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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](#)

Happy New Year! 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

### PCMH Initiative 2019 Launch

We look forward to connecting with at least one representative from each Physician Organization or Practice at our PCMH Initiative 2019 Launch webinar on Tuesday January 8, 2019 from 12-1pm. Topics covered will include a recap of the past year, an overview of the 2019 changes, an outline of resources available to participants, a guide to PCMH Initiative team members and who to contact, reporting requirements and a time for questions and answers. [REGISTER HERE](#) reserve your spot. See you there! Please Note: participation in this webinar is a requirement of the PCMH Initiative.

### 2019 PCMH Initiative Agreement Process

If your organization did not complete an Intent to Continue Participation application, you will *not* receive a formal Agreement for participation in the PCMH Initiative in 2019. The MDHHS Bureau of Purchasing will be emailing the Agreements for signature to the key contact and signatory authority as listed on the Intent to Continue Participation application and will copy the organization's key contact. Agreements must be signed and returned via email to the Bureau of Purchasing ([MDHHS-BOP-MOU@michigan.gov](mailto:MDHHS-BOP-MOU@michigan.gov)). As Agreements are finalized you'll receive more information regarding deadlines and signatory requirements. If you have any questions regarding the process or Agreement itself, please email the PCMH Initiative team at [MDHHS-SIMPCMH@michigan.gov](mailto:MDHHS-SIMPCMH@michigan.gov) with the subject line "2019 Agreement [organization name]".

### 2018 Q4 Progress Report

The PCMH Initiative Quarter 4 Progress Report was released in December and the submission deadline is **January 31 by 5:00pm**. The link to the electronic submission was distributed to your organization's key contact. You can preview the requirements to complete the report in the report template. If you have any questions regarding this report, please email the PCMH Initiative Team at [MDHHS-SIMPCMH@michigan.gov](mailto:MDHHS-SIMPCMH@michigan.gov).

## **PCMH Initiative Practice Self-Assessment**

The PCMH Initiative Self-Assessment tool was released in December. This assessment is intended to assess Participating Practices on their current Patient Centered Medical Home capabilities and identify opportunities for the Initiative to support participants in the future. It will also help sites track progress toward practice transformation. The assessment should be completed by **5pm on February 8, 2019** by each of the participating practices. A PDF document with all the survey questions is available [here](#). Please note that the PCMH Initiative requests that you submit your responses via the Qualtrics link, not the PDF copy of the report. The PDF copy is intended for informational purposes and does not constitute the approved format for submitting the report.

## **January Office Hour: Your Chance to Learn More About Patient and Family Advisory Councils (PFACs)!**

Is your practice or Physician Organization interested in better engaging patients in care and healthy behaviors? Are you in Comprehensive Primary Care+ (CPC+) as well as SIM and must implement Patient and Family Advisory Councils (PFACs) as a care delivery requirement? Though PFACs are not a requirement for SIM, they are for CPC+ and are rapidly growing in implementation.

On January 24, 2019 from 11:30 to 12:30pm, the SIM PCMH Initiative will host a monthly office hour session for interested participants about how to start, run, and get the most out of Patient and Family Advisory Councils. PFACs are a technique to connect a group of patients with a practice for a series of ongoing, regular meetings (usually four to six per year) to delve into the patient perspective on specific areas of interest and opportunities for practice improvement regarding quality and experience of care.

The session will provide some “plug and play” resources that your organization can customize to make their own. As well, we will address common challenges to effective and efficient PFACs and ways to overcome them. [REGISTER HERE](#)

## **February Office Hour: Community Health Innovation Region Updates**

Representatives from the state SIM Community Health Innovation Regions (CHIR) team and local backbone organizations will provide an update on recent developments in the CHIR implementation. The presentation will provide a very brief overview of the purpose and function of the CHIRs, how they are structured, and how each one is working to address nonmedical factors that impact health. Also discussed will be upcoming milestones for the final year of implementation under the SIM Model Test period, as well as plans for sustaining key functions of the CHIRs into the future. There will be time for PCMH partners to pose questions related to the clinical-community linkages (CCL) processes and other potential opportunities for collaboration between PCMH providers and CHIR action teams. [REGISTER HERE](#) to reserve your spot.

## **Your Participation Made the Difference for the 2018 SIM PCMH Initiative Summits**

With the start of a new year, we take a moment to reflect on three very successful regional SIM PCMH Summits in 2018. Here are some highlights:

- Across the three locations, almost 550 SIM PCMH Initiative participants attended
- Top Medicaid Leadership from MDHHS presented at each summit
- 21 expert speakers from throughout the state shared perspectives and techniques to make care better
- 86 people provided their suggestions for “what sustainability means”; these ideas will be categorized and shared with SIM Leadership
- 9 practice and PO leaders served as Summit Ambassadors, participating in the planning of the events as well as serving “hands-on” at the summits

We are grateful for your active participation at the summits and throughout the year. We look forward to

working together to make the 2019 summit experience the most helpful yet!

