations that have not yet requested access. We will reach out to them.
- How do POs and Practices use the Patient Lists?
  - Provide to Care Manager: It identifies Medicaid patients which are considered part of the practice's attributed Initiative population
  - Estimate PMPM quarterly payments
  - The data dictionary describing this file is available on the MDC website: PCMH Patient List Information Guide

# Portal Download Screen Shot



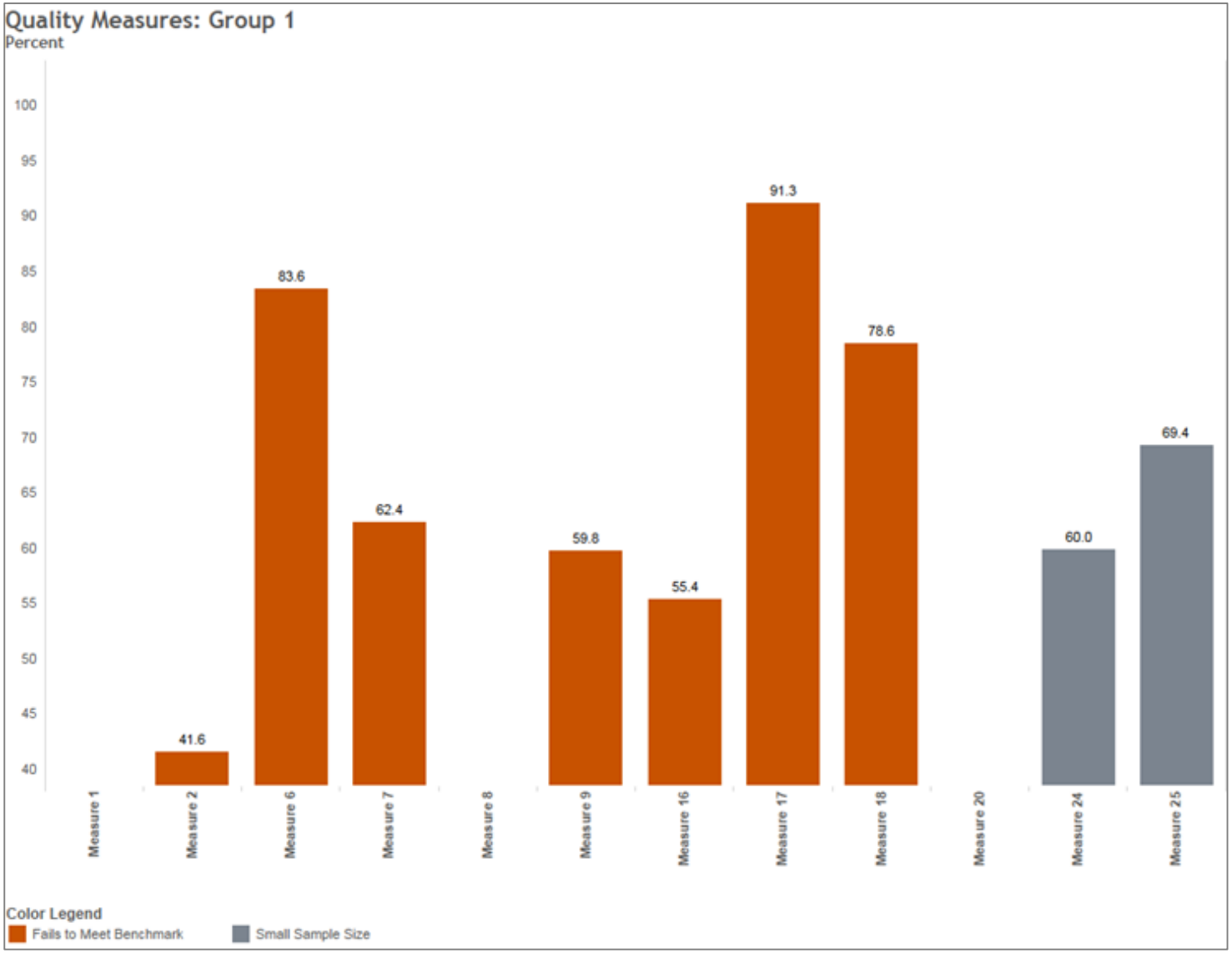
# MDC Future Deliverables

- Add commercial payer patient lists for Blue Cross Blue Shield and Priority Health (target date TBD)
- SIM PCMH Dashboard Release 1 (targeted for the end of May)

  Measure reporting:
  - Breast Cancer Screening
  - Cervical Cancer Screening
  - Emergency Department Visits
  - Diabetes Eye Exam
  - Diabetes HbA1c Testing
  - Diabetes Nephropathy
  - Hospital Admissions
  - Readmissions within 30 days
  - Use of Imaging Studies for Low Back Pain

