Michigan Institute for Care Management & Transformation

2020 Training Framework & Initiatives

2020 Training

Required Training

All primary care-based care team members new to the role must attend the *Introduction to Team-Based Care* and view the *BCBSM billing webinar*.

The Introduction course covers the critical components of getting started as a care team member.

Continuing (Longitudinal) Education

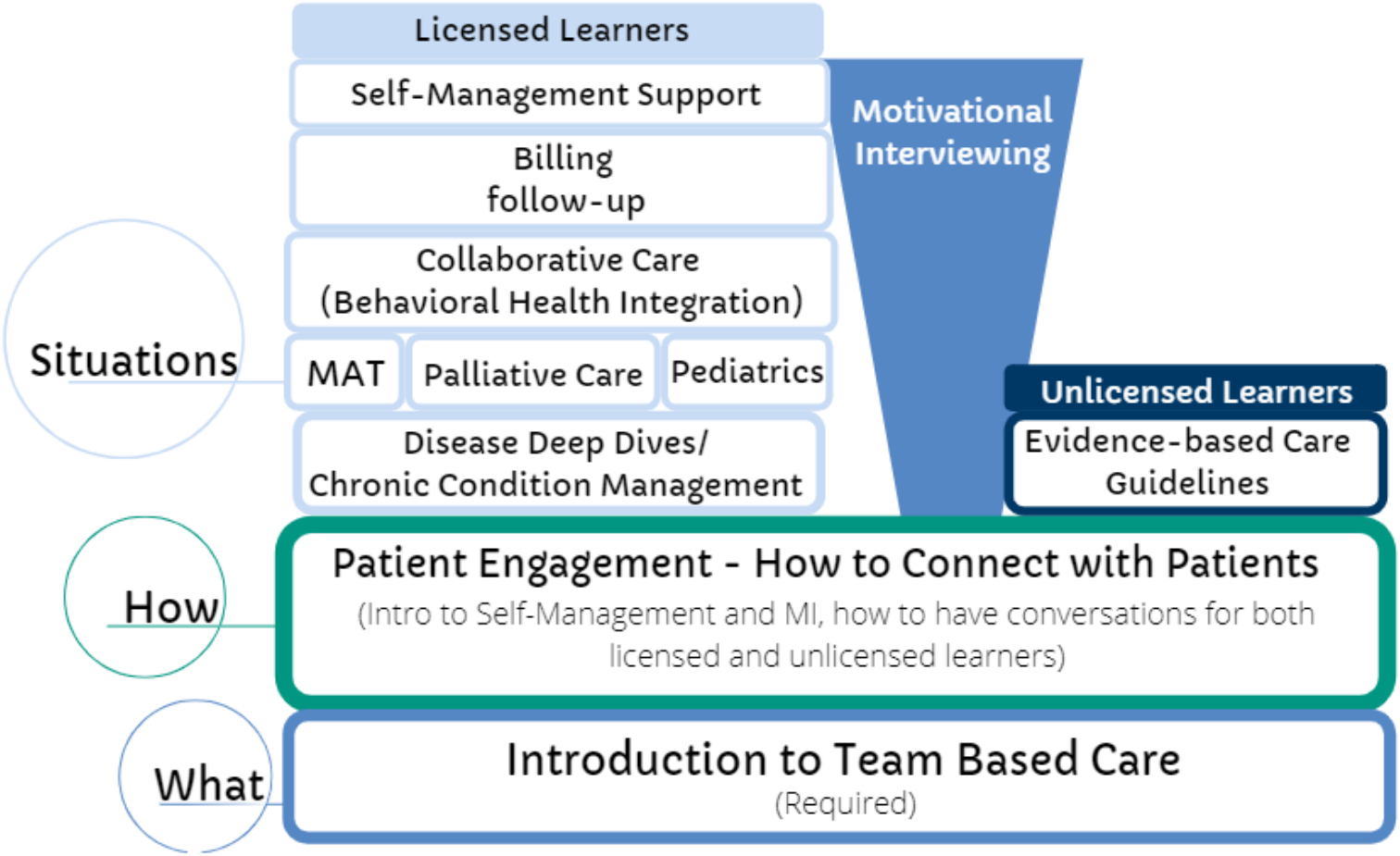
Every learner has to accomplish (8) credit hours of additional training per year.

These (8) credits may include:

1. official continuing education credits for their licensure,
2. webinars/ learnings on the MICMT website, and
3. all courses offered by approved statewide trainers.

