MiCMRC Complex Care Management Course

The State Innovation Model (SIM)

The Michigan Care Management Resource Center

State Innovation Model (SIM)

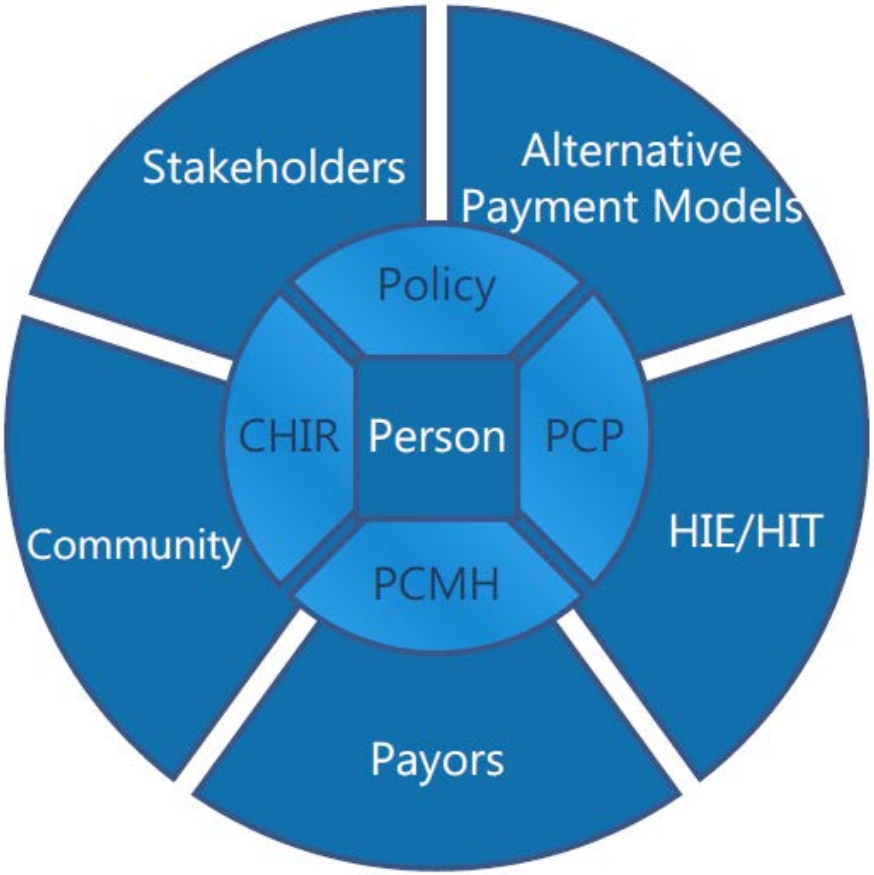
Michigan received a State Innovation Model grant from Centers for Medicaid and Medicare Services (CMS) to test delivery and payment system changes. SIM will facilitate the development and testing of new multi-payer health care payment and services delivery models in Michigan.

- 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.

SIM 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.

SIM Vision


Stakeholders
Alternative Payment Models
Policy
CHIR
Person
PCP
Community
HIE/HIT
PCMH
Payors

Michigan SIM Care Delivery Focus

Support Scale for What's Working

- Support the care delivery foundation in Michigan including team-based care, advanced access, care management, self-care support and core HIT functions

Encourage the "Next Step" for Advancement

- Develop more effective care transitions, informed referrals, integrative treatment, risk stratification, HIT enabled quality improvement and information exchange

Test Promising Practices Where Opportunities Exist

- Encourage a community-centered health focus, fully linking clinical practice with community resources and population health interventions

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Applying Care Delivery Focus to the PCMH Initiative

Support Scale for What's Working	Encourage the "Next Step" for Advancement	Test Promising Practices Where Opportunities Exist
PCMH Accreditation/Recognition as a Foundation	Team-Based Care Practices	Clinical-Community Linkages
Advanced Access	Integrative Treatment Planning	Referral Decision Supports
Electronic Health Record and Registry Base Technology	Provider Collaboration and Integration	Patient Engagement, Health Literacy and Social Determinants Perspectives
Structured Quality Improvement	Robust Care Management and Coordination	Patient-Reported Outcomes
	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	

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Participating Regions

- State Innovation Model (SIM) funding and activities support PCMHs located within SIM's 5 regional test locations and existing MiPCT practices across Michigan (including those outside SIM test locations)
- SIM regional test locations include the following counties:
  - Jackson
  - Muskegon
  - Washtenaw & Livingston
  - Genesee
  - Northern Michigan
    - Emmet, Wexford, Antrim, Kalkaska, Missaukee, Charlevoix, Grand Traverse, Leelanau, Benzie, and Manistee

Provider Types Eligible to Participate in the PCMH Initiative Include:

- Family Physicians
- General Practitioners
- Pediatricians
- Geriatricians
- Internal Medicine Physicians
- Obstetricians
- Gynecologists
- Advanced Practice Registered Nurses
- Physician Assistants
- Safety Net Providers (e.g. federally qualified health centers, rural health clinics, child and adolescent health centers, local public health departments, and Indian health services)