  Chronic Condition Prevalence:
  - Asthma
  - Hypertension
  - Obesity

# Measure Report Screen Shot

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# Care Manager Training and Learning Opportunities

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# PCMH Initiative required Credentials/Licensure for the Care Manager and Care Coordinator

## Care Manager

- Registered Nurse (RN)
- Licensed Practice Nurse (LPN)
- Nurse Practitioner (NP)
- Licensed Master Social Worker (LMSW)
- Licensed Professional Counselor
- Licensed Pharmacist
- Registered Dietician (RD)
- Physician's Assistant (PA)

## Care Coordinator

- Bachelor of Social Work (BSW)
- Certified Community Health Worker (CHW)
- Certified Medical Assistant (MA)
- Social Services Technician

Care Managers and Care Coordinators function as key members of the Care Team.

# PCMH Initiative Care Managers – Examples of Role

- **Identify the targeted population within practice site(s)** per PCP referral, risk stratification, patient lists and other strategies. (Including patients with repeated social and/or health crises.)
- **Target interventions to avoid hospitalizations and emergency department visits**, ensures standards of care, and coordinates care across settings. Focuses on patients with mild to moderate chronic disease and patients with high complexity, high cost, and/or high utilizers of the health care system.
- **Ensure patients have timely and coordinated access** to medically appropriate levels of health and support services and continuity of care.
- **Complete comprehensive assessment** of patient's health conditions, treatments, behaviors, risks, supports resources, values, preferences and overall service needs. This can be done in coordination with other members of the care team.
- **Develop comprehensive, individualized care plans; coordinate services required to implement the plan**; provide continuous patient monitoring to assess the efficacy of the plan; periodically re-evaluate and adapt the plan, as necessary.
- **Provide a range of client-centered services that link patients with health care, psychosocial, and other services**, including benefits/entitlement counseling and referral activities assisting them to access other public and private programs for which they may be eligible (e.g. Medicaid, Medicare Part D, Pharmaceutical Manufacturers' Patient Assistance Programs, and other State or local health care and supportive services); coordination and follow-up of medical treatments; patient-specific advocacy and/or review of utilization of services.
- **Conduct medication reconciliation**
- **Promote patient's and family caregiver's active engagement in self-care**.
- **Coordinate and communicates with all professionals engaged in a patient's care**, especially during transitions from the hospital

# PCMH Initiative Care Coordinators – Credentials and Examples of Role

| Bachelor of Social Work | Certified Medical Assistant | Community Health Worker | Social Services Technician |
|---|---|---|---|
| No Certification | Certification | Certificate Program | No Certification |

- **With the care team, determine the patient's needs for coordination**, including physical, emotional, and psychological health; functional status; current health and health history; self-management knowledge and behaviors; current treatment recommendations and need for support services.
- **Demonstrate knowledge about community resources by providing information on the availability of and, if necessary, coordinate these services** that may help support patients' health and wellness or meet their care goals.
- **Jointly create and manage the individualized plan of care with the patient/family, care team and community based organizations,** that outlines the patient's current and longstanding needs and goals for care and addresses coordination needs and gaps in care.
- **Contribute to ongoing maintenance, which includes monitoring**, following up and responding to changes in the patient's individualized plan of care.
- **Facilitate transitions of care with the practice team members** to ensure timely and complete transmission of information and/or accountability
- **Support self-management goals to promote patient health**
- **Align resources** with patient and population needs
- **Contact patients with identified gaps in care and communicate recommended tests/services** to the patient.
- **Provide additional resources** to under insured patients

# What is a Certified Community Health Worker?

- A Community Health Worker (CHW) is a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. This trusting relationship enables the CHW to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery. Definition provided by the American Public Health Association.

- A CHW also builds individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support and advocacy.

ref: http://www.michwa.org/what-is-a-chw/

# MiCHWA Provides CHW Certificate

- For the SIM PCMH Initiative the Community Health Worker (CHW) must complete a certificate program

- MiCHWA offers a CHW certificate program and is the only recognized provider for CHW certificate/training in the SIM PCMH Initiative

- For information about MiCHWA CHW certificate program http://www.michwa.org/chw-training/

# Care Manager and Coordinator Initial Training Requirements

- Each Care Manager must complete the Michigan Care Management Resource Center (MiCMRC) Complex Care Management Course
  - Complex Care Management Course is offered by MiCMRC. For upcoming course dates/locations and registration visit http://micmrc.org/training/micmrc-complex-Care-management-course

- Each Care Manager and Care Coordinator must complete a Self-Management Support Program approved by the PCMH Initiative/MiCMRC within six months of hire.
  - Access the summary of MiCMRC Approved Self-Management Support Programs for more details
  - *Note: Opportunity available for the MiCCSI Self Management Support program*