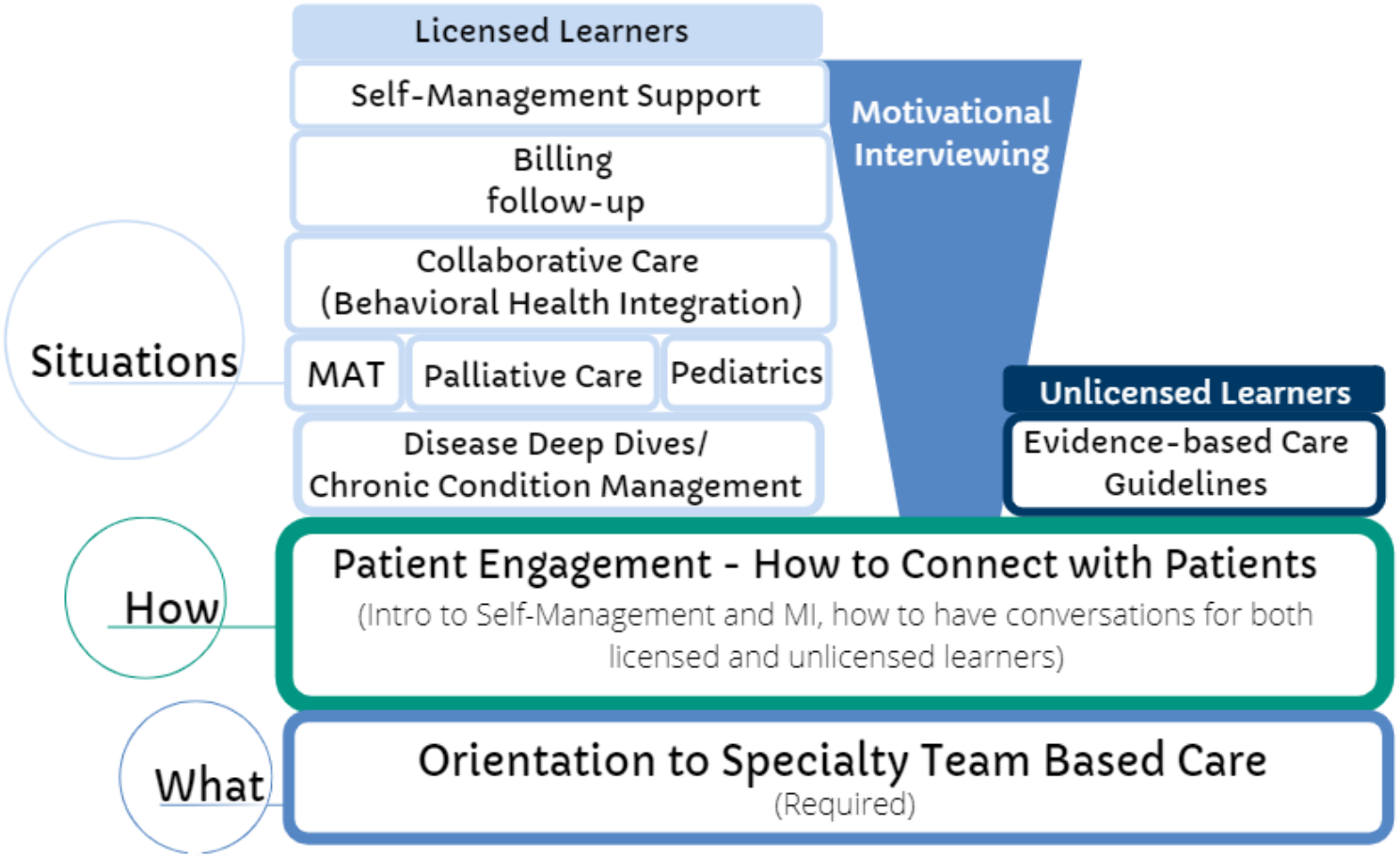
**As we have in the past, MICMT would work with Priority Health and MDHHS to have this course approved for their respective programs. There are other course leads other than MICMT and the current focus is the standardized portion of the course.*

Primary Care Training Framework



MICMT

Specialty Care Training Framework



What are the primary care training requirements for Provider Delivered Care Management?

The PDCM training requirements for Primary Care are as follows:

- All newly hired care team members must:
  - Take the Introduction to Care Management course, which will be in available in April, 2020. This is a full day course.
  - Watch the online billing course available at www.micmt-cares.org
  - All care team members must take at least 8 hours of 'longitudinal education' annually, which is pro-rated in the initial year of hire based on when the care team member was hired. For example, if the care team member started in his/her role in July, then he/she would only need 4 additional hours of training. Longitudinal / continuing education may include:
    1. official continuing education credits for their licensure,
    2. webinars/ learnings on the MICMT website, and
    3. all courses offered by approved statewide trainers.
  - This training will be tracked through a combination of post test tracking through the MICMT website and the care management attestation process.

What is the training reimbursement opportunity?

- BCBSM will reimburse POs in the January PGIP payment for affiliated care team members who complete an MICMT approved training and pass the post-test through an approved state-wide trainer. Trainings conducted by MICMT will not be reimbursed.
- Full day courses will be reimbursed at $500 per learner; half day courses at $250 per learner
- Each PO has a reimbursement limit, but if the limit is surpassed and there are still funds, the un-used funds will be distributed to those POs that surpassed their limit.

