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## 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](mailto: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](#).

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## Program News and Updates

### Progress Report

The Progress Report will be released mid-September with a submission deadline of Wednesday, October 31, 2019 by 5:00 p.m. The link to the electronic submission will be distributed to your organization's key contact. You can preview the requirements to complete the report in the downloadable template found on the first page of the report. If you have any questions, please email the PCMH Initiative at [MDHHS-SIMPCMH@michigan.gov](mailto:MDHHS-SIMPCMH@michigan.gov).

### September Office Hour: Plan for Improving Population Health

This month we will be updating you on the progress to-date on the statewide Plan for Improving Population Health. The Michigan Public Health Institute has been facilitating stakeholder engagement and ongoing support for the Michigan Department of Health and Human Services over the last year. This webinar will be an opportunity to hear from them on the progress the statewide Plan for Improving Population Health has made since their last presentation with us in November 2018. Please join us on September 19 from 12:00-1:00 p.m. Save your spot and [REGISTER HERE!](#)

### Supplemental September Office Hour: Trauma Informed Care

We are excited to announce our September Office Hour session on Trauma Informed care. Our guest speaker will be Laura E. Gultekin, PhD, FNP-BC, RN, Assistant Professor University of Michigan School of Nursing. This webinar will offer an introduction to Trauma Informed Care. Additionally, the webinar will include what Trauma Informed Care looks like and resources to build awareness for a Trauma Informed approach. Please join us on September 24 from 2:00-3:00 p.m. Save your spot and [REGISTER HERE!](#)

## **Register Now for the 2019 SIM PCMH Summit**

The SIM 2019 Summit will be held this year on November 12, 2019 at the Kellogg Center in Lansing. Rather than hosting three regional summits, a day-long central summit will allow an even greater networking experience and the opportunity to hear from a range of state and national leaders in primary care transformation.

The summit will open with a continental breakfast from 7:30 to 8:30. Sessions begin promptly at 8:30 and will include a plenary, a panel of Medicaid Health Plan leaders, State leaders sharing the latest work on the State-Preferred Model and Alternative Payment Methodology progress, as well as breakouts on:

- Lessons from a Partner State: Building Strong Partnerships (for Pediatric Practices and Beyond!)
- Healthier Communities: What Works to Make Real Change
- Acting on SDOH Data: Beyond Screening
- Evaluation Results MPHI evaluation results to date
- Adverse Events: From Trauma to Resiliency
- Adolescent Depression: Presentation, Diagnosis, and Treatment

The day will end at 3:30 p.m. [REGISTER HERE](#) as capacity is expected to fill quickly.

### **Pre-Polling Questions**

We would love for you to take five minutes and answer our pre-polling questions. They are just four short questions that ask about your most impactful SIM PCMH work over the past few years and your perceptions on the biggest Medicaid trends in the next decade. This information will help frame our conversations on November 12, so you can get the most out of the day as possible.

[SURVEY HERE](#)

### **Continuing Education Nursing and Social Work 5.5 CE 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)"

"Michigan Care Management Resource Center is an approved provider with the Michigan Social Work Continuing Education Collaborative". Approved Provider Number: MICEC 110216

For CE questions email [micmt-requests@med.umich.edu](mailto:micmt-requests@med.umich.edu)

### **Culmination to the Care Coordination Collaborative Series: Highlights from the July 30, 2019 Event**

The final segment of the SIM PCMH Care Coordination Collaborative Series was held on July 30<sup>th</sup> in Grand Rapids with 115 participants attending and sharing insights about "Decreasing Unnecessary Utilization and Streamlining Care Efficiency". [Slides](#) for the day's events are available to SIM participants via the SIM website. In addition to an overview of the Michigan Data Collaborative SIM Dashboards available to authorized users in SIM Managing Organizations, the sessions and presenters for the event included:

- Transitional Care Management: A Toolkit for Success - Kerrie Barney, RN, Cherry Health
- Right Time, Right Care, Right Place - Cherie Bostwick, RN, Munson Family Practice
- Coordinating the Coordination of Care and Addressing Social Determinants of Health – Lori Kunkel and Chris Wise, Greater Flint Health Coalition
- Michigan Medicine-Using Internal Data Case Study (Leah Corneail)
- Great Lakes OSC-Using Internal Data Case Study (Marie Wendt)

Thanks to these wonderful presenters and all who participated as well as the CMS Project Officers who traveled to Grand Rapids to learn about the great things happening in Michigan.

### **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.

Date/Time: Thursday, September 12 from Noon – 1 p.m.

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**

MDC plans to release the following deliverables in the coming weeks:

- September 2019 PCMH Patient Lists and Provider Reports – late September 2019
- April 2019 – June 2019 Care Coordination and Claims Detail Reports – early October
  - This is the final care coordination report to be included in the Care Management Improvement Reserve (CMIR) calculations.
  - MDC will reprocess the 4Q18, 1Q19, and 2Q19 reports at the end of the year to include any claims received after the original reports were generated.
  - The SIM PCMH team calculates the final percentage by summing the numerators for the three quarters and averaging the population in the denominator.
- Dashboard Release 10 (July 2018 - June 2019 reporting period) – late October
  - This release applies to the Performance Incentive Plan (PIP)

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

### **Literature Review**

#### **Tackling Diabetes**

By: Lindsay Schohl, BSN, RN

Story Provided By: Jill Maciejewski, RN

Jill has been a nurse for eight years; providing Care Management services at West View Family Medicine for the last two and a half years. Jill has always been very proactive in her nursing practice, which is why she is so great at Care Management in Primary Care. With population health taking its turn on the hot topics of healthcare, Jill took this approach seriously and the results were proven successful.

