2016-2017 BCBSM PCMH capability update.

10.0 Linkages to Community Services

Tracy Lowery

Practice Administrator

Internal Medicine Northern Michigan

Caveat Emptor

- The PCMH program must evolve to meet the needs of BCBSM, our customers and their members.
- This will require substantive changes to the program over time.
- Existing capabilities will change, substantially in some instances.
- We recognize that the modification of existing capabilities may be frustrating. Nonetheless, these changes are necessary to ensure that BCBSM is able to continue to incentivize capabilities, designate PCMH practices and offer the associated financial benefits.

Domain 10 – Community Services

1-yr grace period was in *2016.* *These capabilities are now in effect.*

10.3 – PO in conjunction with Practice Units has established collaborative relationships with appropriate community-based agencies and organizations

- PO in conjunction with practice has conducted outreach to organizations and held in-person meetings or face-to-face events, at least annually, that facilitate interaction between practices and agencies where they discuss the needs of their patient population

10.5 - Systematic team approach is in place for educating all patients about availability of community resources and assessing and discussing the need for referral

- Education process must include intake form and/or conversation in which patients are asked whether they are aware of or in need of community services

10.6 - Systematic approach is in place for referring patients to community resources

- Assessments that identify a patient with need for referral are documented in the medical record to enable providers to follow-up during subsequent visits

2016 – 2017 BCBSM PCMH Guidelines

10.5 - Systematic team approach is in place for ***educating all patients*** about availability of community resources and assessing and discussing the need for referral

- Systematic process is in place for the practice unit team to educate new patients and all patients during annual exam (or other visits, as appropriate) about availability of community resources, and assessing and discussing the need for referral

- i. Education process must include intake form and/or conversation in which patients are asked whether they are aware of or in need of community services. *Where will the documentation be regarding educating all patients if they are aware or in need of community resources?*

- ii. Practice support staff are empowered to alert practice unit staff to possible psychosocial and other needs
- iii. For example, Practice Units may develop an algorithm (or series of algorithms) to guide the assessment and referral process
- iv. Additional information about available community resources should be disseminated via language added to patient-provider partnership documents, PO or Practice Unit website, brochures, waiting room signage, county resource booklets at check-out desk, or other similar mechanisms

Internal Medicine of Northern Michigan

Tracy Lowery , Practice Administrator

To prepare staff members to educate patients, staff review where community resource material is found at the practice.

Nurses Station , Triage, Billing,

Waiting rooms, Exam rooms, IMNM website

Staff education:

Clinical Staff Lead:

Appoints MA/designee who updates community resource information every 6 months.

MA/designee train staff - proactive in recognizing patient needs.

- Staff members are knowledgeable about community resource links available on the NPO website,

  www.npoinc.org – search community resources – access community resources link on left.

10.5  *Educating all Patients*

Provider's MA / NP / PA / Care Manger introduce *all patients* to community resources.

