Annual Meeting
November 1, 2019

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Meeting Agenda

- 9:00 am – 9:30 am **Breakfast**
- 9:30 am – 9:45 am **Welcome and Introductions**
- 9:45 am – 10:15 am **The Value of Team Based Care/PDCM**
- 10:15 am – 10:30 am **Team Based Care Testimonial**
- 10:30 am – 11:30 am **Panel Discussion**
- 11:30 am - noon **Best Practice and Visioning Awards Presentation**
- Noon – 1:00 pm **Lunch**
- 1:00 pm – 1:45 pm **Table Discussions**
- 2:00 pm – 3:00 pm **What's on the Horizon**

MICMT

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Welcome and Introductions

Hae Mi Choe, PharmD, MICMT Executive Director

The Team

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The Value of Team Based Care and Provider Delivered Care Management

Amy McKenzie, MD, MBA
Medical Director, BCBSM

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VALUEPartnerships

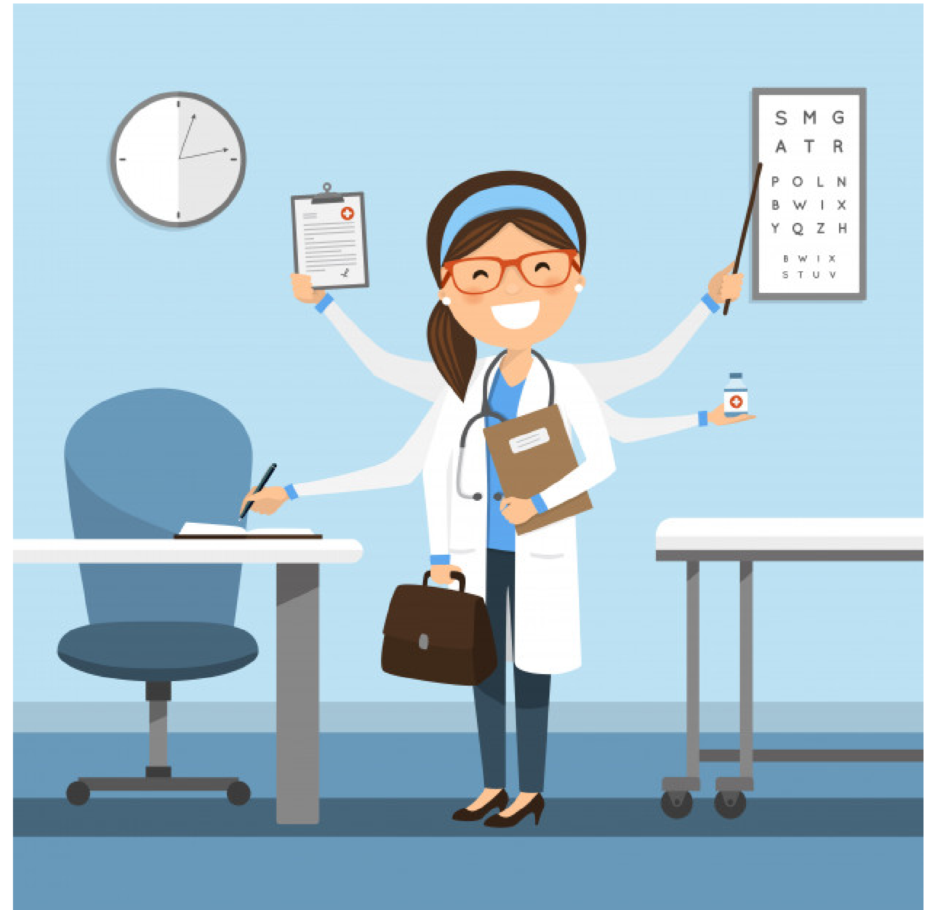
Better Care. Better Outcomes. Better Value.

The Value of Team Based Care and Provider Delivered Care Management

Amy McKenzie MD, MBA
Medical Director, BCBSM

What it feels like to be a primary care physician

- The average PCP's panel size is too large (2,300) for delivering consistently high quality care on their own under the traditional practice model
- PCPs would spend an estimated **21.7 hours per day** to provide all USPSTF recommended acute, chronic, and preventive care for a panel of 2,500 patients
- Estimates suggest patients receive only 55% of recommended chronic and preventive services



Source: Estimating a Reasonable Patient Panel Size for Primary Care Physicians With Team-Based Task Delegation. Justin Altschuler, MD, David Margolius, MD, Thomas Bodenheimer, MD, and Kevin Grumbach, MD Ann Fam Med. 2012 Sep; 10(5):396-400.

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Q: How can PCPs be expected to provide the highest quality care to their patients with continuously growing demands?

A: Through utilization of team based care to provide enhanced support for the physicians and higher quality care to more patients

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Why provide team based care?

- 2 Alternative practice models can support improved quality of care
  - Reduced panel size (would leave many people without primary care)
  - Team Model (distributes patient care among interdisciplinary team to allow for large panels, high quality care, and a reasonable workday)
- Fundamental to the team model is that all team members perform at the top of their skill level
  - Many tasks currently performed by PCPs can be safely and effectively delegated

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Why is Team Based Care/Collaborative Care important?

"The preponderance of studies comparing levels of resource use by primary care practitioners and specialists find that **patients of primary care providers have lower levels of use, such as fewer diagnostic tests and procedures, and incur equal or lower costs of care"**

Primary Care: A Critical Review Of The Evidence On Quality And Costs Of Health Care Health Affairs, 2010; review included 161 articles on looking at primary care

We are facing a declining number of PCPs in the face of increasing needs of a more senior population. Enabling providers to work at the top of their license through team based care is becoming increasingly important.