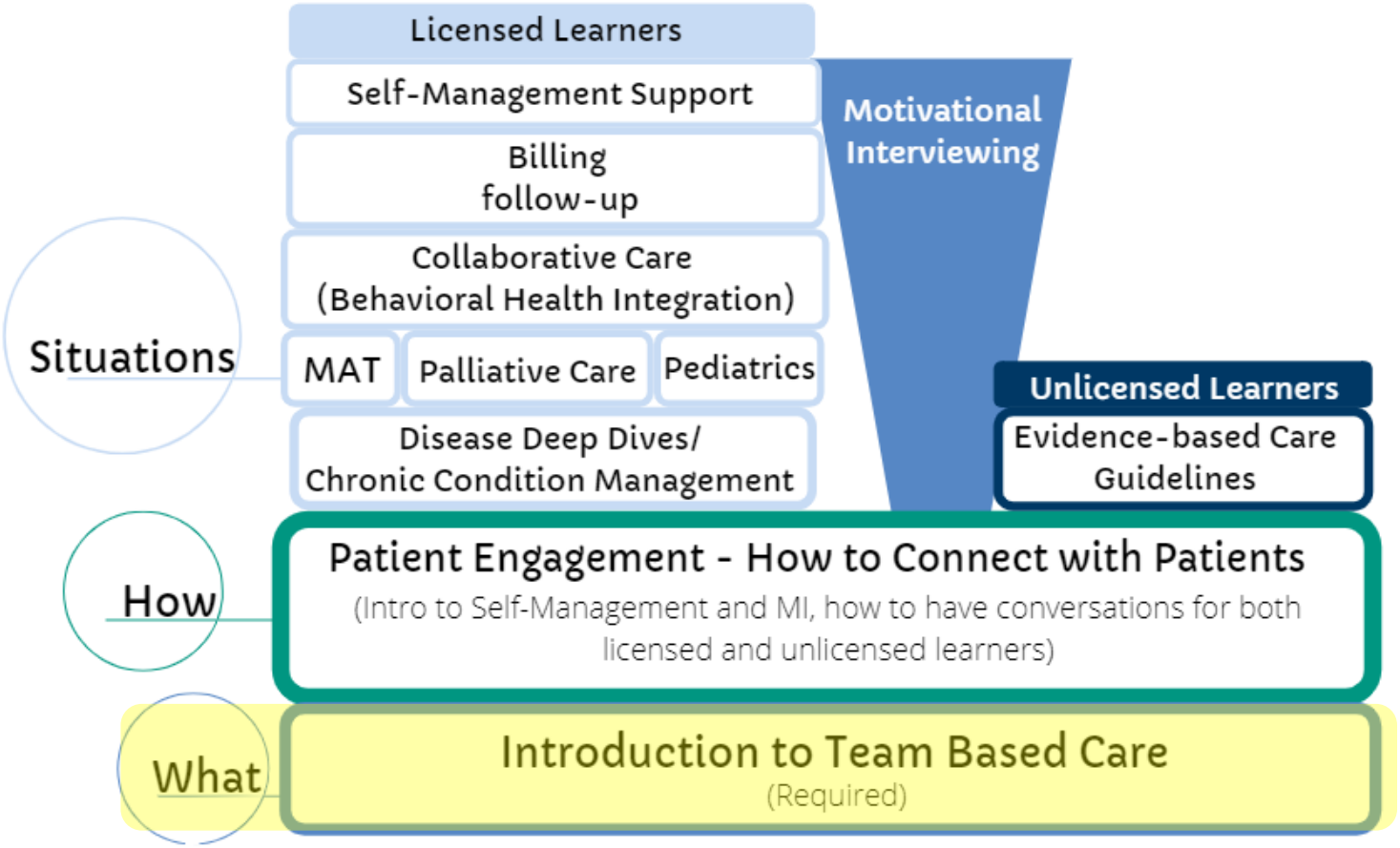
Is there a difference for specialists?

- The only difference is that specialists will have a half-day orientation course available in April.
- As a half-day course, it is reimbursable at $250 when provided by an approved trainer (not if the course is provided by MICMT).

Intro to Team-Based Care

(Formerly Complex Care Management)

Primary Care Training Framework



Why the change from Complex Care Management ?

- Feedback from trainers and learners indicated the need for a modified curriculum.
- To make sure the newest care team members have an appropriate introduction to this role and the things to be successful, licensed or unlicensed.
- To set a common foundation knowledge of the role that can be followed up with subsequent trainings that provide a deeper dive into skill and knowledge building content.

Intro to Team Based Care

Who are the team members developing the curriculum?

Judy Avie, MICMT
Sue Vos, MiCCSI
Ewa Matuszewski, MedNetOne
Ruth Clark, Integrated Health Partners
Lisa Nicolaou, Northern Physicians Organization
Kim Harrison, Priority Health
Lisa Rajt, BCBSM

Draft of Introduction Curriculum

Topic	Learning Objectives	Notes
Chronic Care Model	• Define Chronic Care Model and where the learner fits into it • Describe how the care team works as interdisciplinary team	• Framework for learner's own interactions and how they interact with others in their practice and community on behalf of the patient • Demonstrate how each type of care team member can support productive interactions in a multi-disciplinary team proactively and throughout the course of the visit (prepared, proactive team and productive interactions with the patient)
Purpose and Impact	• Define the measures incentivized by the payers (ED, Inpatient, A1c, Blood Pressure)	• Link back to Chronic Care Model: this is the *why* • Ambulatory guidelines for common conditions/evidence-based base *decision support* • What do learners need to have an impact on? Why is this? • Utilize registry and quality check-points to measure performance
Team Roles	• Define internal team roles and external team roles for care management	• Link back to the Chronic Care Model → start at the bottom of the productive interactions and show how the care team members link to the top (community resources, other specialty offices, etc.) • Better explanation of MA role for unlicensed learners • Internal team/external team • PCMH Capabilities related • Scope of practice • Template that can be modified for roles • Outline of role/scope – who/what/when of the 5 step process • Cite research/resources whenever possible
Care Management Process	• Define critical elements of the care management process	• Common categories of patients (high-risk, longitudinal, episodic) • Care Management Steps: Identification, Assessment, Implementation (Care Plan and Action Plan), and Closing • Link back to the patient experience in the office and the chronic care model

Draft Introduction Curriculum (continued)

Topic	Learning Objectives	Notes
"Day in the Life of…"	• Define how to implement the theories discussed in this orientation	• What does a learner do when they get back to their desk • Workflows, how does the care team member fit in? • What care management codes can be used? • Examples, role-based examples • People together in groups based on office make-up and discuss approach • Typical office visit and where does the care team member fit into this role? • Aligning back with the chronic care model • Delivery system design: where things fit in • Lean value-stream map- link back with current state to help explain the 'why' of care team involvement
Billing	• Illustrate how to use the PDCM codes	• Different level for unlicensed learners • Clarity for different learners
Sustainability	• Describe a financial model for sustainability	• Balance of volume and payer mix • Right work for the right reasons! • How do we support the WHY • Opportunity and what the care team member is in control of impacting