New patients

Annual physicals

Transition of Care phone calls

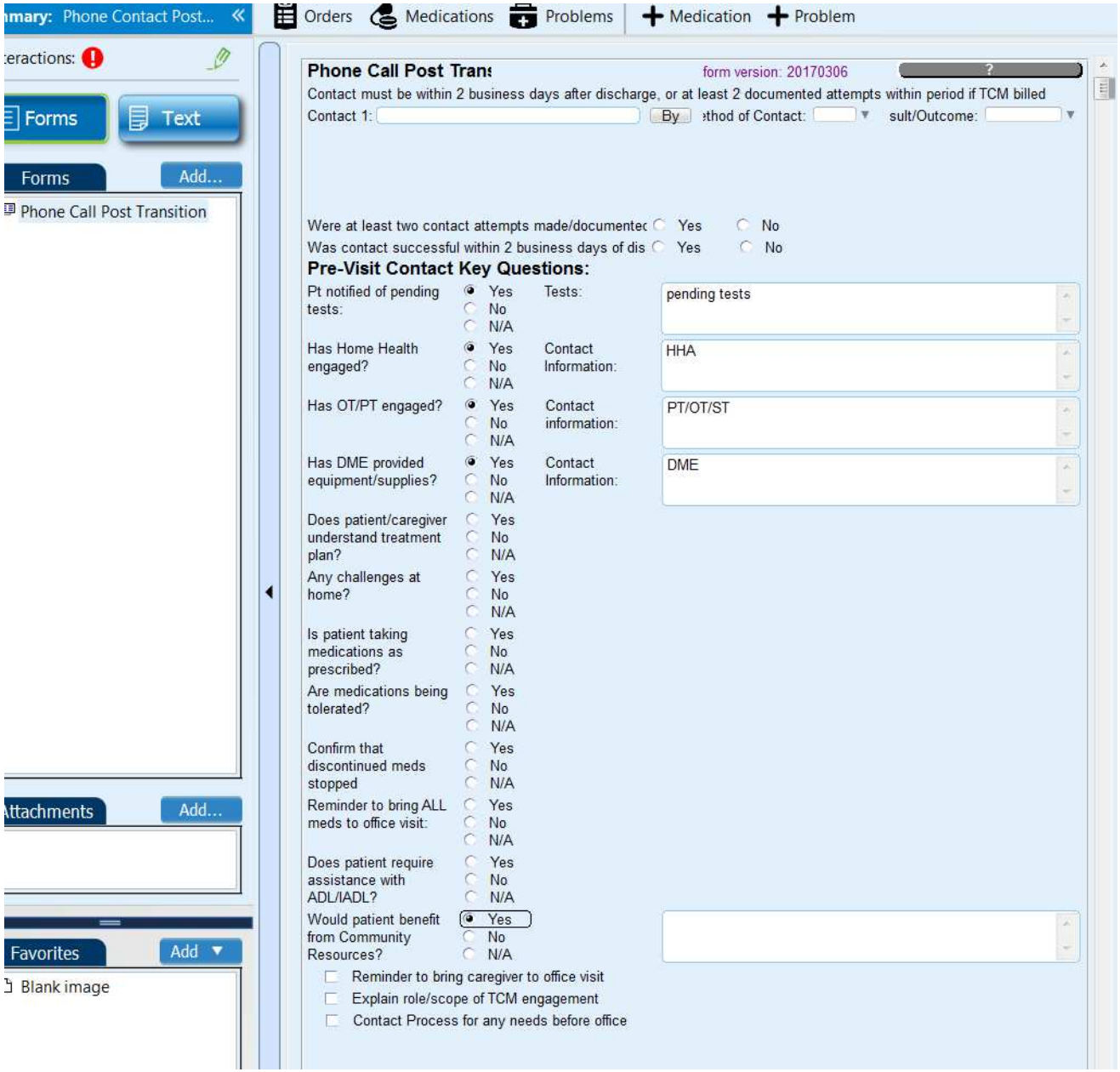
As needed

10.5 ★ *Patient Education Documentation:*

At the same time as PCMH Discussion

- Discussion with patient about the transition of this practice to a Patient Centered Medical Home (PCMH) model, referencing the practice brochure and available materials. Also discussed the patient-provider partnership and mutual expectations about delivering quality healthcare for the patient with their assistance and active cooperation. Answered any questions to the best of my ability, and suggested that any remaining issues be discussed with the physician/provider.