Source: https://www.healthaffairs.org/doi/10.1377/hlthaff.2010.0025

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Emerging competitive dynamics are informing strategies and focus areas for Blue Cross Blue Shield of Michigan

Key Competitive Dynamics

1 Vertical Integration

Competitors are expanding their role in the healthcare ecosystem through vertical integration (e.g., mergers of payers and PBM, acquisition of provider assets, retail clinics)

2 Disruptive Network Strategies

Competitors are deploying disruptive network strategies and exploring local partnerships

3 Pricing and Total Cost of Care Pressure

Aggressive competitor pricing and cost management are putting pressure on BCBSM's traditional advantages (i.e., discounts and network breadth)

4 Engagement and Navigation

Curated member journeys and support in navigating a complex healthcare environment becoming a major focus for employers as members shoulder more of the financial burden for their healthcare

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Various member-centric strategies are emerging across leading carriers

Strategic roles and choices

- Guide the member vs. self-directed care
- Support clinical decision-making vs. automate clinical decisions
- Modernize care delivery primarily via partnerships vs. ownership
- Clinical focus vs. beyond clinical care
- Advance vs. enable adoption of standards of care
- National approach vs. community-based approach

Examples of emerging strategies

Carrier	Strategy
Humana	**Own the home** ▪ A community-centric approach to care delivery for seniors, operating 100+ clinics through its subsidiaries ▪ Focus on helping seniors with chronic conditions and complex needs stay at home
UnitedHealthcare	**Guide through physicians and empower with analytics** ▪ Influence care choices across the continuum through direct ownership of physician organizations ▪ Scale data-driven solutions for providers and members at a national level
CVS aetna	**Front door to health and wellness** ▪ Expand direct-to-member touchpoints through local clinic and retail presence across the country ▪ Complement physical presence with a broad portfolio of digital tools for members
Cigna	**Address every aspect of customers' body and mind** ▪ Offer full suite of traditional insurance products to address physical, emotional, financial, and social health
CENTENE Corporation	**Go narrow in local markets** ▪ Create narrow networks in geographies to control medical cost and better manage care
Geisinger Health Plan	**Changing the face of healthcare** ▪ Create healthy communities by addressing the forces responsible for preventable illness and early death

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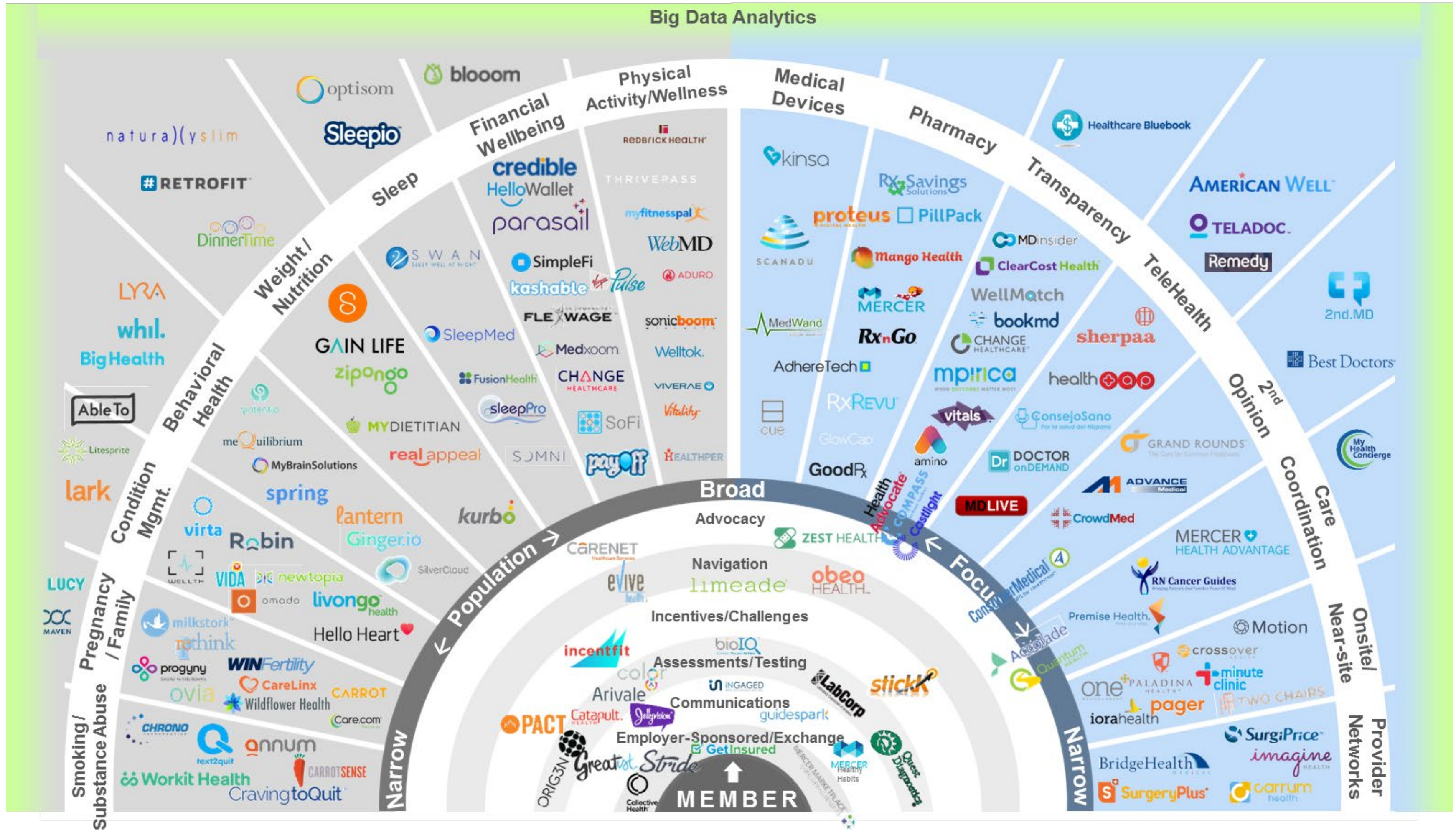
Continued proliferation of point solution vendors provides both challenges and partnership opportunities



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The Cost of Health Care

A closer look at the problem

$3.5T	$10,348	+3.9%
US health care spend in 2017	Annual average cost per person	Rise in costs in 2017

Source: CMS.gov

- Rising health care costs are unsustainable
- This has created a national affordability crisis for our patients, employees and families
- This problem is going to require health systems, providers and payers to work together to solve
- Our Michigan community and Value Partnerships is uniquely positioned but it is going to require renewed efforts and new solutions
- CMS projected that healthcare spending will on average rise 5.5 percent annually from 2017 to 2026 and will comprise 19.7 percent of the U.S. economy in 2026

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Even with Great Care Management BCBSM ED Utilization Exceeds National Benchmarks

350
300
250
200
150
100
50
0

Commercial PPO
MAPPO- group
MA PPO Ind.

