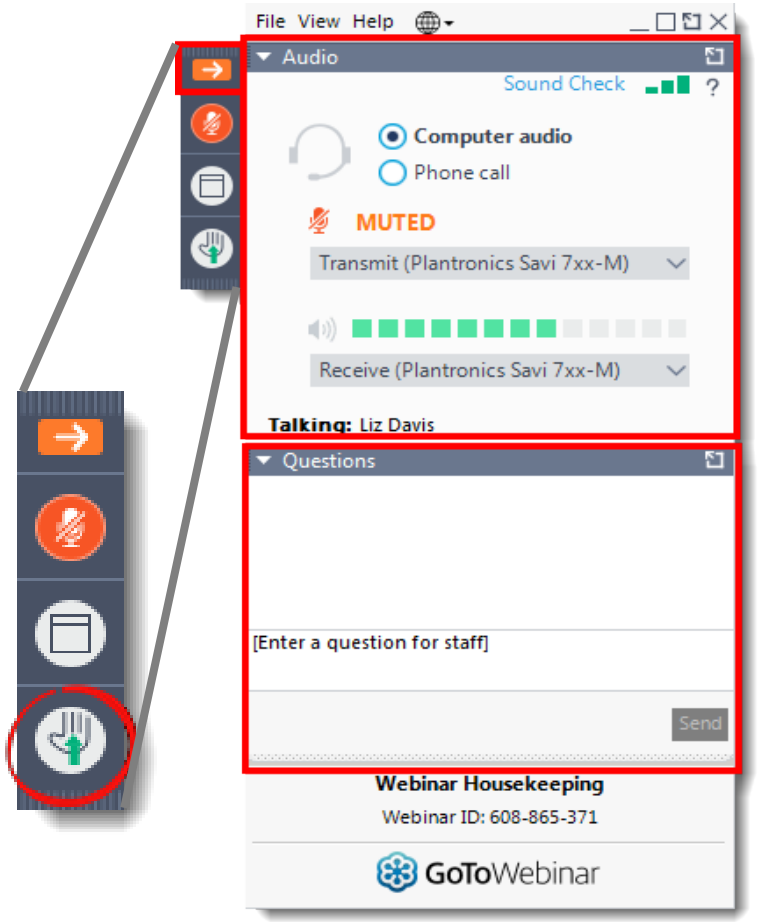
Quarterly Update

STATE INNOVATION MODEL

PATIENT CENTERED MEDICAL HOME INITIATIVE

07.17.2019

Housekeeping:
Webinar Toolbar Features



Your Participation

Open and close your control panel

Join audio:

- Choose **Mic & Speakers** to use VoIP
- Choose **Telephone** and dial using the information provided

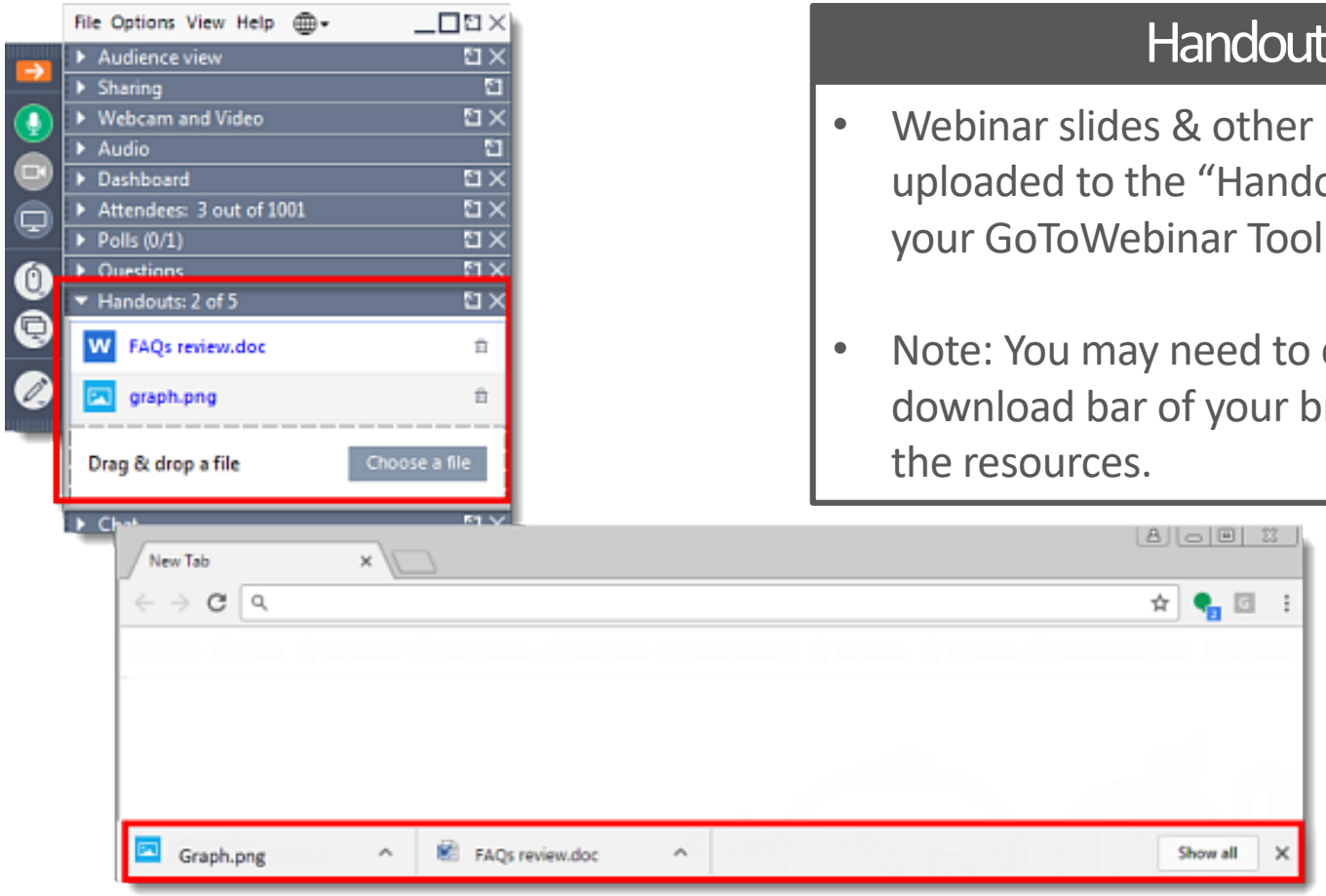
Submit questions and comments via the Questions panel

Note: If time allows, we will unmute participants to ask questions verbally.

- Please raise your hand to be unmuted for verbal questions.

NOTE:
In the event that there is not time to answer questions live, all questions submitted via the Question Function of the GoToWebinar toolbar will be recorded, an Q & A generated and posted to our webpage

Housekeeping:
Webinar Resources/Handouts



Handouts

- Webinar slides & other resources are uploaded to the “Handouts” section of your GoToWebinar Toolbar.
- Note: You may need to check the download bar of your browser to view the resources.