Being proactive, Jill ran reports on patients in her office who were overdue for diabetic labs, and for those who were eligible and might benefit from Care Management services. One patient in particular caught Jill's attention. It had been many years since this patient's Hemoglobin A1C had been checked. Jill collaborated with the patient's physician to find out that the patient had been diabetic for years and was not checking home

blood sugars. The patient had not been following a diabetic diet and was eating multiple servings of bread and pasta every day. The patient was also not living an active lifestyle. With the physician and patient's approval, the patient was enrolled into the Care Management program.

Jill worked diligently with this patient on diabetes self-management. She educated the patient on the importance of routine labs, and shortly after starting services the patient had these completed. The patient's Hemoglobin A1C came back elevated over 11%. Jill collaborated with the physician on medications needed to gain control of the patient's blood sugars, while continuing to work with the patient on lifestyle modifications. Jill provided the patient with medication education, injection demonstration and teach back, diabetic diet teaching, education on risks associated with uncontrolled diabetes, and lifestyle modifications. The patient was hesitant to begin injections, but after a lot of teaching and reinforcement, the patient was able to administer weekly injections at home. The patient was fully engaged in their plan of care.

Jill continued to reach out to this patient on a monthly basis to follow up on the patient's progress toward identified goals. In a span of three months, the patient had already made significant changes to diet and lifestyle habits. The patient stated, "I was overwhelmed with the food choices and had no idea where to start." The Care Management Program was just what this patient needed to get started in the right direction. The patient's labs were rechecked and Hemoglobin A1C had already decreased. The patient lost weight and the majority of the patient's home blood sugars were below 130. The patient felt great, had more energy, and continues to be highly motivated to continue with lifestyle changes. The patient's most recent goal was to see the next Hemoglobin A1C continue to trend down. A more recent lab draw showed the patient's Hemoglobin A1C was lower and the patient was ecstatic. Proactively looking at population health is a main target for Care Management. This patient's success is a direct reflection of the hard work Care Management is doing around the hot topic of population health in primary care, leading the way to a healthier future.

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## [Upcoming Events and Initiative Resources](#)

### **MiCMRC Transition to MICMT and MICMT CCM Course Update**

On January 1, 2019 the Michigan Care Management Resource Center (MiCMRC) along with the Michigan Pharmacists Transforming Care and Quality (MPTCQ) joined together to create a new organization called the Michigan Institute for Care Management and Transformation (MICMT). MiCMRC is now MICMT. The organization is in the transition process and will launch the new MICMT website, Fall 2019.

One area of work MICMT has focused on in 2019 is the development of standardized Complex Care Management (CCM) course content. The intent is to create a standardized training experience across the state.

For the SIM Care Managers, the Initial training requirement has been updated to the following: A component of the initial training for Care Managers is the requirement to complete the MICMT Complex Care Management Training course taught by the MICMT instructors or a MICMT approved Statewide Physician Organization /Trainer Organization within the first six months of hire. The cost of the CCM course provided by the MICMT instructors for new Care Managers will be covered by the PCMH Initiative.

Regarding the MICMT approved Statewide Trainer CCM courses:

- The MICMT CCM course has a new Statewide Trainer application which was launched June 2019. The MICMT CCM course Statewide Trainer application is used to understand whether or not a specific training program may be approved as meeting training criteria for Michigan payer programs. This extends to Blue Cross Blue Shield of Michigan's Provider-Delivered Care

Management program, Priority Health Care Management Program and the SIM PCMH Initiative. The Michigan Department of Health and Human Services recognizes the MICMT approved CCM courses as meeting the SIM PCMH Initiative Care Manager and Coordinator initial training requirements.

- To view the MICMT approved Statewide Trainer POs/Organizations CCM course, click [here](#). The MICMT approved Statewide Physician Organizations/Trainer Organizations identify if they are providing the CCM course for their affiliated practices only or open to practices not affiliated with their organization. This information is available via the link above.

For questions, please contact [micmt-requests@med.umich.edu](mailto:micmt-requests@med.umich.edu)

### **Michigan Institute for Care Management and Transformation Approved Self-Management Support Courses and Resources**

To access the list of the MICMT Approved Self-Management Support courses, please click [here](#). The list of MICMT Approved Self-Management Support Courses provides a detailed summary of each course, with associated objectives, location, cost and more.

Additionally, MICMT has collected resources for Self-Management Support including websites of interest, publications, tools, videos, and even patient materials. MICMT'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. Please click [here](#) to access "Self-Management Support Tools and Resources".

Both documents can also be accessed on the MiCMRC website [home page](#).

### **Upcoming Complex Care Management Course Dates and Registration**

The MICMT CCM course is designed to prepare the healthcare professional for the role of Complex Care Manager. Course content is applicable to all Care Managers and health care professionals in the ambulatory care setting, working with complex patients. Please note, this course has been updated and the new format consists of self-study modules and a 1-day in person training. For CCM Course details [click here](#).

### **Upcoming CCM course dates and course registration:**

September 11 | Dimondale | [REGISTER HERE](#) | Registration deadline: September 4, 2019

September 25 | Lansing | [REGISTER HERE](#) | Registration deadline: September 18, 2019

**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](mailto:MiCMRC-ccm-course@med.umich.edu)

For questions please contact: [MiCMRC-ccm-course@med.umich.edu](mailto:MiCMRC-ccm-course@med.umich.edu)

### **For More Information**

[www.Michigan.gov/SIM](http://www.Michigan.gov/SIM) | [MDHHS-SIMPCMH@michigan.gov](mailto:MDHHS-SIMPCMH@michigan.gov)