ED utilization

2015 2016 2017

Milliman well managed benchmark

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BCBSM Inpatient Utilization Also Exceeds National Benchmarks

200
180
160
140
120
100
80
60
40
20
0

Commercial PPO
MAPPO- group
MA PPO Ind.

2015 2016 2017

Milliman well managed benchmark

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Work in Progress: Doing Different to Do Better

- Value Partnerships in conjunction with POs has developed a **strong platform** that has **improved the quality of care** for Michigan residents

- **Opportunity still exists** to better manage high utilization of costly services (i.e., overuse of ED) and quality outcomes that require multidisciplinary collaboration (i.e., BH outcomes)

- **Cost has reached a breaking point** for patients and employers

- CMS and the market are **pushing for innovation**; 3rd parties/vendors continue to **threaten market disruption**

- Continued **success will require innovation, leadership and collaboration** to continue to solve challenges

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Key Elements of PDCM Re-Design:

Improving Care for Michigan Patients

Payment Model Redesign

- Billing guideline simplification VBR changes
- Recognizing a redefined care team

Partnerships

- To better connect health plan care management and PDCM redesign efforts

Improved Tools for Providers

- Stratification & predictive analytics

Incentive Development for POs

- Significant dollars dedicated to promote innovative partnerships

Retooling Resource Center

- To provide operational support, best practice I.D. & dissemination, build community

Outcomes-Driven

- Focus PU attention on key utilization and chronic care metrics

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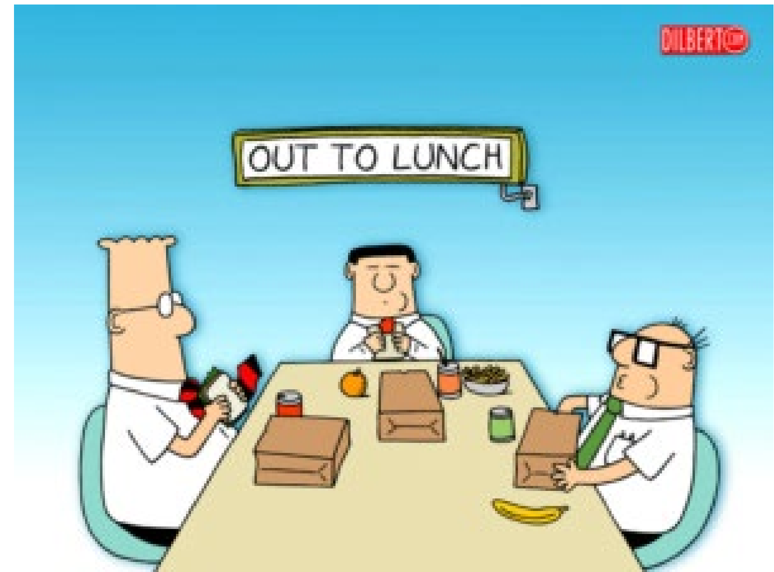
A Key Milestone: MICMT First Annual Meeting

MICMT first annual meeting:
18 months in the making



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MICMT first annual meeting:
18 months in the making

"It's a simple two-part strategy. First, locate the hills. Then head for them."

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MICMT first annual meeting:
18 months in the making

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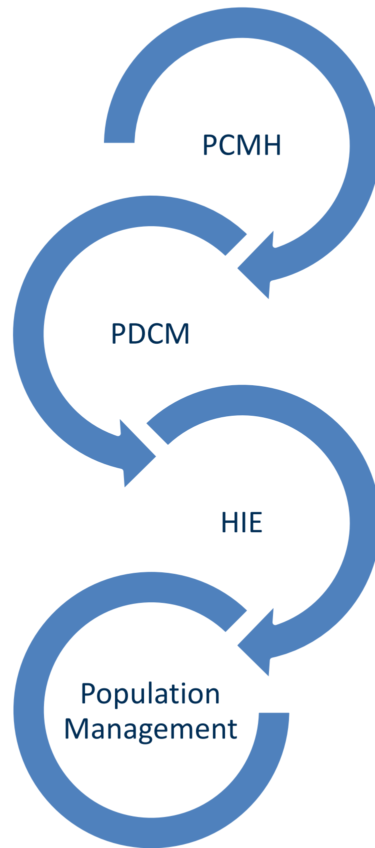
PCMH is Foundational but PDCM and Use of HIE are the Next Evolutionary Steps to Effectively Manage Populations and Help Manage Cost Trend



- These programs work synergistically to achieve better outcomes in population health management
- PCMH providers who are providing **PDCM AND using HIE** are showing the best outcomes on lowering ED visits and controlling IP admissions

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Provider-Delivered Care Management Practices leverage Team Based Care to deliver even better results than PCMH alone

Provider-Delivered Care Management
Adults (18-64)

2.1%
Lower rate of high-tech radiology usage

7.2%
Lower rate of primary care-sensitive emergency department visits

2.5%
Lower rate of low-tech radiology usage

11.5%
Lower rate of ambulatory care- sensitive inpatient discharges

5.1%
Lower rate of emergency department visits

Lower rates are over and above what is delivered through PCMH alone

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Outcomes of team-based care vs traditional practice management