## Upcoming Michigan Data Collaborative Deliverables

### **Updated Reporting Schedule for Care Coordination & Detail Reports**

Starting in January 2019, the *Care Coordination* and *Claims Detail* reports will be posted each month with a rolling quarter timeframe. These reports will replace the previous single month and quarter reports. Each month's report will include the most recent three months of available data to better capture a bigger picture of care coordination services for your population. The January 2019 report's rolling quarter matches up with 3<sup>rd</sup> Quarter 2018 (includes data from July, August, and September 2018). For more information about these reports see the [Care Coordination Reports Reference document](#) on the [Michigan Data Collaborative \(MDC\) Website](#).

### **SIM PCMH Dashboard Release 7.0**

MDC plans to post Release 7.0 at the end of February 2019. It will include the following:

- Paid claims through November 2018 (Medicaid data received by December 15, 2018)
- A 12-month reporting period of October 2017 – September 2018
- September 2018 filtered SIM Participant File (SPF) and Provider Hierarchy data
- Trend lines
- Measurement recalculation to account for multiple HEDIS versions and updated measure definitions

Stay tuned for more information as we get closer to the release date.

### **Upcoming MDC Deliverables**

- December 2018 PCMH Patient Lists and Provider Reports - late December 2018
- August 2018 Care Coordination and Claims Detail Reports - late December 2018
- 4<sup>th</sup> Quarter 2018 Aggregated Patient Reports – early January 2019
- July – Sept 2018 Care Coordination and Claims Detail Reports – mid January 2019
- January 2019 PCMH Patient Lists and Provider Reports – late January 2019
- Aug – Oct 2018 Care Coordination and Claims Detail Reports – late January 2019
- SIM PCMH Dashboard Release 7.0 – late February 2019

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

### **PCMH Initiative Success Story: Oakland Southfield Physicians**

Oakland Southfield Physicians (OSP) Social Work Care Manager – Kristina Sigler  
Beaumont Northside Family Medicine

As a result of a positive screening via the practice social determinants of health (SDoH) screening tool, it was identified that Mary, a patient of the practice, was having difficulty paying her utility bill. This urgent need triggered a referral to the care manager for assistance. Mary had a history of hypertension, diabetes and obesity. Although Mary was self-managing her diabetes, there was concern that if the utilities were shut off, there would be no way of ensuring that her insulin would remain viable. In addition, Mary was the primary care giver for her brother who was diabetic, a double amputee and wheelchair bound.

Their DTE bill was over \$700 and they were not able to pay for it. Mary at the time was not working and did not have an income. She had recently applied for disability. The OSP social work care manager contacted DTE and requested a 10-day extension, meaning her electricity would not be disconnected for 10 days. Once the 10-day extension expired, the team contacted DTE again and requested a 30-day medical hold extension. The patient and her brother were granted the additional extension due to having a diagnosis of diabetes and it being medically necessary to keep electricity on, as their insulin needed to be refrigerated. The extension granted by DTE, and the hard work of the OSP social work care manager and practice team, allowed the patient and her brother enough time to complete and submit the required Service Emergency Relief documents for MDHHS. With that, MDHHS was able to cover \$500 of the \$700 which left a remaining balance of \$200. OSP social work care manager contacted a local non-profit organization who was willing to cover the remaining amount. Over the next couple of months, the care manager continued to follow up with the patient by phone was encouraged to call the office if they should need additional help.

This situation highlights the effective work of the OSP social work care manager and practice team in finding resources to assist Mary, and in doing so preventing a possible situation of not having her insulin, which could have then lead to complications that may have required the need of emergency services or, even worse, admission to the hospital.

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## Upcoming Events and Initiative Resources

### Michigan Care Management Resource Center 2019 Care Management Educational Webinars

**Title:** Suicide Assessment, Risk and Prevention

**Date and Time:** Wednesday, January 23, 2019 2-3 pm

**Presenter:** Kristyn Spangler, LMSW  
Behavioral Health Program Manager  
Integrated Health Associates

[REGISTER HERE](#)

**Title:** 5 Steps to Help Patients Prevent Type 2 Diabetes

**Date and Time:** Wednesday, February 27, 2019 2-3 pm

**Presenter:** Tamah Gustafson, MPH, CHES  
Public Health Consultant  
Diabetes and Kidney Disease Unit  
Michigan Department of Health and Human Services

[REGISTER HERE](#)

### Michigan Care Management Resource Center Approved Self-Management Course Registration

The Michigan Care Management Resource Center (MiCMRC) approved Self-Management Support courses list is available [here](#). This list provides a detailed summary of each course, with associated objectives, location, cost and more.

Additionally, MiCMRC has collected resources for Self-Management Support including: websites of interest, publications, tools, videos, and patient materials. The document entitled “Self-Management Support Tools and Resources” offers an at a glance list and summary of these resources, along with descriptions and website links for quick access. Click [here](#) to access this resource.

These documents can also be accessed on the Michigan Care Management Resource Center [website](#).

## Upcoming Complex Care Management Course Dates and Registration

The Michigan Care Management Resource Center Complex Care Management (CCM) course is designed to prepare healthcare professionals for the role of Complex Care Manager. Course content is applicable to all Care Managers in the ambulatory care setting, working with complex patients. CCM course details can be accessed [here](#).

January 14-17, 2019 | Dimondale | [REGISTER HERE](#) | Registration deadline: January 10, 2019

February 4-7, 2019 | Lansing | [REGISTER HERE](#) | Registration deadline: January 31, 2019

**NOTE:** 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)