PCMH Initiative Team:

MDHHS Team Members

Katie Commey, MPH
SIM Care Delivery Lead

Lyndsay Tyler
Business Analyst

Nell Newton
Project Manager

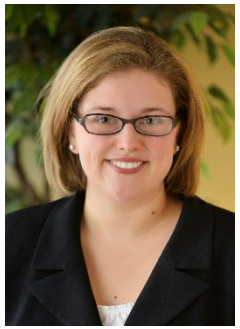
MI-SIM Care Delivery Governance Team	
Kathy Stiffler	Medicaid Care Management and Quality Assurance, Deputy Director
Brian Keisling	Medicaid Operations and Actuarial Services, Bureau Administrator
Kim Hamilton	Managed Care Plan, Division Director
Penny Rutledge	Actuarial Division, Manager
Theresa Landfair	Managed Care Plan Division, Specialist
Tom Curtis	Quality Improvement and Program Development, Section Manager

PCMH Initiative Team:
U of M Team Members

Clinical Values Institute

Veralyn Klink
Administrator

Diane Marriott
Director



Amanda First-Kallus, MHSA
Analyst

Yi Mao
Analyst

Michigan Data Collaborative

Jessie Chen
Application Systems Analyst / Programmer

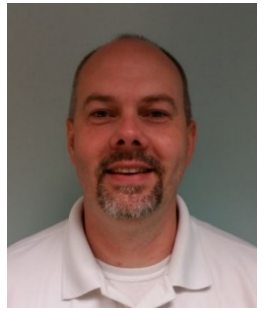
Susan Stephan
Sr. System Analyst

Alice Stanulis
Manager, Michigan Data Collaborative

Justin Bielak
Business Systems Analyst

Michigan Institute for Care Management and Transformation

Marie Beisel
Administrative Manager, Sr. Healthcare



Scott Johnson
Int. Project Manager

Betty Rakowski,
Curriculum Designer

Sarah Fraley, Int. Project Manager

Program Updates

LYNDSAY TYLER

NELL NEWTON

Upcoming Events:
July - September 2019

Date	Type of Event	Topic	Registration Link
July 30 9:00 – 3:00	Care Coordination Collaborative	In-person Event	Contact Vera Klink to be placed on waitlist vklink@med.umich.edu
August 27 11:30 – 12:30	SIM PCMH Initiative Office Hours--August	Servicing the Invisible Patient	REGISTER HERE
September 12 12:00 – 1:00	Pediatric Office Hours -- September	Pediatric Depression	REGISTER HERE
September 19 12:00 – 1:00	SIM PCMH Initiative Office Hours---September	Plan for Improving Population Health	REGISTER HERE
September 24 2:00 – 3:00	SIM PCMH Initiative Supplemental Office Hours – September	Trauma Informed Care	REGISTER HERE

Upcoming Events: *2019 Summit*

THEME: "Sustaining the Gains Through Smart Delivery and Cost-Effective Care"

Date: November 12th (Full day from 8:30 to 3:30)

Approach: One central summit for all

Location: Kellogg Center, Lansing MI

Who Should Attend: Care Managers and Coordinators, Practice Management Staff, PO Administrators, and others from participating SIM practices, managing organizations or CHIRs

Pre-Polling Questions: SURVEY HERE

Upcoming Events: *2019 Summit*

AGENDA PREVIEW

- Plenary: "Sustaining the Gains Through Smart Delivery and Cost-Effective Care”
- Lessons from a Partner State: Building Strong Patient Care Partnerships
- Healthier Communities: What Works to Make Real Change
- Acting on SDoH Data: Beyond Screening
- SIM Evaluation Results
- Adverse Events: From Trauma to Resiliency
- Adolescent Depression: Presentation, Diagnosis, and Treatment
- Medicaid Health Plan (MHP) Panel
- Next Steps and Alternative Payment Models

Care Delivery

The Patient Centered Medical Home (PCMH) Initiative is the core component of
strategy for coordinated care delivery, focused on developing and testing servic
care coordination, lower costs, and improved health outcomes for Michiganders
upon the principles of a patient-centered medical home that generally define the
organization. Value is placed on core functions of a medical home, such as enha
and expanded care teams that focus on comprehensive coordinated care. To in
healthcare practices to provide high-quality and cost-efficient care, SIM is also w
alternative payment models (APMs).

This initiative is aligned with the overall SIM Care Delivery goals of:

- Championing models of care that engage patients using comprehensive,
  accessible and high-quality services centered on an individual's health an
- Supporting and creating clear accountability for quantifiable improvement
  well as health outcomes.
- Creating opportunities for Michigan primary care providers to participate i

If you have questions about the PCMH Initiative, please contact the SIM team a
SIMPCMH@michigan.gov.

Newsletters

April 2019
March 2019
February 2019
January 2019

Upcoming Events

- 2019 Participant Guide Release
- 2019 Agreement Release
- **View all events**

2019 SIM PCMH Initiative Summit

Resources

MDHHS Michigan Department of Health & Human Services

Search

Assistance Programs | Adult & Children's Services | Safety & Injury Prevention | Keeping Michigan Healthy | Doing Business with MDHHS | Inside MDHHS

- Doing Business with MDHHS
- Birth, Death, Marriage and Divorce Records
- Boards and Commissions
- Bridge Card Participation
- Child & Adult Provider Payments
- Child Care Fund
- Child Welfare
- Contractor Resources
- Community & Faith-Based Programs

MDHHS / DOING BUSINESS WITH MDHHS / STATE INNOVATION MODEL / CARE DELIVERY

2019 PCMH Initiative Summit

REGISTRATION LINK COMING SOON!
November 12: Kellogg Center
East Lansing, Michigan

Agenda:

8:30 - 8:40	Welcome/Context Setting/ State Kick-Off
8:40 - 9:40	"Sustaining the Gains Through Smart Delivery & Cost-Effective Care"
9:40 - 10:50	Morning Breakout Options
	1. Lessons from a Partner State: Building Strong Partnerships

Our Care Delivery website has a dedicated page for our PCMH Initiative Annual Summit. View supplemental documents and Nursing, Social Work, CCMC Continuing Education Credits information.

Care Coordination Collaborative (CCC) Series 2019 Overview:

First 2019 In-Person Event on April 9 (In Lansing)

- Focus on Social Determinants of Health (SDoH) Gap Closure
- Over 120 participants
- Expert panel of five wonderful speakers on joint partner collaboration (plan/practice; practice/community organization/plan)
- Materials are posted on the SIM PCMH Initiative Resources tab

Second 2019 In-Person Event on July 30 (in Grand Rapids from 9 to 3 at the Amway Grand)

- Focus on ***Decreasing Unnecessary Utilization and Streamlining Care***
- Contact Vera Klink to be placed on waitlist: vklink@med.umich.edu
- Expert panels with speakers from successful practices, POs and community partners
- Morning and afternoon intensive working group sessions

Q2 (April - June) 2019 Payment Details

Reminders:

- Care Management and Coordination PMPMs see 2019 Participation Guide.
- Payments will be made by each individual Medicaid Health Plan, the PCMH Initiative will send a summary email with details of expected payments

Anticipated Payment Timeframe: MHPs should make payments to participants in September

Reminders:

- SNF, INC, and DEC – reconciliation for 2018 attributed members
- Please ensure practice and provider updates are submitted using the online Change Form.