Study conclusion and results: Receipt of primary care at team-based care practices compared with traditional practice model practices was associated with higher rates of some measures of quality of care, lower rates for some measures of acute care utilization, and lower actual payments received by the delivery system

CLINICAL STUDY RESULTS
TEAM-BASED CARE vs. TRADITIONAL PRACTICE MANAGEMENT

10-YEAR STUDY

- 113,452 Participants
- 113 Primary care providers
- 27 Team-based care medical practices
- 75 Traditional practice management medical practices

Measure	Team	Traditional
SCREENED FOR DEPRESSION	46.1%	24.1%
ADHERED TO DIABETES PROTOCOL	24.6%	19.5%
DOCUMENTED SELF CARE PLAN	48.4%	8.7%

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Intermountain Healthcare

THE IMPACT OF TEAM-BASED CARE ON UTILIZATION AND COST

- EMERGENCY ROOM VISITS — Reduced 23%
- HOSPITAL ADMISSIONS — Reduced 10.6%
- PRIMARY CARE ENCOUNTERS — Reduced 7%
- PAYMENTS TO PROVIDERS — Reduced 3.3%

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Intermountain Healthcare

https://intermountainhealthcare.org/blogs/topics/research/2016/08/new-jama-study/
https://jamanetwork.com/journals/jama/fullarticle/2545685

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Benefits of Team Based Care and Collaborative Care Models

- Increased Primary Care Access
  - Frees up time for PCPs to focus on what they are uniquely qualified to do as physicians, increasing availability and access to care
- Reduced Primary Care Burnout
  - Higher levels of integrated care were associated with higher personal accomplishment and lower depersonalization for physicians, demonstrating that collaborative care may relieve PCP burnout.
- Reduced Inpatient Utilization
  - A literature review by McKinsey found that patients who receive integrated care have a 19% reduction in hospital admissions

Researchers Investigate Primary Care Professional Burnout. Root Cause: Underutilized Team Based Care
January 2018 , AAFP

Team Based Care: Saving Time and Improving Efficiency
November 2014, Family Practice Management

Associations Between Integrated Care Practice and Burnout Factors of Primary Care Physicians
2018, Family Medicine

Implementing Optimal Team Based Care to reduce Clinical Burnout
September 2018, National Academy of Medicine

Elements of Team Based Care in a PCMH are Associated with Lower PCP Burnout Among VA Primary Care Employees
April 2014, Journal of General Internal Medicine

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Developing the Vision

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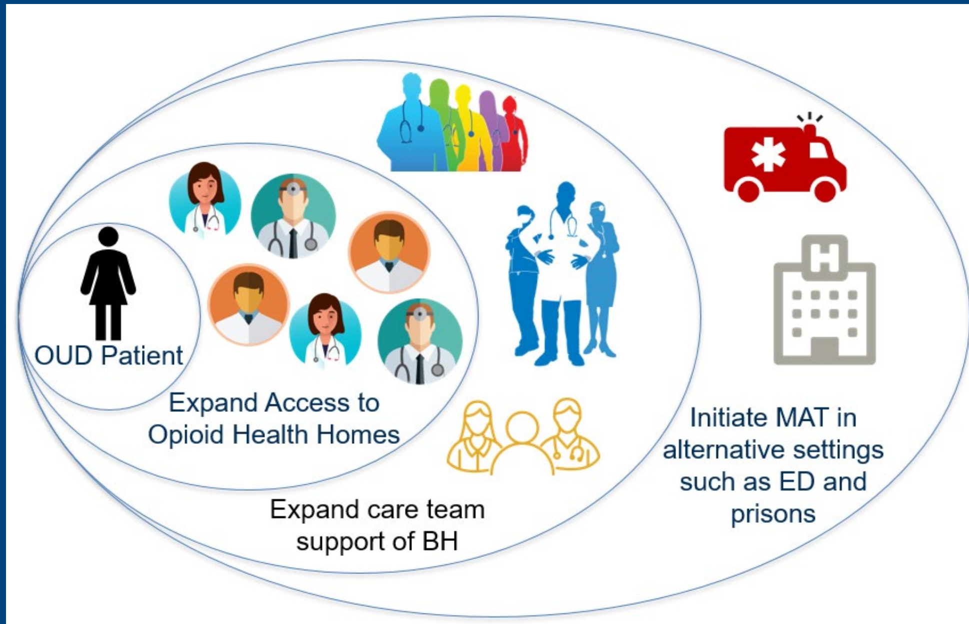
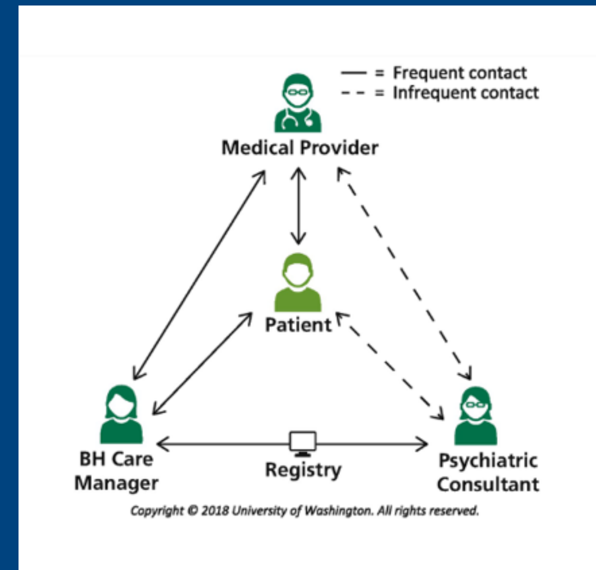
The Evolution of PDCM

September 2019 – Launch of Medication Assisted Treatment (MAT) initiative aimed at tackling statewide challenges related to substance abuse



Behavioral Health Collaborative Care



Increasing Specialist Team Based Care and Remote Monitoring applications with goal of managing chronic illnesses more proactively and keeping people out of the hospital.