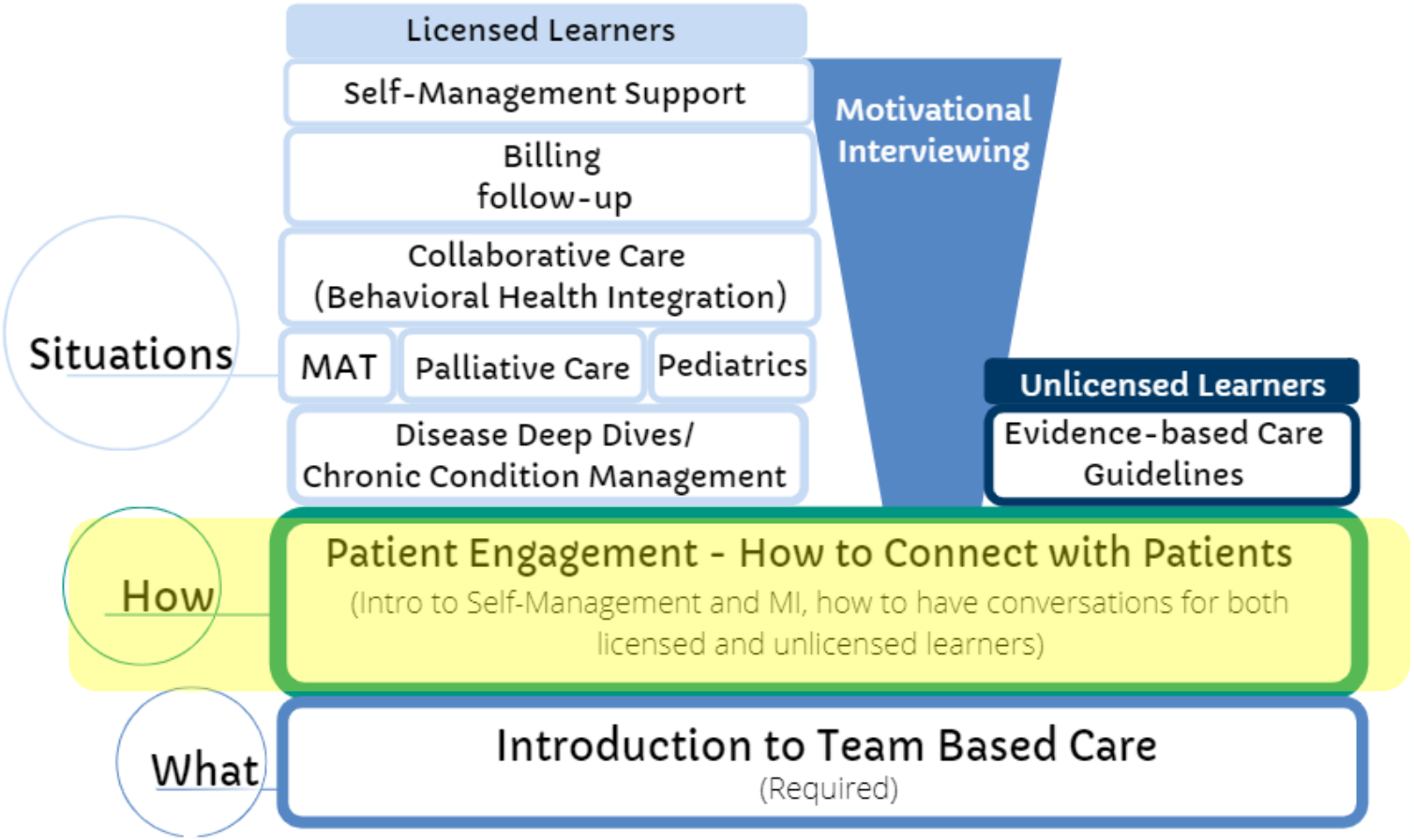
Intro to Team Based Care

How do I become an approved trainer?	Complete the trainers' application on our **website**
How many longitudinal credits for this training and what is the reimbursement?	**8 longitudinal credits** and **$500 reimbursement** per training
How do I find out about upcoming trainings?	Upcoming trainings will be listed on our **website**

Patient Engagement

(Formerly Self-Management Support)

Primary Care Training Framework



Why the change from Self-Management Support?

- Feedback from trainers and learners directed us towards a more generic patient engagement training, rather than focusing on self-management support.

Patient Engagement Goals

The *how* of care management

Building block of all longitudinal courses

Goal for all CM team members to learn the important concepts of how to talk with patients about their health

Patient Engagement

Who are the team members developing the curriculum?

Sarah Fraley, MICMT
Sue Vos, MICCSI
Robin Schreur, Spectrum Health
Tiffany Turner, Infinity Counseling
Casidhe Harte, IHA
Beth Jurczak, IHA
Ruth Clark, Integrated Health Partners