Support & Learning

MARIE BEISEL

Pediatric Curriculum Planning Work Group

Pediatric Webinar Series	
Topic: ADHD Medication Education Presenter: Tiffany Munzer, MD	Recording
Topic: Pediatric Asthma Presenter: Tisa Vorce MA, RRT	Recording
Topic: Pediatric Depression Presenter: Thomas Atkins, MD Date/Time: Thursday, September 12, 2019 from 12 – 1 pm	REGISTER HERE

*you can also access the webinar recordings via https://micmrc.org/webinars

Michigan Institute for Care Management and Transformation (MICMT): Webinars, E –Learning and Resources

Registration for MiCMRC webinars: http://micmrc.org/webinars

2019 MICMT CCM course – New Format

June 2019 and forward – MICMT Complex Care Management Course (CCM) has a new format:

- A blended learning activity with *self study modules and a one day* in person training

Successful completion of the course:

- CCM course Introduction (recorded webinar)
- Self-study modules (web based)
- One day training in person – 8 hours
- MICMT CCM global course post test, achieve a passing score of 80%, and complete the course evaluation.

- Opportunity to earn Nursing and Social Work CE contact hours
- For MICMT CCM course information/registration: www.micmrc.org or click here

MICMT CCM Course Approved Statewide Trainer Organizations

June 2019, MICMT launched a standardized Complex Care Management course curriculum and a Statewide Trainer application.

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 BCBSM PDCM program, Priority Health Care Management Program and the MDHHS State Innovation Model (SIM) Patient Centered Medical Home (PCMH) Initiative.

MDHHS recognizes the MICMT approved CCM courses as meeting the SIM PCMH Initiative Care Manager and Coordinator initial training requirements.

A list of MICMT Approved CCM Course Trainer Organizations to date is available on the micmrc.org web site; click here

MICMT Longitudinal Learning Activities – 2019 recorded webinars

Title	Presenter
Pre- Diabetes	Tamah Gustafson, MPH, CHES
Social Determinants Of Health: A Service Provisioning and Motivational Interviewing	Michael C. Ramsey and Maryam W. Tout
Suicide Assessment, Risk, and Prevention	Kristyn Spangler, LMSW
Identifying and Addressing Anxiety in Primary Care	Teague Simoncic, LMSW

Access a library of recorded webinars and e Learning modules: www.micmrc.org

Participant Reporting

AMANDA KALLUS

NELL NEWTON

SUSAN STEPHAN

Upcoming Compliance: Schedule

Report/Audit	Due Date
Semi-annual Practice Transformation Report (SAPTR)	7/31/2019
Audits: 24/7 Access, Alternative Visits, Utilize EHR, 30% Open Access	7/2019
Audits: Utilize Dashboards, Utilize Patient Lists	8/2019
Final Progress Report	10/31/2019
Final SAPTR	TBD

Upcoming Compliance:
Semi-annual Practice Transformation Report

Due: July 31, 2019

Content:

1. Clinical-Community Linkages (CCL), with the following sub-sections:
    1.1 Assessing social determinants of health
    1.2 Linkage methodology
    1.3 Quality improvement activities

2. Population Health Management (New)
    2.1 Ensuring engagement of clinical and administrative leadership
    2.2 Empaneling patient population
    2.3 Using feedback reports

Note: Participant Key Contact receive an email with report link and supplemental excel document in June 2019. The PO will complete the report on behalf of all participating practices.

Upcoming Compliance:
Clinical-Community Linkages

CCL Data Partnership

Regular Initiative reporting provides valuable information on how the provider community is executing screening and linking requirements. The CCL Data Partnership was designed to provide details on the individual connection and solution to better understand the link between social needs and individual health and wellbeing.

- 11 PCMH Initiative Participants submitting SDoH data
- All historical production files received
- **HOLD FUTURE QUARTERLY SUBMISSIONS UNTIL FURTHER NOTICE**

Upcoming Deliverables End of July

Dashboard Release 9

- Reporting Period April 2018 – March 2019
- Patients and provider attribution from March 2019

Reports

- February 2019 – April 2019 Care Management and Coordination
  - Percent of Patients with Care Management
  - Inpatient Stay With a Follow-Up Visit within 14 days
- July Patient and Provider Lists

Reporting for Care Management Improvement Reserve (CMIR) and Performance Incentive Program(PIP)

- The remaining reporting for 2019 to support CMIR and PIP are listed below
- There is a planned "True-Up" for Care Management reports to occur in the 4th quarter to include claims that were received after the initial report was produced (4Q18, 1Q19, and 2Q19)

Deliverable	Target Date	Reporting Period	Program
Percentage of Patients with a Care Management Claim	Early October 2019	April – June 2019	CMIR
Dashboard Release 10	End of October 2019	July 2018 – June 2019	PIP

SIM PCMH Initiative Evaluation Components

Evaluation Activity	Purpose	Target Audience	Timeline	Owner
Provider Survey (PO reps, PCPs, CM/CC, Office Managers)	Identify attitudes and experiences of health providers who participate in Clinical Community Linkages (CCLs) directly or indirectly	• PCMH Initiative Participants identified as members or partners of a CHIR	May – July, 2018	MSU ✓
		• PCMH Initiative Participants in CHIRs NOT identified as members or partners	Aug. 1-31, 2018	MPHI ✓
		• PCMH Initiative Participants outside of CHIRs	Aug. 1-31, 2018	MPHI ✓
Patient Experience Survey	Identify experiences of patients who participate in CCLs	• Sample of patients from PCMH Initiative Participants	Fall, 2018	CHEAR ✓
CCL Data Partnership *(optional)*	Connect individual-level CCL data (Social Determinant of Health screening and linkages) to Medicaid utilization and costs (claims data from MDC)	• Patients within PCMH Initiative participants selected to participate.	Oct. 2018, quarterly thereafter	MPHI **In process**

