SIM PCMH Initiative Newsletter

A publication of Michigan's State Innovation Model

May 2019

In this Issue

- Program News and Updates
- Upcoming Events and Initiative Resources

About the Initiative

The Patient Centered Medical Home (PCMH) Initiative is a core component of the State Innovation Model (SIM) strategy for coordinated care delivery, focusing on the development and testing of health care payment and service delivery models to achieve better care coordination, lower costs, and improved health outcomes for Michiganders. For more information and resources, check out our webpage.

Contact Us

Questions can be sent to: MDHHS-SIMPCMH@michigan.gov

Links

SIM Initiative website

SIM Care Delivery webpage

SIM Population Health webpage

Welcome to the 2019 Patient Centered Medical Home Initiative monthly newsletter. Each month we will bring together all the updates, news and upcoming events relevant to PCMH Initiative Participants.

You will continue to receive other regular communications and event reminders from the PCMH Initiative. This newsletter has been developed as a method to share information in one common location. Previous editions of the newsletter can be found here.

Program News and Updates

Care Management Longitudinal Learning Requirements

The PCMH Initiative is reducing the number of hours of care management and self-management training required by SIM Care Mangers and Care Coordinators (CM/CC) from twelve to eight hours per year. These changes are reflected in the 2019 Participation Guide, and each participating organization is required to sign a formal amendment to the 2019 Agreement to accept this change. You must return a signed amendment to the MDHHS Bureau of Purchasing (MDHHS-BOP-MOU@michigan.gov) two weeks after it is received. The exact due date will be indicated in the email from BOP.

Office Hour: SDoH - A Service Provision Including Motivational Interviewing

We look forward to connecting with you at our PCMH Initiative Office Hour webinar on Thursday May 2, 2018 from 12:30-1:30pm. We are excited to host a panel discussion by some of our SIM participants. They will be sharing their expertise and experience on how they have incorporated motivational interviewing in their organizations. There will be an opportunity to share best practices and ask questions. See you there! REGISTER HERE

CHAMPS Enrollment

This is a reminder that health care providers that serve Medicaid beneficiaries within the SIM PCMH Initiative are required to be enrolled in CHAMPS to continue to receive payments from the SIM program. This was a requirement implemented by MDHHS in late 2018 that stated: "For dates of service on or after Jan. 1, 2019, MDHHS will prohibit contracted Medicaid Health Plans and Dental Health Plans from making payments to typical providers not actively enrolled in CHAMPS." Please be sure that providers serving Medicaid beneficiaries in the State Innovation Model are currently enrolled in CHAMPS. If you have any additional questions you may visit the Provider Enrollment Website.

Save the Date: SIM PCMH Initiative 2019 Summit

2019 marks the culmination of the State Innovation Model. In recognition of this, the SIM PCMH Summit for 2019 will be held in one location (Lansing) on November 12th. The SIM Summit Planning Committee has worked hard on providing guidance to help to create a great agenda, informative and engaging speakers, and lots of room for interactive sessions and networking. Since sustainability and keeping the good work going, the theme will be: "Sustaining the Gains Through Smart Delivery and Cost-Effective Care". All SIM PCMH Initiative participants in practices and Physician Organizations are invited.

If you have ideas or suggestions for the Planning Group to consider, please send them to the SIM PCMH mailbox with the subject line "Summit Ideas". As well, please spread the word to save November 12th on your calendars. We will provide additional updates in forthcoming editions of the newsletter.

Evaluation

The Michigan Public Health Institute is preparing to release the 2019 Clinical-Community Linkage Provider Survey. You will receive an email from MPHI soon indicating how you can participate and next steps. This survey is similar to what was administered last year that requested feedback from providers, care managers and coordinators, and office managers on their experiences with the CCL process.

Pediatric Office Hours: Announcing Dates for 2019

SIM PCMH Initiative Pediatric Office Hours will continue with a series of three webinars in 2019. We would like to thank the SIM PCMH Initiative Pediatric Curriculum Planning Workgroup members for their commitment and expertise to guide the planning in 2019.

The following are topics of interest with expert presenters:

Date/Time: Wednesday, June 26 from 2 pm – 3 pm
Topic: Pediatric Asthma
Presenter: Tisa Vorce MA, RRT
REGISTER HERE

Date/Time: Thursday, September 12 from Noon – 1 pm
Topic: Pediatric Depression
Presenter: Thomas Atkins, MD
REGISTER HERE

This presentation is supported by Funding Opportunity Number CMS-1G1-14-001 from the U.S. Department of Health and Human Services (HHS), Centers for Medicare and Medicaid Services. The content provided is solely the responsibility of the authors and does not necessarily represent the official views of HHS or any of its agencies. The Pediatric Office Hours are open to all.

Upcoming Michigan Data Collaborative Deliverables

Dashboard Release 7.0 - Office Hours Recording

Michigan Data Collaborative (MDC) posted Dashboard Release 7.0 on 2/28. It included three new pages (Incentives, Trends, and Care Coordination Trends). We highlighted these pages and how to use them in the March 21st Office Hours Session. You can view the slides and listen to the recording here.

Upcoming MDC Deliverables

- April 2019 PCMH Patient Lists and Provider Reports – *late April 2019*

- Nov 2018 – Jan 2019 Care Coordination and Claims Detail Reports – *early May 2019*
- May 2019 PCMH Patient Lists and Provider Reports – *late May 2019*

You can view an up-to-date list of upcoming deliverables on the SIM PCMH page of the MDC Website.