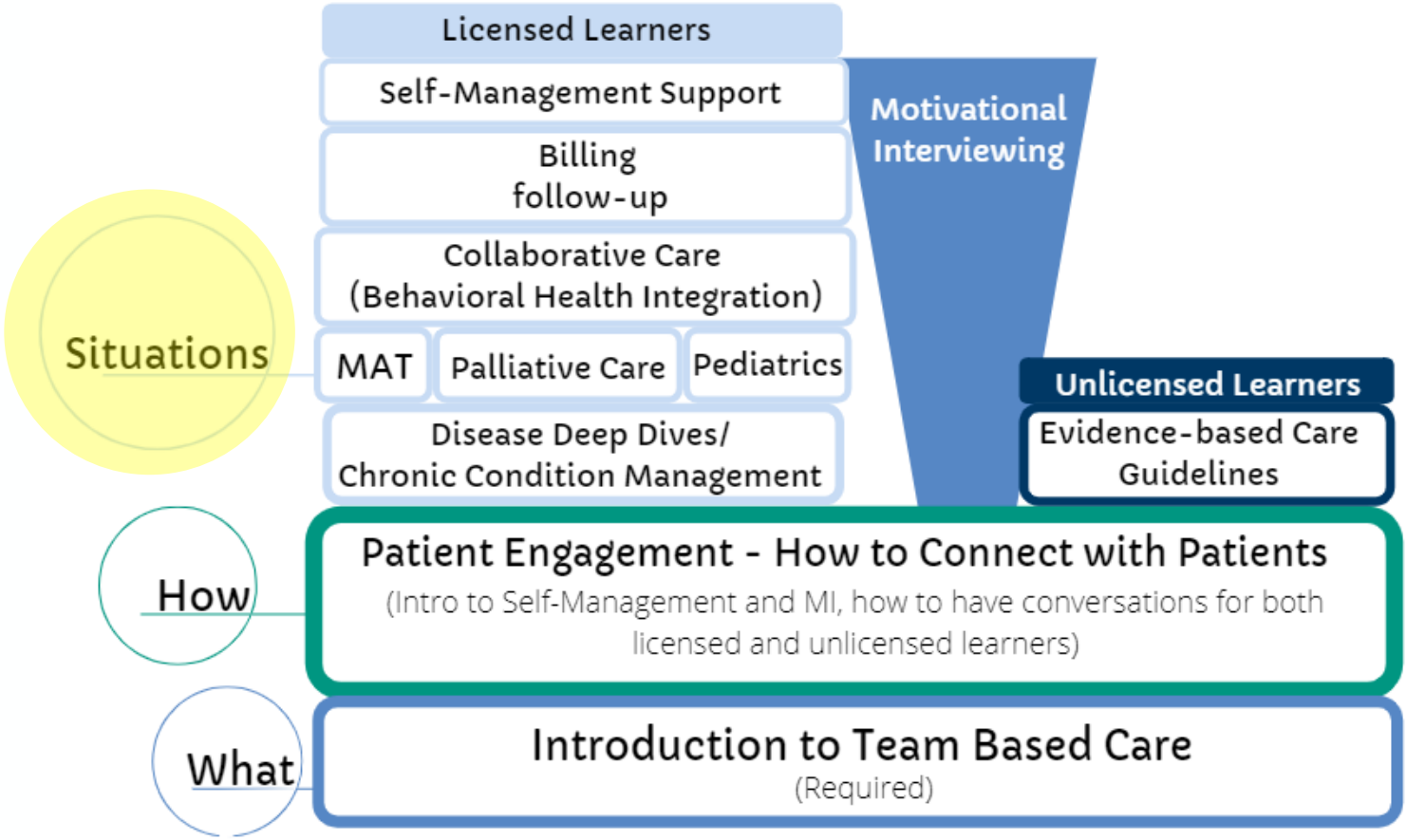
Lisa Nicolaou, Northern Physicians Organization
Jamie Mallory, Wexford PHO
Christen Walters, Integrated Health Partners
Maureen Braun, IHA
Erika Perpich, Olympia
Lynn Klima
Ewa Matuszewski, MedNetOne

Patient Engagement

How do I become an approved trainer?	Complete the trainers' application on our **website**
How many longitudinal credits for this training and what is the reimbursement?	**8 longitudinal credits** and **$500 reimbursement** per training
How do I find out about upcoming trainings?	Upcoming trainings will be listed on our **website**

Medication Assisted Treatment (MAT) Orientation

Primary Care Training Framework



MAT Orientation Training Objectives

MAT Orientation is designed to introduce care team members to their role in supporting physicians who are providing Medication Assisted Treatment to patients with opioid use disorder (OUD).

Team members will engage with trainers in topics about addiction, harm reduction and stigma.

There will be an overview of the medications used in MAT and the process of starting a patient on those medications.

MAT Orientation

Who are the team members developing the curriculum?

Alicia Majcher, MICMT
Julie Geyer, MICMT
Nicole Rockey, MICMT
Sarah Fraley, MICMT
Sue Vos, MICCSI
Robin Schreur, Spectrum Health
Ewa Matuszewski, MedNetOne

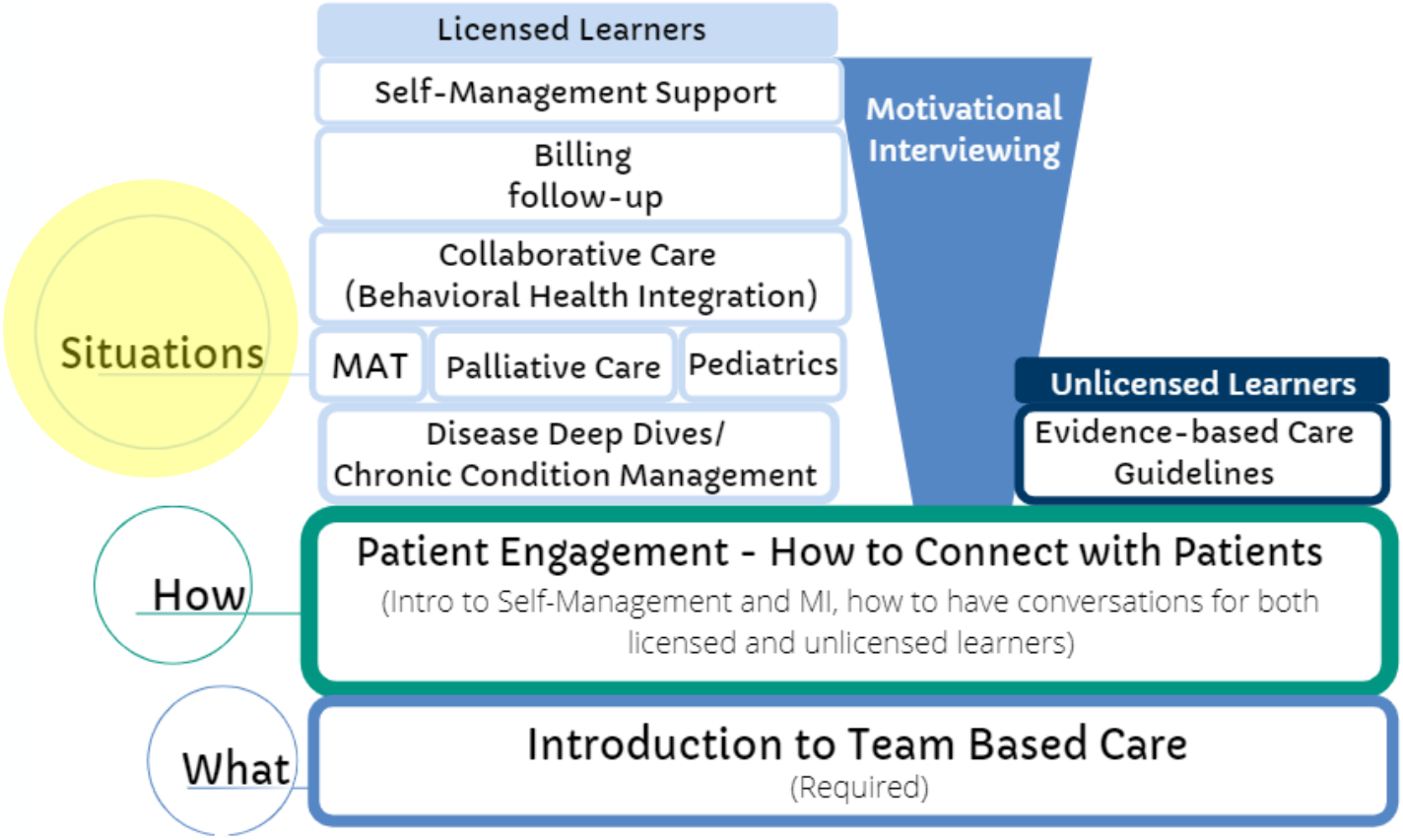
Dania Berjaoui, Michigan Medicine
Fiona Linn, Michigan Medicine
Maryam Khodadost, Michigan Medicine
Minu Aghevli, MOC
Suzanne Kapica, MOC
Marissa Palmer, MidMichigan
Richard Bates, MidMichigan
Kathy Dollard, MidMichigan