Continuity of Best Practices

AMANDA KALLUS

NELL NEWTON

LOOKING BACK

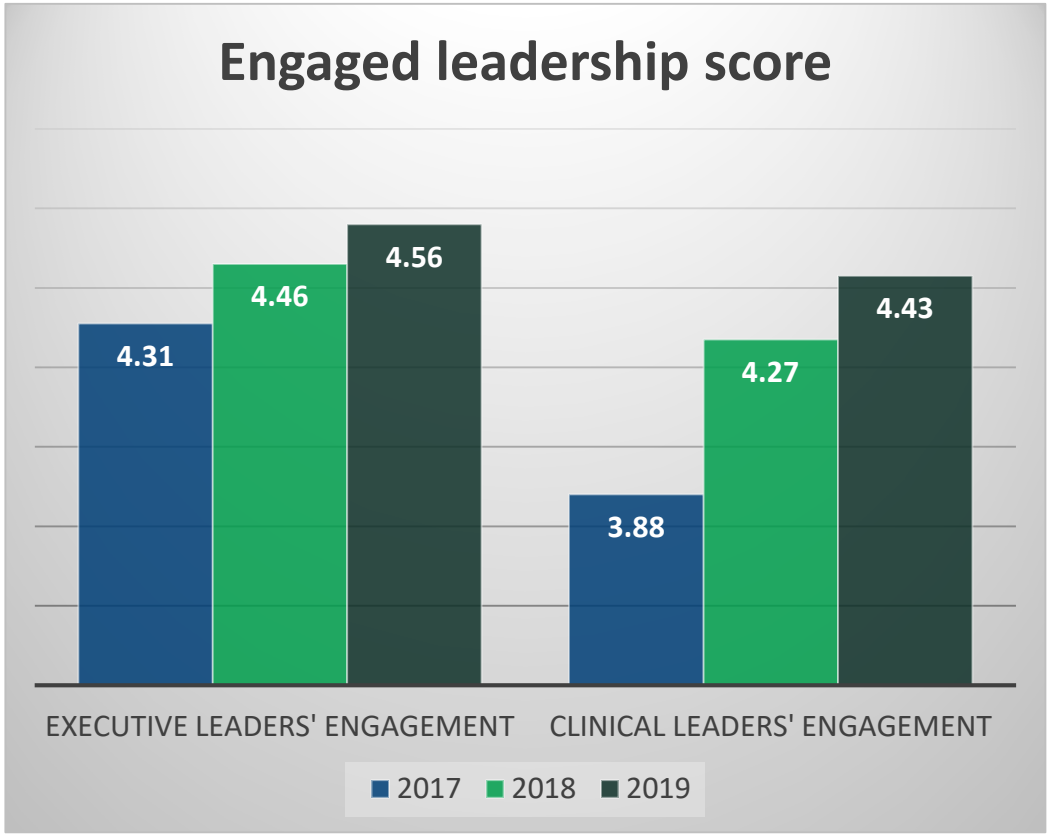
LOOKING AHEAD

2019 Self-Assessment
Summary

	2017	2018	2019
Respondents	357	327	321
Areas scored	26	27	25
Areas with a score <3	4	1	0
Areas with a score >4	10	18	20
Areas improved from previous year		25	21
Areas dropped from previous year		1	2

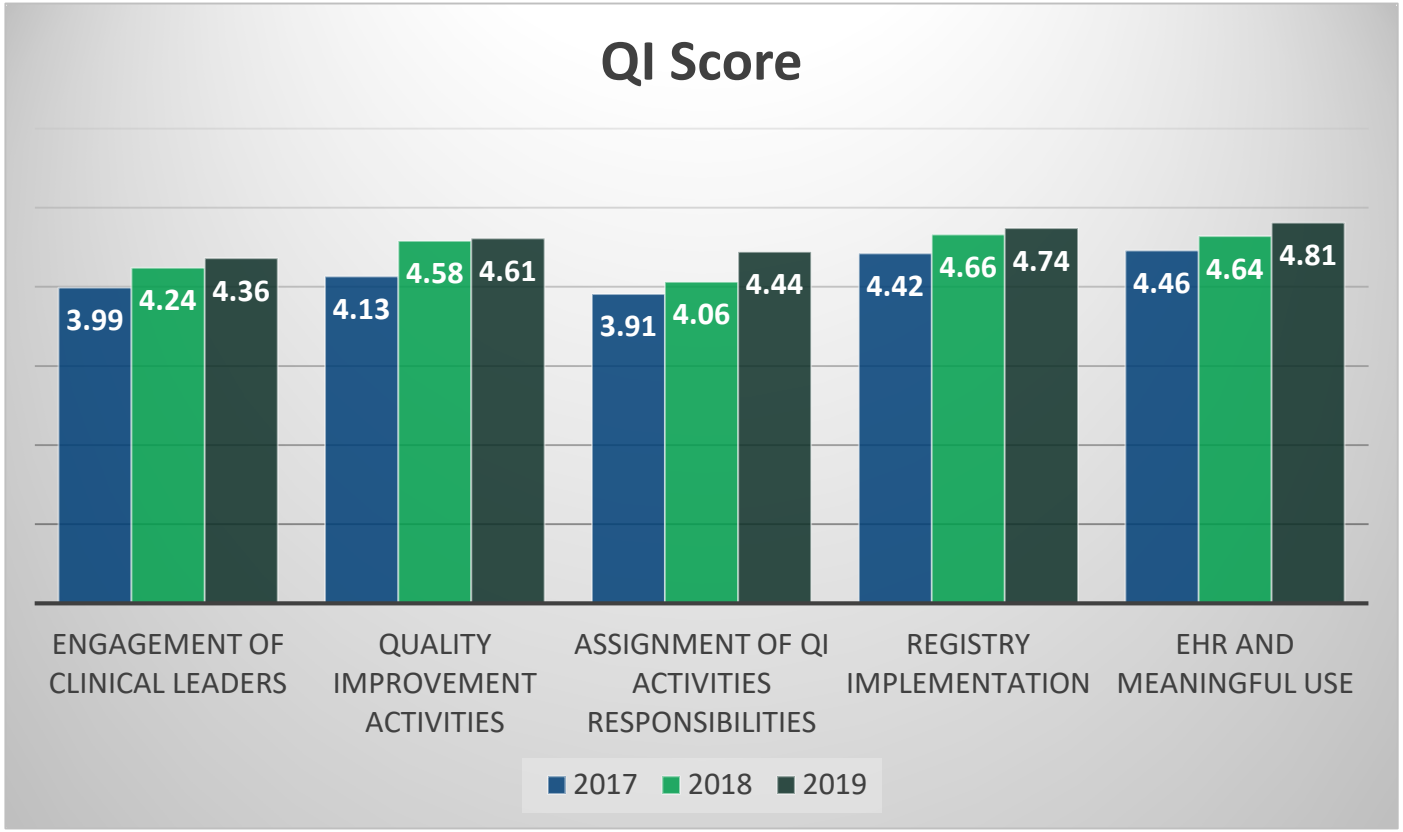
- Areas of strength (>4.5): Behavioral health screening, EHR and meaningful use, utilization of patient registry, QI activities, identification of overdue appointment for preventive care or chronic care, leadership engagement in improving outcomes, outreach activities based on gap analysis of care reports
- Areas of weakness (<3.5): Close collaboration with mental health provider in a fully integrated system
- Areas with impressive improvements (>=10%): Documentation, utilization, evaluation and modification of practice workflows, risk level assessment and follow-up, outreach for overdue care, panel assignment and regular review
- Areas with slight score drop: Close collaboration with mental health provider in a fully integrated system, identification of overdue appointment for preventive care or chronic care

2019 Self-Assessment
Engaged Leadership



- Executive leadership engagement score has been improved continuously from 2017-2019. More executive leaders consistently champion and engage interdisciplinary teams in improving patient experience and clinical outcomes.
- Clinical leadership engagement score has been improved continuously from 2017-2019. More clinical leaders consistently support and champion population health, all-patient registries, and working cooperatively with care managers and coordinators.