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Mental Health in Michigan

In July 2019, Altarum in conjunction with the Michigan Health Endowment Fund published their final report highlighting challenges in accessing behavioral health and substance abuse care across Michigan

Key Findings

38%	Michigan residents with Mental Illness in Michigan go untreated
80%	Michigan residents with Substance Use Disorder (SUD) go untreated
25	Michigan counties have no psychiatrist
67	Michigan counties that have no SUD treatment facility

Barriers to Behavioral Health Care access include:

Shortages of Providers
Cost of Care
Reluctance to Seek Care

Figure 21: Counties Lacking Behavioral Health Clinicians

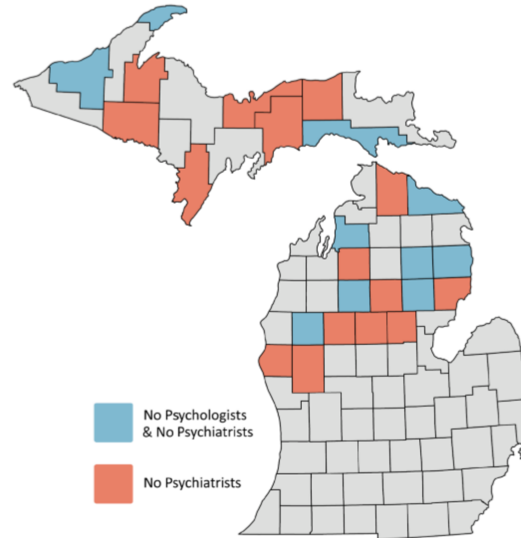
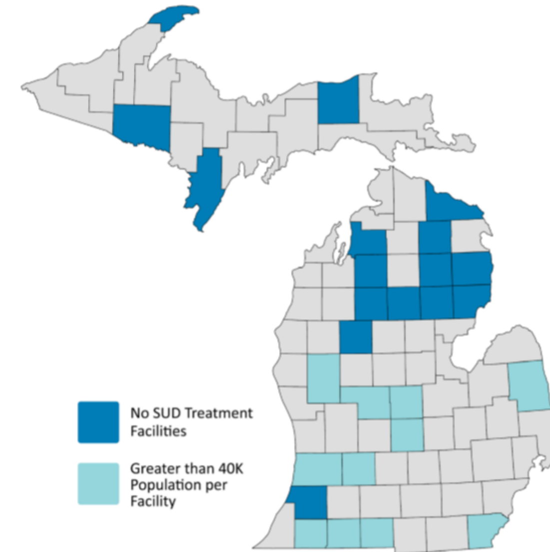


Figure 22: Counties Lacking SUD Treatment Facilities



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Medication Assisted Treatment for Opioid Use Disorder – Launched September 2019

OUD Patient

Expand Access to Opioid Health Homes

Expand care team support of BH

Initiate MAT in alternative settings such as ED and prisons

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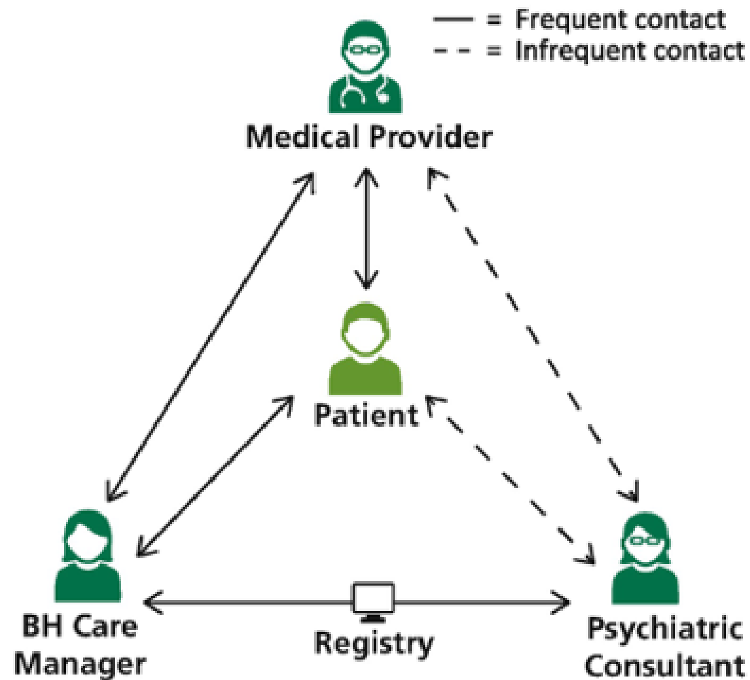
Behavioral Health Collaborative Care



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- **BH care managers integrated at the PCP office** collaborate with psychiatrist to improve access to high quality BH care
- Offices are having **success with the model**; demonstrating improved management of depression and anxiety through standardized scales
- Physician Organizations are beginning to adopt the Collaborative Care Model and finding results.
  - Ex. Average increase of 39 depression free days in 6 months compared to those receiving traditional care based on PO experience.

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Improving Care Management with Specialists

- Increasing PDCM as an integral part of specialist clinic models
- Improving coordination between PCPs and specialists
- Addition of remote monitoring applications with goal of managing chronic illnesses more proactively and keeping people out of the hospital

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Leading the shift to value-based care, aligning provider incentives and providing significant enablement support

Strong BCBSM track record of value-based leadership:

- Largest single-state Patient Centered Medical Home program
- Deployed nationally recognized Collaborative Quality Initiatives
- Saved over $2 billion through Value Partnerships initiatives

2005

PGIP rewards primary care physicians for cost and quality improvements

PGIP expanded to include specialist providers

Value-based hospital contracting aligns provider and facility strategies

2020+

Blueprint for Affordability enhances risk-sharing and enabling support

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BLUEPRINT GUIDING PRINCIPLES

The traditional fee-for-service model does not align payer and provider incentives toward higher-value care

Spectrum of Fee-for-service to Fee-for-value

Traditional fee-for-service

Pay for each unit of service

- **Separate fees** paid for:
  - Check-ups
  - ER visits
  - Scans
- **No financial accountability** for frequent ER visits and duplication of scans