MAT Orientation

How do I become an approved trainer?	Complete the trainers' application on our **website**
How many longitudinal credits for this training and what is the reimbursement?	**4 longitudinal credits** and **$250 reimbursement** per training
How do I find out about upcoming trainings?	Upcoming trainings will be listed on our **website**

Palliative Care

Primary Care Training Framework



Palliative Care Goals

Create an orientation to Palliative Care concepts to empower multidisciplinary teams and generalists to provide palliative care support for their patient

Palliative Care

How do I become an approved trainer?	Complete the trainers' application on our **website**
How many longitudinal credits for this training and what is the reimbursement?	**4 longitudinal credits** and **$250 reimbursement** per training
How do I find out about upcoming trainings?	Upcoming trainings will be listed on our **website**

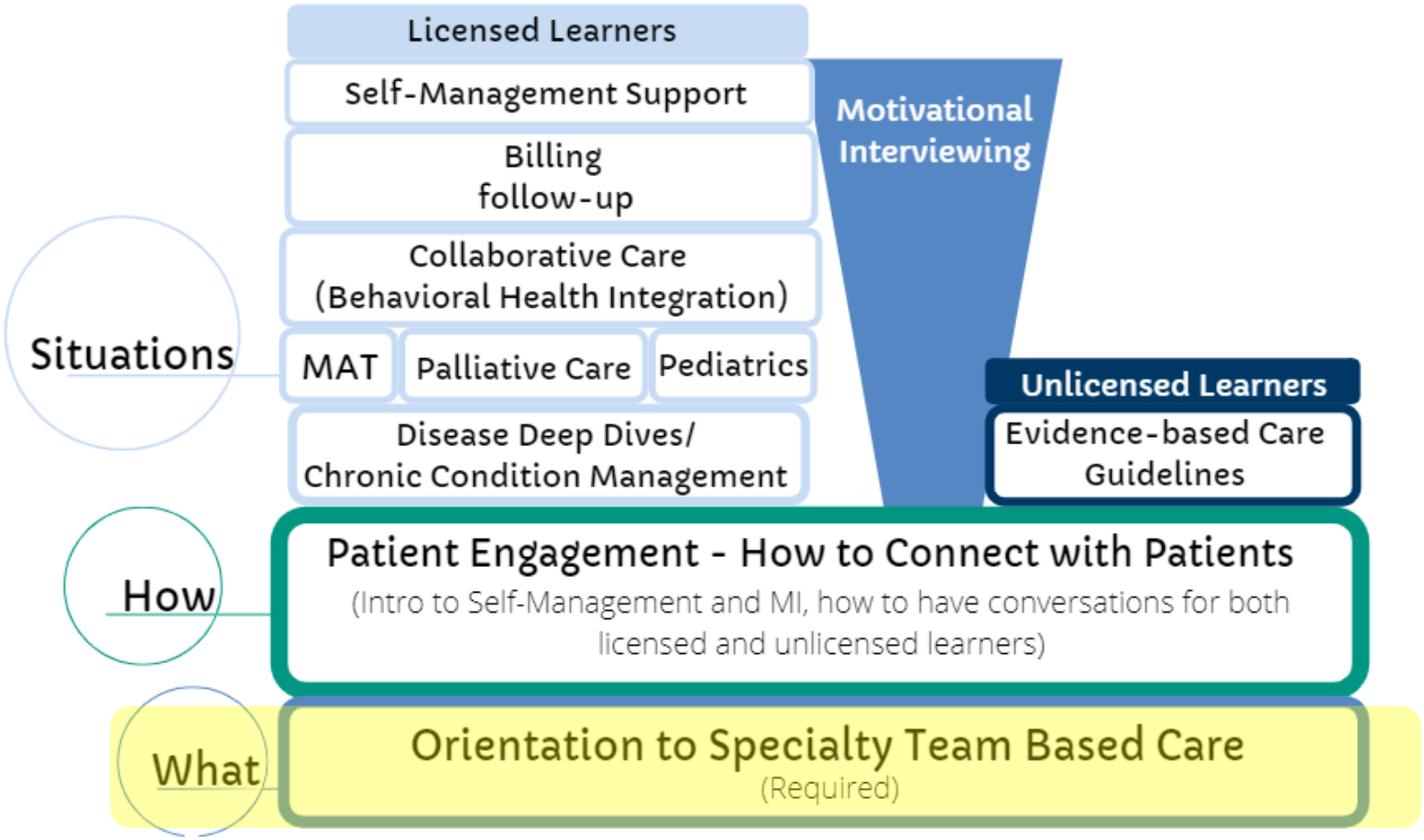
Palliative Care

Who are the team members developing the curriculum?