# Care Manager and Coordinator Initial Training Requirements

Each Care Manager must complete the Michigan Care Management Resource Center (MiCMRC) Complex Care Management Course

- MiCMRC Complex Care Management (CCM) course is offered monthly
- CCM course is a blended learning activity:
  - Day 1 Live webinar – one hour
  - Day 1-2 Self study modules – six hours
  - Day 3-4 In person days – 8 hours each day
  - Details about course content – see CCM course flyer
  - CE credit for Nursing and Social Work upon completion of the course
- Complex Care Management Course is offered by MiCMRC. For upcoming course dates/locations and registration visit the MiCMRC website
- If you would like the CCM course in your region, MiCMRC is able to provide regional training if there are 15 care manager attendees. Please notify MiCMRC of your request for regional training via micmrc-ccm-course@med.umich.edu

# MiCCSI Self-Management Support Training Opportunity

The Michigan Center for Clinical Systems Improvement (MiCCSI) provides a MiCRMC approved Self-Management Support Training Program

- The MiCCSI Self-Management Support (SMS) training teaches the concepts and techniques of self-management, helping patients understand how they can manage their conditions and make behavioral changes.
- SMS Training is offered monthly, for upcoming dates see MiCCSI website
- SMS course is a blended learning activity:
  - There are 8 hours of self-study web-based training, followed by 2 on-site days of face-to-face learning, including role-playing
  - Details about course content – see MiCCSI website
  - CE credit for Nursing and Social Work upon completion of the course
- ***There is not a charge for the training (the cost is borne by the SIM PCMH Initiative).*** *Breakfast and lunch are provided for the on-site sessions. Travel costs, etc. are the responsibility of the participant or their organization.*

# SIM PCMH Initial Training Requirements cont.

In addition to the above, both ***Care Managers and Coordinators, newly hired or existing must complete self-study modules*** as indicated in the table below. The self-study modules are recorded webinars. Access the required self-study webinars at http://micmrc.org/training/supported-programs/sim-pcmh

PCMH Initiative Care Manager and Care Coordinator Initial training requirements:

| Course | Care Coordinator | Care Manager |
|---|---|---|
| MiCMRC Approved Self-Management Support Course | X | X* |
| MiCMRC CCM Course | | X |
| SIM Overview Module (Self-Study) | X | X |
| PCMH Module (Self-Study) | X | X |
| Team-Based Role Integration Module (Self-Study) | X | X |
| Social Determinants of Health Module (Self-Study) *Coming Soon* | X | X |

*Care managers are strongly encouraged to complete this course prior to registering in the MiCMRC CCM Course

*NOTE*: Existing Care Coordinators and Care Managers that have completed the MiCMRC approved self-management course and/or the MiCMRC Complex Care Management are not required to attend the courses again.

# Partnership with Michigan Community Health Workers Alliance (MiCHWA)

MiCHWA and MiCMRC will provide Social Determinants of Health (SDoH) curriculum. This curriculum is in development.

**Initial training requirement – includes the SDoH as follows:**

- **MiCMRC Complex Care Management course** will have an expanded curriculum addressing SDoH in April- Early May 2017
- **SDoH Self Study** curriculum will also be provided as a self study module. This module is a requirement of Initial Learning. Will be available April-Early May 2017
  - To be completed by Care Coordinators and Care Managers
  - Care Managers who attended the CCM course prior to planned April/May 2017 start date of the expanded SDoH content, will be required to complete the SDoH required self study module when available

# Longitudinal Learning Activity Requirements per Year

The PCMH Initiative requires Care Coordinators and Care Managers must complete twelve (12) hours of education per year.

- The requirement of training throughout the year is termed "longitudinal learning activity". This can be satisfied by:
  - Twelve (12) hours of PCMH Initiative -led Care Manager and Care Coordinator webinars/sessions (e.g., topic based live and recorded webinar trainings, web based interactive self-study eLearning modules, in person Summit, etc.), OR
  - Six (6) hours of PCMH Initiative - led Care Manager and Care Coordinator webinars/sessions PLUS six (6) hours of PO-led, or other related learning activity events. No preapproval is necessary for PO-led care manager, care coordinator training sessions

# Longitudinal Learning Activity Requirements

**Examples of Longitudinal Educational offerings:**

- Care Management Webinars offered monthly by MiCMRC
  - Live and recorded webinars
  - Several of the Live and recorded provide CEs for Nursing and Social Work
- Basic Care Management Program – web based, interactive eLearning
  - CEs for Nursing and Social Work upon completion of each module
  - Modules
    - Medication Reconciliation
    - Transition of Care
    - Introduction to Palliative Care and Advance Care Planning
- SDoH Longitudinal educational offerings – coming soon!
  - Offered virtually, likely will be webinars live and recorded (developed by MiCHWA and MiCMRC)
  - Completion of the SDoH longitudinal educational offering is highly encouraged and will count toward the longitudinal learning activity hours