Success Stories:

Genesys Physician Health Organization
Submitted by Kelly Stein

A 64-year-old male patient with multiple chronic conditions has been in and out of care management since 2015. Most of the care management services centered around post hospital admission follow up. The patient has multiple comorbidities including diabetes, end stage renal disease, cirrhosis, hepatitis B, hypertension, hyperlipidemia, back pain and fracture, anxiety, and depression. He also has a history of smoking and alcohol abuse. He did quit smoking and drinking. A more recent history of liver cirrhosis complicated by ascites had him undergoing paracentesis approximately every two weeks. He utilizes a wheelchair and cane and he lives alone. With his declining health he was relying on his brother for transportation to medical appointments and help around the house.

A combination of financial constraints and his worsening condition, including pain management, made it more difficult for him to care for himself at home and follow up with his providers. He shared with his care manager, that he wants to stay in his home if he is able. To work on his wish to live in his home, his care manager and physician discussed the possibility of a referral to the Genesys PACE (Programs of All-Inclusive Care for the Elderly) program of Genesee County. PACE is a Medicare/Medicaid program for older adults who meet the program criteria.

The comprehensive PACE service package permits the individual to continue living at home while receiving services rather than being institutionalized. PACE offers an interdisciplinary team of professionals who coordinate care, so individuals can continue to live in their community. The program provides several covered benefits such as primary and specialty care, prescription drug coverage, transportation, home care, physical therapy social work counseling, social services, and nursing home stays when necessary, respite care for families, and Adult day care. The patient was agreeable to meet with the PACE staff and physician. He enjoyed the visit and signed the papers to begin PACE on 12/1/2018.
To learn more about PACE in Michigan, click here.

Ascension Medical Group Promed
Submitted by Stacy Campbell, RN

In February of 2018 the PCP referred a 71-year-old patient to care management who had a diagnosis of Chronic Obstructive Pulmonary Disease (COPD) as well as multiple hospital admissions. The patient also had a history of arthritis in his knees and hips, and nasal cancer. Because of the nasal cancer the patient had a large cavity which was covered most of the time with gauze which made it difficult to breath especially in the summer months. Prior history includes surgery to have a skin graft from his left arm to close the nasal cavity. Subsequently the graft failed, and the surgery resulted in the patient having nerve damage to his left arm. The nerve damage to his arm resulted in decreased range of motion and he has difficulties carrying out some of his activities of daily living. His only means of income was social security.

During a visit with the primary care provider in July of 2018 the patient shared that he was homeless and had been living out of his leased vehicle and then staying (squatting) in a cousin's home that was uninhabited but had no utilities (water, heat, air conditioning, electric). He was utilizing local businesses' facilities to wash up, use the bathroom, etc. He had limited financial means to purchase food or medications because he was paying the lease on his vehicle, which he needed for air conditioning and heat in inclement weather. His only

means of insurance was Medicare. The patient was skeptical of using local shelters secondary to a couple of bad experiences. Because of this the Care Manager linked the patient with Adult Protective Services initially and was able to get him a temporary room in a local hotel for a week. She also connected him with MDHHS, Meals on Wheels, the local Senior Services Center and outreached to multiple subsidized housing agencies. In addition, he was guided through the Medicaid application process. Through the hard work and determination of the care manager and her team this patient was qualified for food stamps, was able to get into his own apartment and had not been hospitalized for his COPD now that he had access to his medications and was in a suitable living environment. He eventually let the lease on his car lapse, utilized Lyft for transportation and has redirected his funds to his rent and purchasing his medication. The patient still to this day stays in contact with the care manager to share how he is doing. This story illustrates the importance of screening for social determinants of health and the impact these determinants have on an individual's ability to care for themselves and manage their disease.

Upcoming Events and Initiative Resources

Michigan Care Management Resource Center 2019 Care Management Educational Webinars

Title: Identifying and Addressing Anxiety in Primary Care
Date and Time: Wednesday, March 27, 2019 at 2pm
Presenter:
Teague Simoncic, LMSW
Behavioral Health Care Manager Preceptor, IHA
REGISTER HERE

Title: ADHD Medication Education
Date and Time: Tuesday, April 23, 2019 at 11am
Presenter:
Tiffany Munzer, MD
Fellow in Developmental Behavioral Pediatrics
Michigan Medicine
REGISTER HERE

Michigan Care Management Resource Center Approved Self-Management Course Registration

To access the list of the Michigan Care Management Resource Center (Michigan Care Management Resource Center) approved Self-Management Support courses. The list of Michigan Care Management Resource Center approved Self-Management Support Courses provides a detailed summary of each course, with associated objectives, location, cost and more.

Additionally, Michigan Care Management Resource Center has collected resources for Self-Management Support including: websites of interest, publications, tools, videos, and even patient materials. Michigan Care Management Resource Center's "Self-Management Support Tools and Resources" document offers an at a glance list and summary of these resources, along with descriptions and website links for quick access. Click here for "Self-Management Support Tools and Resources".

Both documents can also be accessed on the Michigan Care Management Resource Center website home page.

Upcoming Complex Care Management Course Dates and Registration

The Michigan Care Management Resource Center Complex Care Management (CCM) course is designed to prepare the healthcare professional for the role of Complex Care Manager. Course content is applicable to all

Care Managers in the ambulatory care setting, working with complex patients. For CCM Course details click here.

April 29-May 2 | Livonia | REGISTER HERE | Registration deadline: April 25th, 2019

May 6-9 | Marquette | REGISTER HERE | Registration Deadline: May 2nd, 2019

May 20-23 |Auburn Hills | REGISTER HERE | Registration Deadline: May 16th, 2019

In the upcoming weeks we will post additional CCM course dates/registration – check here

NOTES: If you have 15 or more Care Managers in your area and would like the Michigan Care Management Resource Center team to provide a regional training at your location please submit your request to: MICMRC-ccm-course@med.umich.edu

For questions please contact: MiCMRC-ccm-course@med.umich.edu