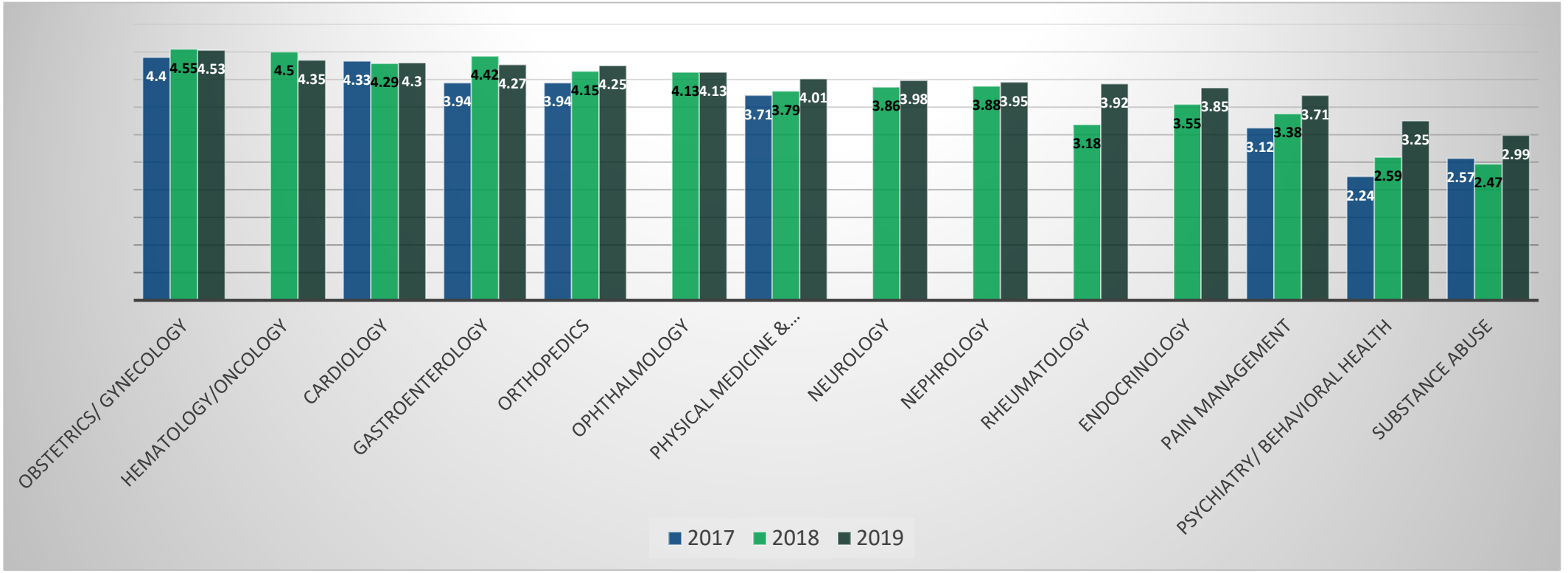
2019 Self-Assessment
Quality Improvement



- Scores of all QI engagement and activities have been improved continuously from 2017 to 2019

2019 Self-Assessment

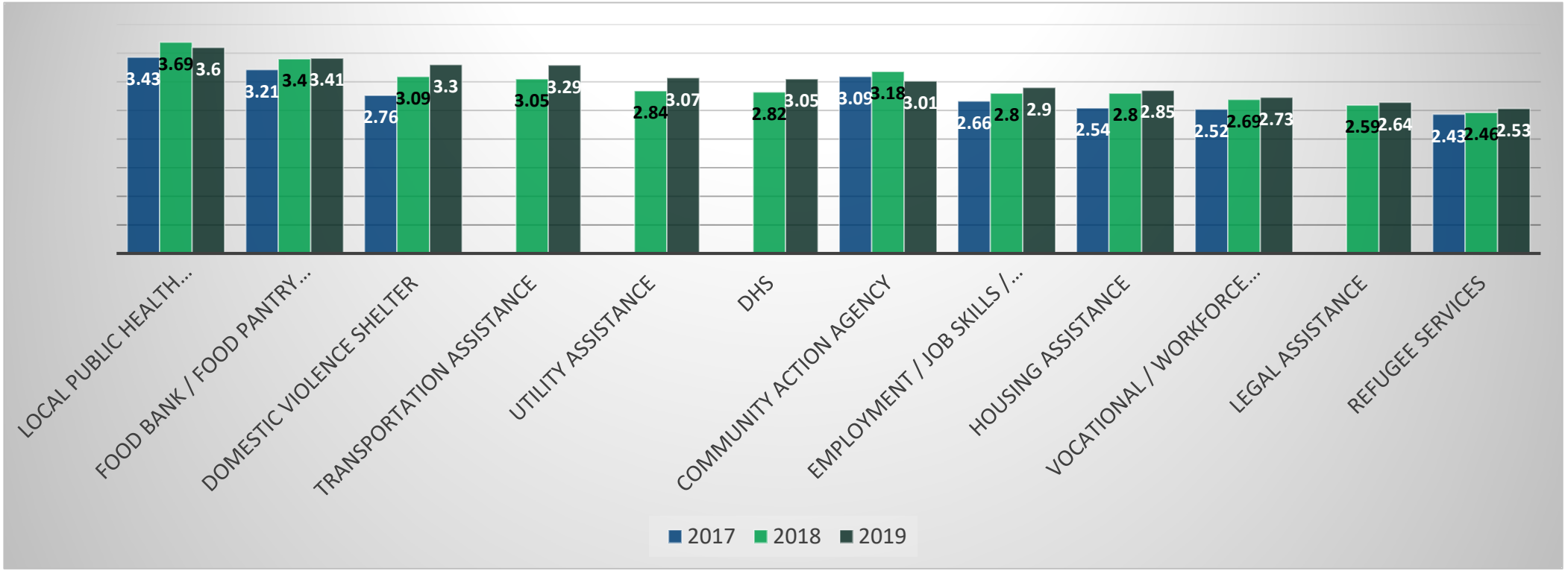
Clinical Referral Availability & Follow-up



- 10 out of 14 referral conditions have improvements in availability and follow-up compared to 2018.
- Areas with a score <3: substance use