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MiCMRC provides training and support for the following statewide Care Management initiatives:
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The MiCMRC Complex Care Management course is designed to prepare the healthcare professional for the role of Complex Care Manager. Read More
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MiCMRC approves Self-Management Support Programs. For a detailed summary listing program objectives, resources, tools, locations and more, click to view or download the PDF file
Care Management Connection Newsletter
Upcoming Webinars
MiCMRC Educational Webinar
Wednesday, April 12, 2017 - 2:00pm
DIABETES
Diabetes and Pregnancy
Presented by
Kim Lombard, MS, RD, CDE
Webinar Registration

# Navigating to the Required Self Study Modules on the MiCMRC website

## SIM PCMH Required Self-Study Modules

***Please note that the webinars listed below are only eligible for a Certificate of Completion.**

**SIM PCMH**

MAR 7 2017

### State Innovation Model PCMH - Overview Module Self-Study

**Objectives:**

- Define the State Innovation Model PCMH Initiative
- Describe the participation and training requirements

To obtain a certificate of completion **Click Here.**

Webinar replay video

0:00

Presentation Slides

# Training Requirements for Care Coordinator and Care Manager

Resources:

- SIM PCMH Initiative Participation Guide describes required Initial learning activities and longitudinal education requirements
- MiCMRC SIM web page to access the required Initial self study modules
- MiCMRC Complex Care Management Course registration
- Questions for MiCMRC, please submit to micmrc-requests@med.umich.edu


Michigan Department of Health & Human Services

# Use Case Onboarding

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

# SIM PCMH Participants

**Managing Organizations:**

- 29 Physician Organizations
- 5 Multi-Site Practices

**Practices:**

- 345 Total Practices
  - Includes 9 Independent Practices

**Providers:**

- 2127 Physicians

# SIM Legal Agreement Status

| SIM Participants | MUCA/SDOA/QDSOA | ADT | ACRS | HD | QMI | CKS |
|---|---|---|---|---|---|---|
| Medicaid Health Plans | 100% | 100% | 100% | 100% | 100% | 100% |
| Managing Organizations | 100% | 100% | 100% | 100% | 100% | 100% |
| Multi-site Practices | 100% | 100% | 100% | 100% | 100% | 100% |
| Independent Practice Units | 100% | 100% | 100% | 100% | 100% | 100% |

# SIM Onboarding Status

| SIM Participants | ACRS | ADT | HD | QMI | CKS |
|---|---|---|---|---|---|
| 29 Managing Organizations | 76% In Production | 76% In Production | 70% In Production | Scheduled Q2 | Scheduled Q2 |
| 5 Multi-Site Practices | 100% In Process<br>20% In Production | 100% In Process | 100% In Process<br>20% In Production | Scheduled Q2 | Scheduled Q2 |
| 9 Independent Practice Units | 100% In Process<br>67% In Production | 100% In Process<br>22% In Production | 100% In Process<br>83% In Production | Scheduled Q2 | Scheduled Q2 |

**MiHIN and the PCMH Initiative Team are working with participants that need assistance with technical onboarding**

# SIM Medicaid Health Plan Onboarding Status

| Medicaid Health Plan | ACRS | ADT | HD | QMI | CKS |
|---|---|---|---|---|---|
| Aetna | In Process | In Process | In Process | Scheduled Q2 | Scheduled Q2 |
| Blue Cross Complete | In Production | In Production | In Production | Scheduled Q2 | Scheduled Q2 |
| HAP Midwest Health Plan | In Production | In Production | In Production | Scheduled Q2 | Scheduled Q2 |
| Harbor Health Plan | In Production | In Production | In Production | Scheduled Q2 | Scheduled Q2 |
| McLaren Health Plan | In Production | In Production | In Production | Scheduled Q2 | Scheduled Q2 |
| Meridian Health Plan | In Process | In Process | In Process | Scheduled Q2 | Scheduled Q2 |
| Molina Healthcare | In Process | In Process | In Process | Scheduled Q2 | Scheduled Q2 |
| Priority Health | In Production | In Process | In Production | Scheduled Q2 | Scheduled Q2 |
| Total Health Care | In Production | In Production | In Production | Scheduled Q2 | Scheduled Q2 |
| United Healthcare Community Plan | In Process | In Process | In Process | Scheduled Q2 | Scheduled Q2 |
| Upper Peninsula Health Plan | In Production | In Production | In Production | Scheduled Q2 | Scheduled Q2 |


Michigan Department of Health & Human Services

# Quarterly Update(Q1)

*State Innovation Model*

*Patient Centered Medical Home Initiative*

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