Fee-for-value / Pay-for-performance

Incentives for high performance

- **Separate fees** paid for:
  - Check-ups
  - ER visits (fewer)
  - Scans (fewer)
- **Incentives paid based on high-quality** service, low complications (e.g., few / no ER visits)

We are here

Shared financial accountability

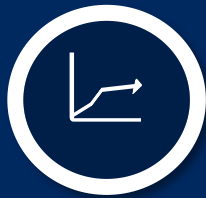
Pay for effectiveness and efficiency of services

- **Provider shares responsibility** for all care provided (check-ups, scans)
- **Provider is paid gains / responsible for losses vs. a target for total cost of care**
- **Payer/provider incentive alignment**

Value-based care: Provides incentives for delivering high-quality, lower-cost care

A look at impacts

Blueprint is designed lower network cost trend and identify areas of cost and quality improvement by enabling provider collaboration and sharing financial risk and reward



Decreased future cost trend and volatility

- Lower health care cost trend over time for providers in Blueprint
- Manage annual volatility of trend

Increased collaboration between BCBSM + providers

- Build on deep partnership with community providers to improve cost performance
- Enhance provider reporting / analytics to identify areas of opportunity
- Increase collaboration among providers

All-party shared financial participation

- Involve all parties in driving to affordability: BCBSM, providers, and customers

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Congratulations

Efforts to grow PDCM services are paying off!

The number of members engaged in PDCM has nearly doubled between 2017 and 2018

PDCM Engagement

50,000
45,000
40,000
35,000
30,000
25,000
20,000
15,000
10,000
5,000
0

100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%

2016
2017
2018

% eligible PCMH provider delivering PDCM services
Members in PDCM

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Questions

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Team Based Care Testimonial

Lance M. Owens, DO

Metro Health Integrated Network

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Team Based Care

Lance M. Owens, DO

Who is Metro?

208 LICENSED INPATIENT BEDS

1 METRO HEALTH HOSPITAL, 25 OUTPATIENT FACILITIES

3,063 EMPLOYEES

600 MEDICAL STAFF

750 NURSES

75 RESIDENTS IN TRAINING ACROSS 9 SPECIALTIES

10,485 DISCHARGES

68,358 EMERGENCY/ URGENT CARE VISITS

9,113 SURGERIES

1,741 DELIVERIES

BY THE NUMBERS

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MISSION ACCOMPLISHED

HIMSS | EMRAM STAGE 7 | O-EMRAM STAGE 7

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Who am I?

- Family Practice / Wilderness Medicine
- 11.5 years as a Naval Medical Officer
- Practicing at Metro for 15 years
- Over 7000 patients assigned to my Care Team (in Epic)
- Privileged to be a testing ground of sorts
  - Studied Team Based Care
  - Studied design concepts of future medical offices
  - First to have multiple APPs, Non-MiPCT CM, and PharmD
- Associate Chief Medical Informatics Officer
- Sit on Hospital Board

Metro's Care Team Journey

- Started developing care team probably about 20 years ago
- Started with APPs
- Dabbled with imbedded Mental Health
- Progressed to Ambulatory RN's
- MiPCT Program
- Expanded Care Management - Took the hand cuffs off
- Imbedded Medical Social Workers
- Started Pharmacist involvement with Priority Health Program
- MPTCQ

Current Care Team

- Physician
- Advanced Practice Providers
- RN Care Managers
- Ambulatory RNs
- Ambulatory Pharmacists
- Medical Social Workers
- Population Health Specialist
- MA’s
- Practice Managers

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On the horizon

- Revenue Integrity Specialist
  - Certified billers/coders
- Expanding Population Health Specialists
- Life/Health Coaches
- Leveraging Predictive Analytics

What does the Care Team mean to me?

“Team Above All”

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“I was developing my exit strategy from practice”

–Lance M. Owens, DO

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Everyone practices at the top of their license

- Chronic Disease Management
  - HTN/DM/HLP - Team Effort
- Home Care
- Mental Health
- Form Completion
- Prior Authorizations
- Quality
- Anything we can do to help the patient

A moment of THANKS!

Team Based Care Panel Discussion

- **Lance Owens**, Physician, Metro Health Integrated Network
- **Corie Lawrence**, Pharmacist, Metro Health Integrated Network
- **Muriel Lord,** Medical Assistant, Medical Network One
- **Jon Broek**, Dietician, Medical Advantage Group
- **Danielle Trieskey**, Behavioral Health Specialist, IHA
- **Maria Castillo** Community Health Worker, Washtenaw County Health Department
- **Cheryl Howard**, Registered Nurse, Wexford PHO

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Best Practice and Visioning Awards

62 Best Practice Submissions from 28 POs

17 Visioning Submissions from 17 POs

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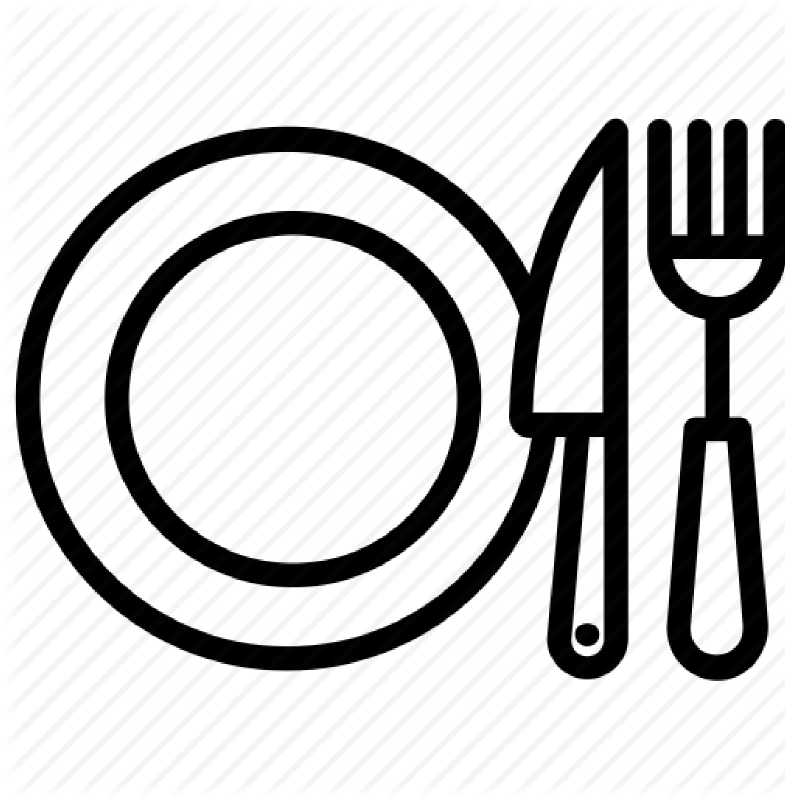
Lunch