Scott Johnson, MICMT
Ewa Matuszewski, MedNetOne
Ruth Clark, Integrated Health Partners
Kim Harrison, Priority Health
Sharon Kim, BCBSM
Michael Smith, Michigan Medicine
Tom O'Neal, Arbor Hospice

Specialty Care

Specialty Care Training Framework



Which specialists are eligible to bill PDCM codes?

Effective 1/1/19, all specialty types are eligible to bill the PDCM codes, provided they meet all three of the following requirements:

- Have access to a care team
- Members of the care team have been trained appropriately or will receive training within 6 months of starting to bill the codes
- Practice worked with PO to implement the five PCMH capabilities listed below.

What are the PCMH-N capability requirements for PDCM-Specialist?

The specialty practice must have the following five PCMH-N capabilities in place and actively in use within six months of starting to bill PDCM codes. Blue Cross reserves the right to validate that these capabilities are in place for any practice that has billed the PDCM codes. For more information, please refer to the PCMH Interpretive Guidelines:

- Evidence-based guidelines used at point of care (4.3)
- Action plan and self-management goal setting (4.5)
- Medication review and management (4.10)
- Identify candidates for care management (4.19)
- Systematic process to notify patients of availability of care management (4.20)

Specialty Care

Who are the team members developing the curriculum?

Marie Beisel, MICMT
Sue Vos, MICCSI
Ewa Matuszewski, MedNetOne
Ruth Clark, Integrated Health Partners
Ashley Rosa, Bronson
Joan Kirk, Answer Health
Sheri Lee, BCBSM
Alicia Majcher, Michigan Medicine

Draft Curriculum

Topic	Learning Objective
Chronic Care Model	• Explain how the prepared, proactive team contributes to positive patient outcomes • Describe how the components of the Chronic Care Model support the practice team
Care Coordination	• Identify the role of the care manager in care coordination • Develop a process for coordinating care with primary care practice care managers
Care Management Process	• Describe the steps in the care management process • Develop workflows to implement each step of the care management process
Team Roles	• Define team roles necessary for effective functioning in the care team process
Billing	• Identify acceptable billing codes for care management services provided by the specialty practice
Team-Based Care	• Describe how care teams work as multidisciplinary teams

Specialty Care

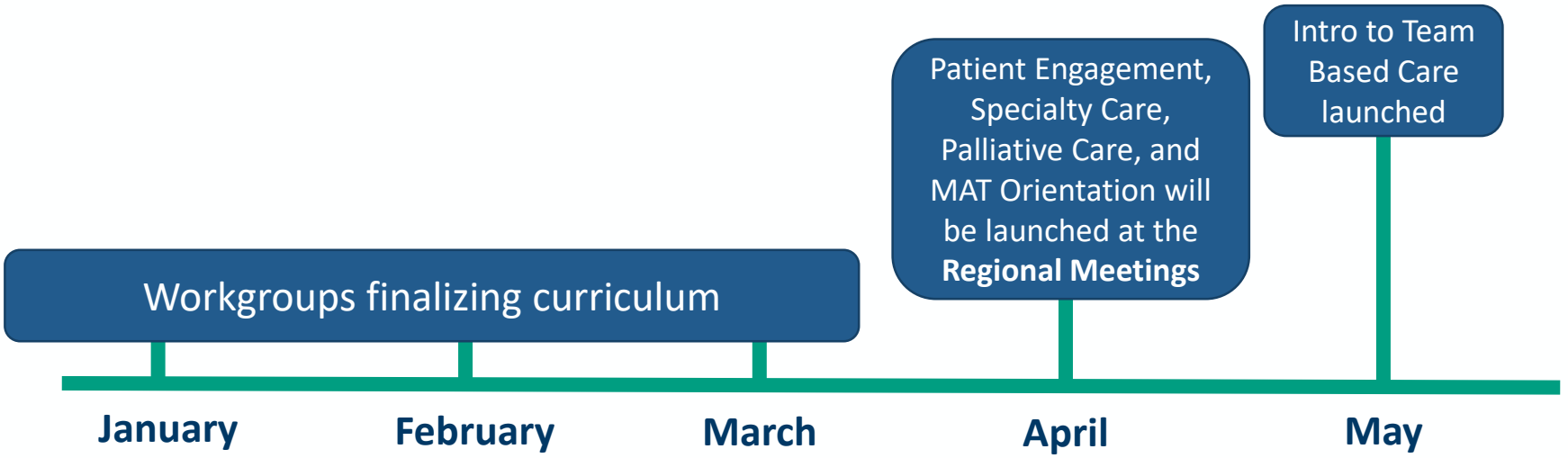
How do I become an approved trainer?	Complete the trainers' application on our **website**
How many longitudinal credits for this training and what is the reimbursement?	**4 longitudinal credits** and **$250 reimbursement** per training
How do I find out about upcoming trainings?	Upcoming trainings will be listed on our **website**

Summary

Current Curriculum Name	Purpose	Required?	Reimburse-ment?*	Historical Curriculum Name	Reason for change
Intro to Team-Based Care	Orientation to the role; describe **what** new care team members need to know.	Yes for all Primary Care.	$500	Complex Care Management	More inclusive to all learners, organize learning elements.
Patient Engagement	Describe **how** care team members can use evidence-based motivational interviewing / self-management support skills to engage with patients.	No	$500	Self-Management Support	Focus on skill development, moving away from broad program info like billing.
Intro to Specialty Team-Based Care	Orientation to the role; describe **what** new care team members need to know.	Yes for all Specialty Care.	$250	NA	Focus on the specialty role.
Orientation to MAT	Introductory level training to educate care team members about MAT for OUD.	No	$250	NA	NA
Introduction to Palliative Care	Introductory level training to educate care team members about Palliative Care.	No	$250	NA	NA

Training Timeline

Timeline



MICMT will be providing trainings on a quarterly basis, but the statewide approved trainers will be providing additional trainers.