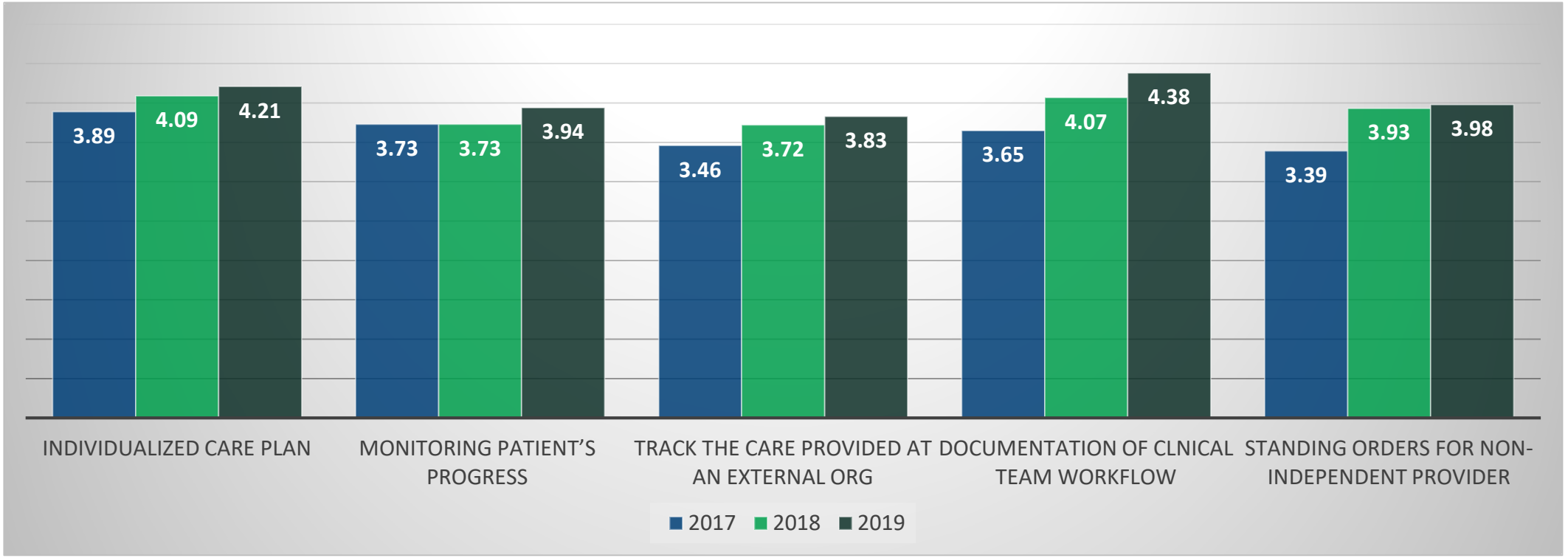
2019 Self-Assessment

Clinical Referral Availability & Follow-up cont.



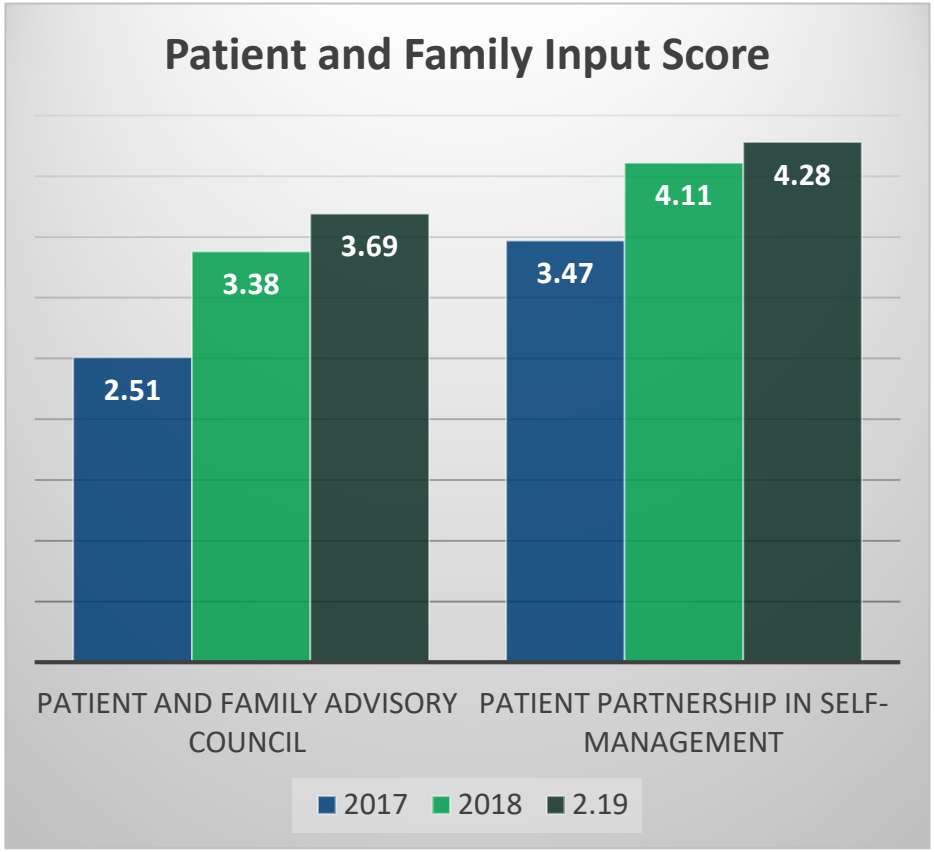
- 8 out of 10 community-based resources have improvements in availability and follow-up compared to 2018.
- Areas with a score <3: Employment support, Workforce training, Housing assistance, Refugee services, Legal assistance, Utility assistance, DHS

2019 Self-Assessment
Team Based Care



- All of the team-based care activity scores have been improved from 2018.

2019 Self-Assessment
Patient and Family Engagement



- The score of Patient and Family Advisory Council has been improved continuously from 2017 to 2019. Over 60% of the practices have regular communication and meetings with patient and family advisors and/or advisory councils.
- The score of patient partnership in self-management has been improved has been improved continuously from 2017 to 2019.

Post-SIM
State-preferred PCMH Model

Michigan's Medicaid Managed Care Plan Division (MCPD), in collaboration with Medicaid Health Plans (MHPs) have been developing a set of PCMH program parameters for integration into MHP future payment/contract models.

<u>Highlights:</u>

- Funds will be added to MHP capitation rates to directly administer preferred PCMH programs and care management/care coordination services.
- Developing a measure to assess utilization of care management/care coordination services by MHP members in the State.
    - Meeting the utilization targets will be linked to MHPs' ability to earn bonus payments beginning in FY 2020.

Post-SIM
State-preferred PCMH Model Interest Application

MDHHS facilitated an application process in partnership with the MHPs to identify provider interest in participating in MHP PCMH programs.

Application Results:

- 73 applications
- 870 Practices
- 560 Meet Minimum Eligibility Requirements
- 114 Contingent Status – pending MHP determination
- 289 Current SIM PCMH Initiative Participants

Notification: Applicants will receive email from MDHHS-SIMPCMH@Michigan.gov indicating status communicated to MHPs (Eligible, Contingent, Fail) with respect to minimum eligibility requirements*.