Multi-Payer Care Management Council Meeting in Room 138

MICMT

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Table Discussions

A1c Performance – Remain in Main Room

Blood Pressure – Remain in Main Room

Emergency Department Utilization – Room B110

Inpatient Utilization – Room B108

Report-out at 1:45 pm – Main Room

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What’s on the horizon?

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From 2019 to 2020

11/1/2019 Annual Meeting Presentation

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Agenda

2019 Review

- Progress on the 2019 Strategy
- Review global responses to the 2019 Scorecard
  - Additionally provide an initial picture of care management programs in Michigan
- Training

2020 Strategy

- Annual and Regional Meetings
- 2020 Scorecard
- MAT support plan

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2019 Review

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MICMT Strategy

1

Engage with POs and other care management stakeholders to gather best practices and provide a supportive care management community.

- Quarterly, 30-minute phone conversations with MICMT leadership
- Convene all of the POs in the state in at least 1 meeting around team-based care management in 2019 and both regional and statewide meetings in 2020
  - "Office Hours" for Pharmacy, Social Work, and Nursing
  - MICMT Advisory Council

2

Boost PO formal commitment to care management through the development and implementation of care management strategic plans.

3

Support expanded role of POs in care management training through new training program and guidelines

- New CCM training program survey recently released!
- New CCM program likely to be available mid-summer
- Develop a toolkit to support care management program development.

4

Evaluate the BCBSM care management program with regards to a scorecard, 4 selected outcomes metrics (A1c, CBP, EDU, IPU) and overall outreach to the BCBSM population.

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2019 Scorecard

Preliminary Data

40 total POs in PGIP…

- 93% of POs submitted a Strategic Plan
- 70% participating in PPQC
- 45% are aggregating or submitting SDoH data to MiHIN
- 93% of POs received full points for the strategic plan portion
- 88% POs completed 3 quarterly meetings with MICMT
- 95% of POs RSVP'd for the Annual Meeting

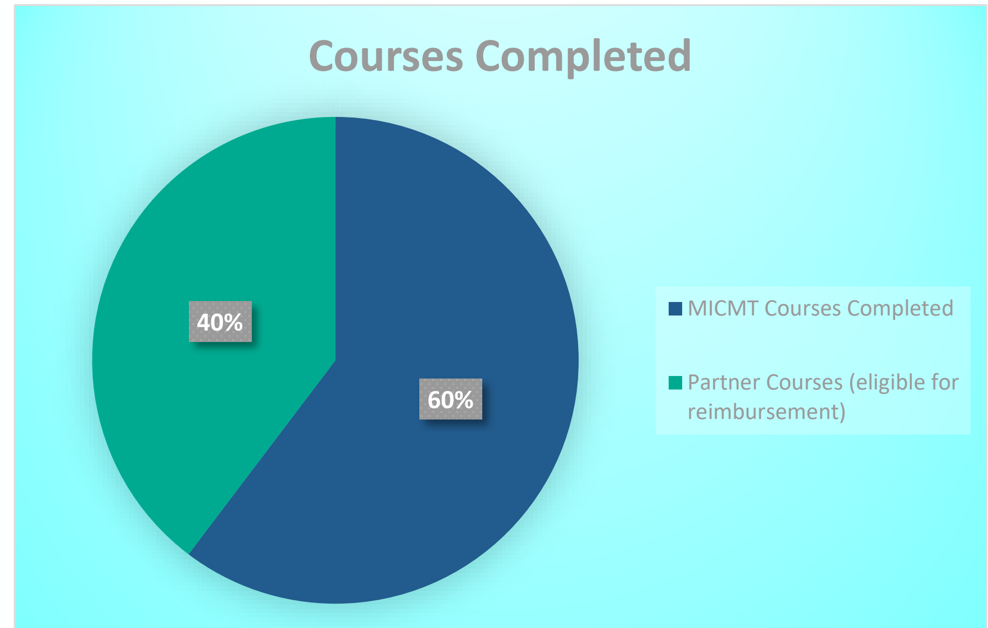
2019 MICMT / PDCM Award Program – Year 1, Baseline
PO Scorecard submission by October 15th, 2019 to MICMT

Program Summary: 40 Physician Organizations (No responses for 3 POs)