Practice Requirements

- 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

- 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, SCD)
  - Stage 1 / modified Stage 2 Meaningful Use achievement

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Participating Practices

- MDHHS completed an application process for the 2017 PCMH Initiative in September
- The Department received applications encompassing 486 practice units and over 2,400 primary care providers
- MDHHS announced the selection decisions in October 2016

PCMH Initiative Patient Population

- Represent a broad array of individuals including healthy patients and those with single or multiple chronic diseases
- A sustentative portion of the Initiative's performance metrics will be targeted toward patients with more significant needs including Michigan's SIM target populations (high utilizers of emergency department services, patients with multiple chronic diseases etc.)
- Medicaid managed care beneficiaries will be attributed to PCMHs based on their selected/assigned primary care provider

PCMH Initiative Patient Population

- The following Medicaid beneficiaries will be excluded from the PCMH Initiative (not an exhaustive list):
  - Fee-for-Service
  - Primary Care Health Homes (MI Care Team)
  - Integrated Care Demonstration (MI Health Link)
  - Incarceration
  - Emergency Services Only
  - Maternity Outpatient Medical Services
  - Nursing Home
  - Program of All-Inclusive Care for the Elderly (PACE)
  - Plan First!
  - Spenddown
  - State Psychiatric Hospital
  - Care Facilities for Intellectual Disabilities

PCMH Initiative Payment

- The PCMH Initiative payment structure supports participating practices through two types of payments:
  - Care Management and Coordination
    - To support staffing resources and delivery of Care Management and Coordination Services to an array of patients with varying needs
  - Practice Transformation
    - To support the advancement of infrastructure within (or accessible to) PCMH practice environments. Practice transformation in this context is not focused on (or funded to support) the act of delivering a service to an individual patient. Rather, practice transformation support in the PCMH Initiative is geared toward building capability and developing structures which make the work of a PCMH participating practice more effective in the required and selected objective focus areas.

PCMH Initiative Care Management

- A participating practice's care team(s) must include embedded care management and care coordination staff members functioning as integral, fully-involved members of the team

- At least one member of the team will be required to be a licensed Care Manager
  - The following types of professionals will be eligible to serve as a Care Manager:
    - Registered Nurse, Licensed Practical Nurse, Licensed Master's Social Worker, Licensed Professional Counselor, Licensed Pharmacist
  - The following types of professionals will be eligible to serve as a Care Coordinator :
    - Licensed Bachelor's Social Worker, Registered Dietician, Social Service Technician, Certified Medical Assistant, Certified Community Health Worker

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Care Management Learning 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

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

Care Management Learning Activity Requirements

- The PCMH Initiative maintains the expectation that all Care Managers and Coordinators will maintain their current licensure/certification, including the requirements to seek continuing education approved by the appropriate professional organization/association.
- Each care manager and care coordinator must complete a total of twelve (12) contact hours of continuing education per year. This can be satisfied by either:
  - Twelve (12) hours of PCMH Initiative -led care manager and care coordinator webinars/sessions (e.g., Annual SIM Summit Care Manager Skill Building), 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 continuing education credit-granting events. No preapproval is necessary for PO-led care manager, care coordinator training sessions.

PCMH Initiative Metrics

- The PCMH Initiative will be measuring participants through the following metrics:
  - Quality of Care and Health Outcome Measures
  - Utilization and Cost Measures
  - Initiative defined Care Management and Coordination Measures

Quality of Care and Health Outcome Measures

First Release	Second Release	Third Release	Fourth Release
CDC: A1c Testing	Chlamydia Screening	Anti-Depressant Medication Management	CDC: A1c Control
CDC: Eye Exam	Childhood Immunization	Follow-Up Care for Children Prescribed ADHD Medication	CDC: Blood Pressure Control
CDC: Attention for Nephropathy	Adolescent Immunization		Controlling High Blood Pressure
Colorectal Cancer Screening	Well Child Visits (15 Months)		Weight Assessment and Counseling for Nutrition and Physical Activity
Cervical Cancer Screening	Well Child Visits (3-6 Years)		Adult BMI Assessment
Breast Cancer Screening	Well Child Visits (Adolescent)		Tobacco Use Screening and Cessation
Use of Imaging Studies for Low Back Pain	Use of High Risk Medications in the Elderly		Screening for Depression and Follow-Up
Hypertension Prevalence	Lead Screening		
Asthma Prevalence	Diabetes Prevalence		
Obesity Prevalence			

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Utilization, Cost and Care Management Metrics

First Release	Second Release	Third Release	Fourth Release
All Cause Acute Inpatient Hospitalization Rate	Percent of Attributed Patients Receiving Care Management*	Total PMPM Cost	
Emergency Room Visit Rate	Timely Follow-Up with a PCP After Inpatient Discharge*	Preventable Emergency Room Visits	
30 Day Re-Admission Rate		Ambulatory Care Sensitive Hospitalizations	

* The benchmarks for these measures to monitor compliance against will be established by the Initiative no later than June 30, 2017

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