Contracting: MHPs will contract directly with providers (MDHHS is supporting a central application process only)

*additional advanced practice requirements will be required for consideration, MHPs may have additional criteria beyond MDHHS' preferred model program requirements

Post-SIM
Roles and Responsibilities

What MCPD is doing…	What MHPs should consider…
Folding directed payments into MHP rates for FY 20	Identify the providers in your network you anticipate getting value from for your investment Determine your payment methodology
Providing common PCMH parameters for MHPs to follow in contracting with PCMHs starting CY 20	Add state-preferred PCMH parameters to provider contracts incorporating PCMH and care management/care coordination services
Measuring utilization of care management and care coordination using encounter codes to ensure utilization consistent with historic Medicaid investment	Ensure a balance between volume of providers in network with PCMH parameters in contract, enticing payment methodology for providing services, and engaged providers who will provide services
Looking at standardizing quality measures for PCMH model and/or by region	Align with quality measures at the PCMH level to the extent possible

Post-SIM
Care Management & Coordination

CY 2017 – CY 2019

- Providers receive CM & CC $ for SIM PCMH Initiative participation and requirements
- Accreditation
- Practice Requirements
- HIE
- SDoH

CY 2020

- MHPs will receive added Capitation $ for CM & CC Services
- MHPs will contract with providers to deliver CM & CC Services
- Providers will meet MHP requirements
- Accreditation or Practice Requirements
- Quality/ CM & CC Performance
- Panel Size

Post-SIM
FY20 CM & CC Utilization Measure

CM & CC Utilization Measure will be based on previous efforts by MDHHS

CM & CC Utilization Measure includes ALL managed care populations, not specific to age or diagnosis

CM & CC Benchmark will be set based on historical data to ensure that the level of utilization for beneficiaries does not fall below that of historical levels

Post-SIM
CM & CC Utilization Measure(s)

Code	Description
G9001	Comprehensive Assessment
G9002	In-person CM/CC Encounters
G9007	Care Team Conferences
G9008	Provider Oversight
98966	Telephone CM/CC Services
98967	Telephone CM/CC Services
98968	Telephone CM/CC Services
98961	Education/Training for Patient Self-Management
98962	Education/Training for Patient Self-Management
99495	Care Transitions
99496	Care Transitions
S0257	End of Life Counseling

Next Steps

- Ensure you are in conversations with MHPs asking about the State-preferred PCMH Model and how that relates to your contracting opportunities

Legislative Budget Update
MI Executive Budget Proposal FY20

The Governor included a line item in the proposed Fiscal Year executive budget to support the continuing to evaluate aspects of the State Innovation Model related to Community Health Innovation Regions (CHIRS).

The proposed budget is under review, Legislative hearings are expected to continue into September.

Questions and Additional Resources

MDHHS-SIMPCMH@michigan.gov

SIM
MDHHS State Innovation Model

Thank you for joining us today!

www.michigan.gov/SIM

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

Resources

MiCMRC is now MICMT

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).

MICMT will:

- convene thought leaders, care managers, and PO leaders throughout the state to support collaboration and disseminate best practices
- support the development and implementation of best-practice infused care management strategies within Michigan POs
- develop and maintain a library of materials, self-learning modules, and training opportunities that support the programs and goals described above
- align efforts along a common set of success metrics, which include both outreach and outcomes (quality/ utilization) metrics, and provide evaluation of those metrics at a PO and state level

For questions please contact: www.micmt-requests@med.umich.edu

2019 Self-Management Training Options

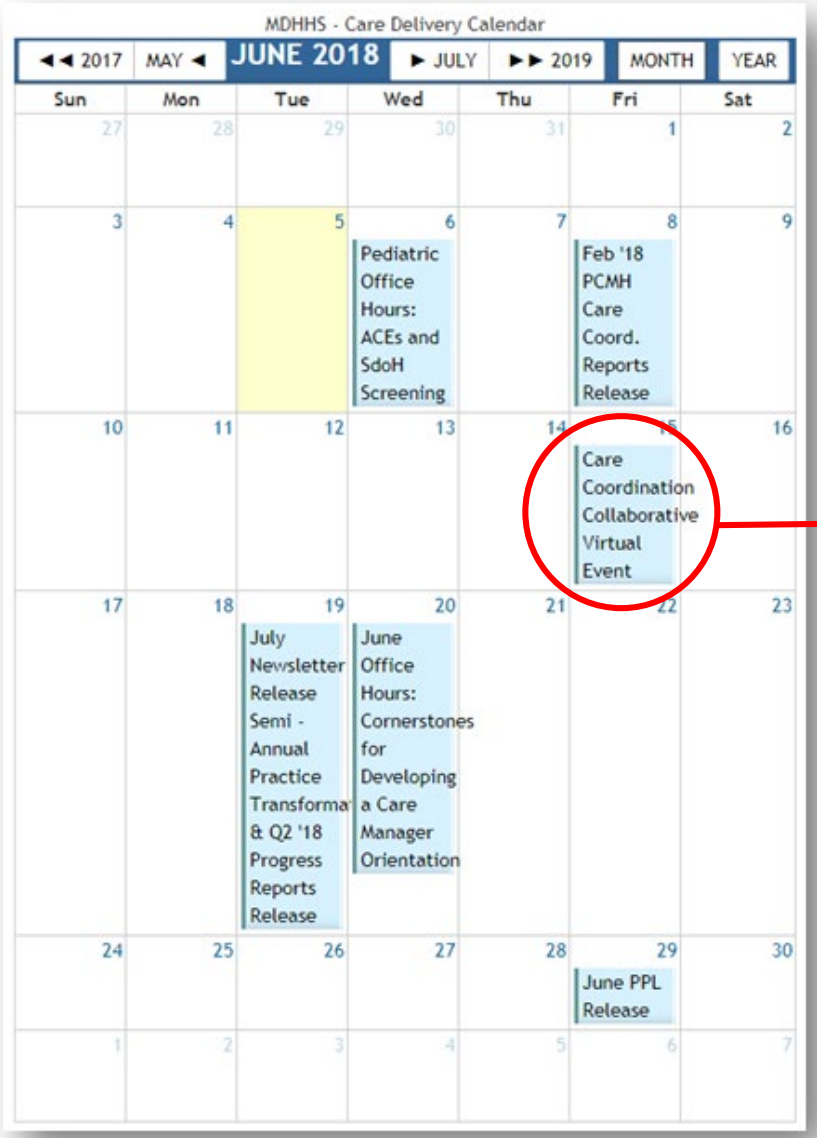
Class availability and the number of training slots may vary at each organization. If classes with a particular vendor are f ull, you will be put on a wait list or can explore availability at the other organizations.

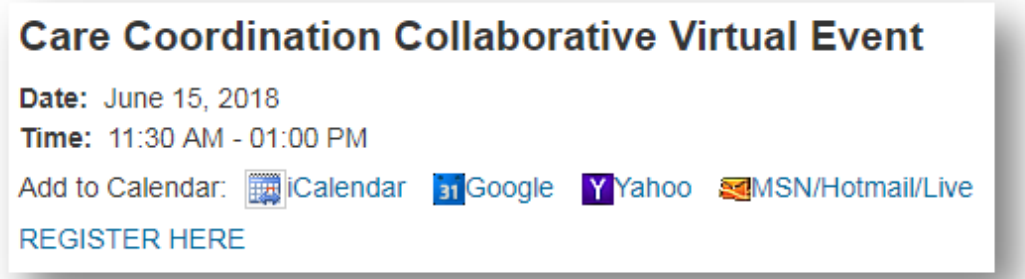
The links for each organization are:

- Integrated Health Partners (IHP) - based in Battle Creek
  - http://www.integratedhealthpartners.net/events
  - To be placed on a wait list, contact: Emily Moe | moee@integratedhealthpartners.net | Phone: 269-425-7138.
- Michigan Center for Clinical Systems Improvement (Mi-CCSI) - based in Grand Rapids
  - https://www.miccsi.org/training/upcoming-events/
  - To be placed on a wait list, contact: Amy Wales | amy.wales@miccsi.org | Phone: 616-551-0795 ext. 11
- Practice Transformation Institute (PTI) - based in Southfield
  - http://www.transformcoach.org/care-manager-training/
  - To be placed on a wait list, contact: Yang Yang | yyang@transformcoach.org | Phone: 248-475-4839

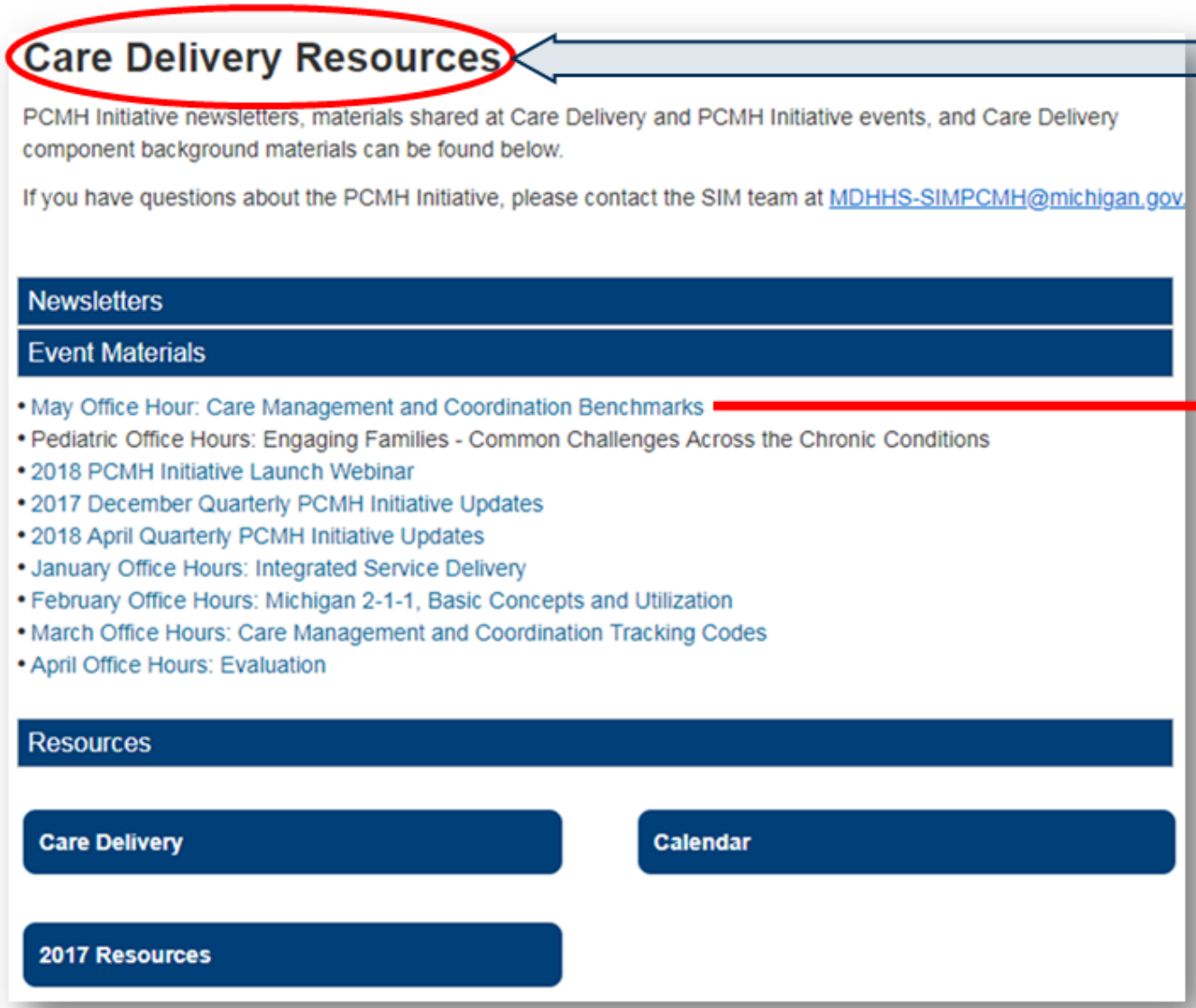
For “At a Glance” information about each organization’s Self-Management training visit: http://micmrc.org/

Care Delivery Website

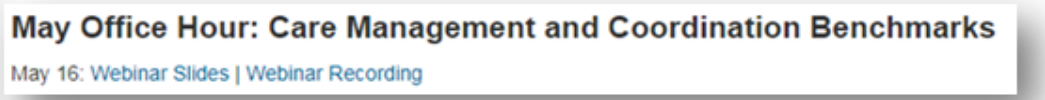




Selecting an event in the calendar will allow you to register and add it to your calendar with one click!



To ensure you're viewing the correct resources make sure you're on the Care Delivery page.



Click on an event listed in the drop down menu and you will be able to access any available materials related to it: webinar slides, webinar recording, any supplemental documents.

Practice Support and Learning Opportunities: *Monthly Newsletters*

Distributed via GovDelivery & on our website!

- To sign up for the distribution:
  - Email us at MDHHS-SIMPCMH@michigan.gov, or
  - Sign up for MDHHS subscriptions: when managing your "subscriptions" select State Innovation Model Patient Centered Medical Home Initiative"

Will be released late month for the following month (ex. February Newsletter will be released in late January)

Designed to have upcoming events, training information, topics of interest, participant highlights, suggested resources and other pertinent information

Suggestions always welcome, please email them to MDHHS-SIMPCMH@Michigan.gov

MDHHS
Michigan Department of Health & Human Services

SIM PCMH Initiative Newsletter

A publication of Michigan's State Innovation Model
December 2017

In this Issue

- Initiative Announcements
- Upcoming Events
- Monthly Calendar

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 multi-payer health care payment and service delivery models in order 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

Welcome to the 2017 Patient Centered Medical Home Initiative, and the eleventh release of our monthly newsletter. Each month we will bring together all the updates, news and upcoming events relevant to PCMH Initiative Participants. Additionally, we will provide updates on other happenings across the State Innovation Model.

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

PCMH Initiative Quarter 4 Progress Report

The PCMH Initiative Quarter 4 Progress Report is expected to be released on December 21, 2017. Submission deadline is Wednesday, January 31, 2018 by 5:00pm. The link to the electronic submission will be distributed to your organization's key contact. You can preview the requirements and instructions to complete report in the report guide. The guide can be found under "Resources" at the main PCMH Initiative website.

PCMH Initiative 2018 Launch

We look forward to connecting with at least one representative from each Physician Organization or Practice at our PCMH Initiative 2018 Launch webinar on January 9, 2018 from 12:00-1:00pm. Topics covered will include a recap of 2017, an overview of 2018, an outline of resources available to participants, a guide to PCMH Initiative team members and who to contact, reporting requirements including the 2018 Practice Self-Assessment, and a time for questions and answers. Register to reserve your spot. See you there! Please Note: participation in this webinar is a requirement of the PCMH Initiative.