Meas. #	Weight	Measure Description		N / % of PO's
1	30	**Information Sharing**		
		Establish a working process for sharing clinical data in the appropriate format to MiHIN in coordination with PPQC and SIM efforts by September 1, 2019. (https://mihin.org/wp-content/uploads/2018/08/MiHIN-UCIG-Commercial-Payers-PPQC-SIM-Data-Aggregator-v20-07-31-18.pdf)	Yes	28 / 70.0%
			No	9 / 22.5%
		Establish a working process for aggregating Social Determinants of Health questionnaire results. In 2019, there is no required percentage of patients included in the process; the purpose is establishing the pipeline for aggregating and submitting data.	Sending information to MiHIN along one of their approved pathways for at least 2 offices. (15 points)	13 / 32.5%
			Aggregation process developed and successful with at least 2 offices and a plan for future offices in 2020. (10 points)	5 / 12.5%
			Plan for data aggregation is developed, ready for implementation, no offices sending data. (5 points)	7 / 17.5%
			Plan for data aggregation is still in development. (0 points)	12 / 30.0%
2	70	**Engagement**		
		Timely submission and approval of the PO level care management plan (template provided by MICMT)		
		Care Management Plan discusses how the PO will improve performance on at least 1 core utilization (ED, IP)	Smart Goal (2 points)	37 / 92.5%
			Current State (2 points)	37 / 92.5%
			Plan (2 points)	37 / 92.5%
			Timeframe (2 points)	37 / 92.5%
			Measurement / tracking (2 points)	37 / 92.5%
		Care Management Plan discusses how the PO will improve performance on at least 1 core clinical measure (BP, A1c)	Smart Goal (2 points)	37 / 92.5%
			Current State (2 points)	37 / 92.5%
			Plan (2 points)	37 / 92.5%
			Timeframe (2 points)	37 / 92.5%
			Measurement / tracking (2 points)	37 / 92.5%
		Care Management Plan addresses an increase in practices achieving the PDCM VBR award from PO baseline.	Smart Goal (2 points)	37 / 92.5%
			Current State (2 points)	37 / 92.5%
			Plan (2 points)	37 / 92.5%
			Timeframe (2 points)	37 / 92.5%
			Measurement / tracking (2 points)	37 / 92.5%
		Care Management Plan addresses how information provided at the annual MICMT meeting will be disseminated throughout the PO.	Yes	37 / 92.5%
			No	3 / 7.5%
		At least 3 scheduled phone conference (30 minutes) with the MICMT to review scorecard performance and program updates	Yes	35 / 87.5%
			No	5 / 12.5%
		Participation in the annual MICMT meeting by at least 1 PO Representative with a leadership role in Care Management activity at the PO level.	Yes	38 / 95.0%
			No	2 / 5.0%

Training

- **Please note that you don't get reimbursed for MICMT conducted trainings, and we would like to encourage you to investigate options with our partner trainers!**
- Of the $475,000 we budgeted for reimbursements, we are reimbursing $90,000.



We encourage POs to become approved trainers and work with our Statewide Trainer Groups!

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Become an approved trainer!

Application Process

CCM:

https://micmrc.org/micmt-complex-care-management-course-trainers-page

- Contact Scott Johnson at scojoh@med.umich.edu

SMS:

https://micmrc.org/self-management-support-course-statewide-trainer-organization-application-and-resources

- Contact Sarah Fraley at svoor@med.umich.edu

*Note – we provide all of the materials for a new trainer to revise / use as is.

Mentorship

- Attend a training from the perspective of a trainer.
- MICMT team members will attend your first training (at a minimum) to provide feedback and assist with any continuing questions on the course material.
- Ongoing support and coaching sessions.
- Inclusion on annual material revision meeting.

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Current List of Approved Trainers

PO / Organization	CCM	SMS
IHP		X
Infinity Counseling		X
Med Net One		X
MiCCSI	X	X
NPO	X	X
Olympia	X	
OSP	X	
UPHG	X	X
Wexford	X	

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2020 Strategy

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Statewide Meetings

Regional Meetings

- April 22, 2020 – Livonia
- April 29, 2020 – Grand Rapids
- “Boots on the ground”
- Poster Session

Annual Meeting

- October 23, 2020
- PO Leadership / CM Leadership

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PO Support – Program Development

- Connection with other best practice sites
  - Thanks to the 60+ submitters! We may contact you!
- Participation in PO meetings to talk with physicians/practices about PDCM – whether it's getting started or refining the approach

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2020 Scorecard

Focus on:

- **SDoH**
- **Outcomes**

2020 Scorecard				
Measure #	Weight	Measure Description	Points	
1	40	**Information Sharing:**		
		Consistently follow the process for sharing clinical data in the appropriate format to MiHIN in coordination with PPQC and SIM throughout 2020. • PO should send clinical data on all patients and all payers • Expectation is that the PO is sending info from, at minimum, all PDCM-defined offices		10
		Expand the PO process for aggregating Social Determinants of Health questionnaire results and sending to MiHIN; to be completed by **October 1, 2020.**		**16 total**
		2020 requirements → Send SDoH data for all practice units who reached the 2 touches on 1% of the population in CY2018. BCBSM/MICMT will provide a list of those offices.	**% of PDCM offices**	**# of points**
			90%	**16**
			75%	**12**
			50%	**8**
			25%	**5**
		Expand the PO process for screening among Practice Units.		**10 total**
		Points provided for the percentage of PDCM-defined practice units with PCMH capabilities 10.5 in place.	**% of PDCM offices**	**# of points**
			90%	**10**
			75%	**7**
			50%	**5**
			25%	**3**
		Develop/expand the PO process for creating a feedback loop for social needs among Practice Units.		**8 total**
		Points provided for the percentage of PDCM-defined practice units with PCMH capabilities 10.5 in place.	**% of PDCM offices**	**# of points**
			90%	**8**
			75%	**6**
			50%	**4**
			25%	**2**
2	16	**Engagement:**		
		Care Team Survey & Attestation / Verification		5
		At least 3 scheduled phone conferences (30 minutes) with the MICMT to review scorecard performance and program updates		5
		Participation in a Regional MICMT meetings by at least 1 PO representative.		3
		Participation in the Annual MICMT meeting by at least 1 PO Representative with a leadership role in Care Management activity at the PO level.		3
3	40	**Outcomes:**		
		A1c performance		10
		BP Performance		10
		ED Utilization		10
		IP Utilization		10

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MAT Support - 2020

- Establish regional MAT Champions.
- Coordinate introductions of the MAT Champions to their regions.
- Coordination of efforts with Michigan Opioid Collaborative (MOC)
- Team and physician focused virtual calls that cover topics selected and coordinated by MICMT, MAT Champions, and our state-wide partners.
- Program evaluation.

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Thank you for attending!

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