Applications to become an approved Statewide Trainer will be available after the April launch.

MICMT Approved Trainer Organizations

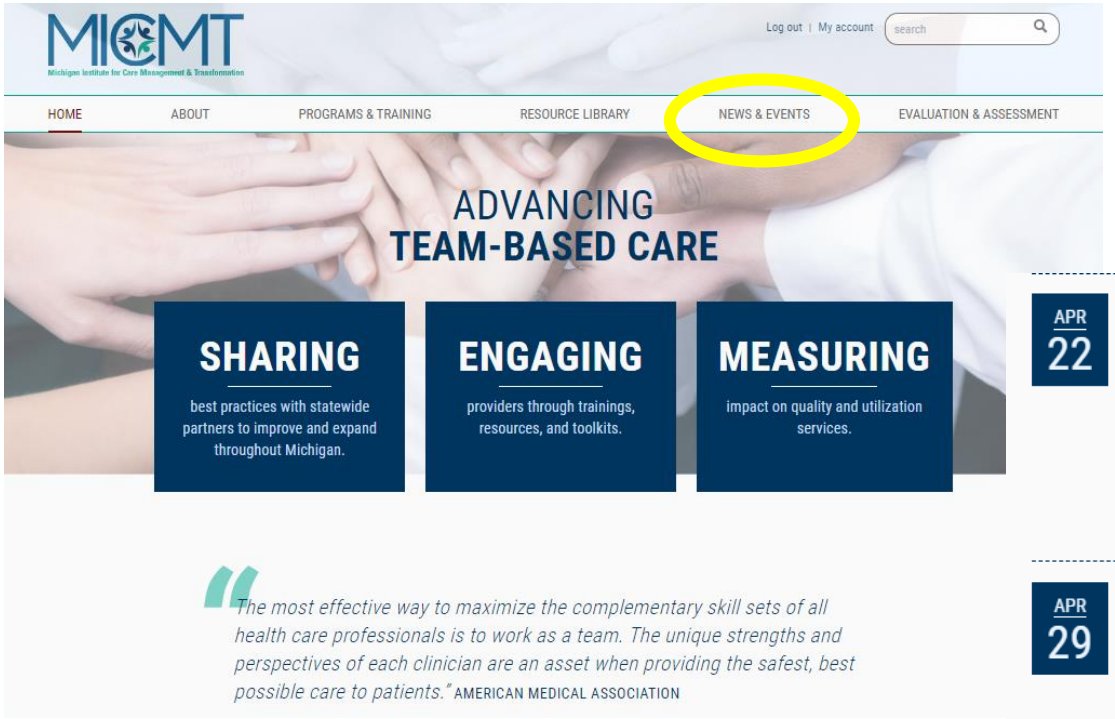
Complex Care Management
Northern Physician Organization Lisa Nicolaou
Oakland Southfield Physicians Annaliese Brindley
Wexford PHO Jamie Mallory
MiCCSI Sue Vos
Olympia Erika Perpich
IHA Casidhe Harte
Upper Peninsula Health Group Kaitlyn Schroderus
Bronson Health Network Ashley Rosa

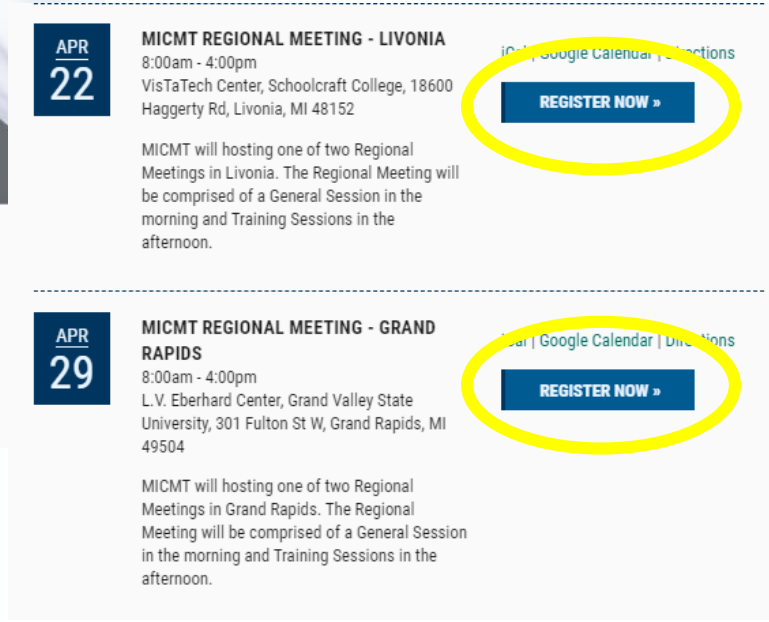
https://micmt-cares.org/training/complex-care

Self-Management Support
Integrated Health Partners Christen Walters
Practice Transformation Institute Yang Yang
MiCCSI Sue Vos
Dr. Lynn Klima
Northern Physician Organization Lisa Nicolaou
Infinity Counseling Tiffany Turner
IHA Casidhe Harte

https://micmt-cares.org/training/self-management

Regional Meeting Registration





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