- Patient Education regarding Community Resources will be included during the PCMH conversation in which patients are asked whether they are aware of or in need of community services.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Attachments
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Favorites
Add
Blank image
Phone Call Post Trans
form version: 20170306
Contact must be within 2 business days after discharge, or at least 2 documented attempts within period if TCM billed
Contact 1:
By
thod of Contact:
sult/Outcome:
Were at least two contact attempts made/documentec Yes No
Was contact successful within 2 business days of dis Yes No
Pre-Visit Contact Key Questions:
Pt notified of pending tests: Yes No N/A
Tests: pending tests
Has Home Health engaged? Yes No N/A
Contact Information: HHA
Has OT/PT engaged? Yes No N/A
Contact information: PT/OT/ST
Has DME provided equipment/supplies? Yes No N/A
Contact Information: DME
Does patient/caregiver understand treatment plan? Yes No N/A
Any challenges at home? Yes No N/A
Is patient taking medications as prescribed? Yes No N/A
Are medications being tolerated? Yes No N/A
Confirm that discontinued meds stopped Yes No N/A
Reminder to bring ALL meds to office visit: Yes No N/A
Does patient require assistance with ADL/IADL? Yes No N/A
Would patient benefit from Community Resources? Yes No N/A
Reminder to bring caregiver to office visit
Explain role/scope of TCM engagement
Contact Process for any needs before office

10.6

Internal Medicine of Northern Michigan
560 West Mitchell St Suite 300, Petoskey, MI 49770-2278
(231) 487-2460 Fax: (231) 487-6596

Referral Form

Authorizing Provider: Paul D Blanchard MD
Signing Provider: Paul D Blanchard MD
Service Provider:

Phone: (231) 487-2460
Fax: (231) 487-6596
Phone:
Fax:

Patient Name: [redacted]
Home Phone: [redacted]
Work Phone:
Resp. Provider: Paul D Blanchard MD
DOB: [redacted] **Age:**
Sex: F **SSN:** [redacted]

Primary Ins:	MEDICARE WPS
Group:	
Policy:	
Insured ID:	[redacted]
Subscriber:	[redacted]
Relationship:	Self
Subscriber DOB:	[redacted]

Secondary Ins:	MEDICAID
Group:	
Policy:	
Insured ID:	[redacted]
Subscriber:	
Relationship:	
Subscriber DOB:	

Code	Description	Diagnoses
CONCOMM	REFERRAL TO COMMUNITY RESOURCES	DIFFICULTY IN WALKING, NOT ELSEWHERE CLASSIFIED(ICD-R26.2)

Order Number: 181700-6
Auth#:
Maximum Visits: 0
Start Date: 10/11/2016 **End Date:** 10/11/2016
Duration:
Electronically signed by: Paul D Blanchard MD
Signed on: 10/11/2016 3:19:00PM
Reason: Services: Friendship Center (Done by PDB)

United Way - Call 211 (if available) or Regional United Way Offices:
Northwest Michigan 877-211-5253
Northeast Michigan 888-636-4211
Upper Penninsula (all) 800-338-1119

Note: Please also print HANDOUT on Community Resources. A Community Resource binder also available in Waiting Room, Scheduling Wait and Triage.

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04/18/2017 11:08 AM
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Referral Form

Referral Form

Authorizing Provider:	Melanie S Manary MD	**Service Provider:**	IMNM
Signing Provider:	Melanie S Manary MD		
Phone:	(231) 487-2460	**Phone:**	
Fax:	(231) 487-6596	**Fax:**	(231) 487-6596
Patient Name:	[redacted]	**DOB:**	[redacted] **Age:**
Home Phone:	[redacted]	**Sex:**	F **SSN:** [redacted]
Work Phone:			
Resp. Provider:	Melanie S Manary MD		

Primary Ins:	PRIORITY HEALTH PPO	**Secondary Ins:**	
Group:		**Group:**	
Policy:	[redacted]	**Policy:**	
Insured ID:	[redacted]	**Insured ID:**	
Subscriber:		**Subscriber:**	
Relationship:		**Relationship:**	
Subscriber DOB:		**Subscriber DOB:**	

Code	Description	Diagnoses
CONCM	Refer to Care Management (INTERNAL)	HYPERLIPIDEMIA(ICD-E78.5) RENAL DISEASE, CHRONIC, STAGE III(ICD-N18.3) DEPRESSION(ICD-F32.9) SJOGREN'S SYNDROME(ICD-M35.00)

Order Number:	163605-10
Auth#:	NA
Maximum Visits:	1
Start Date:	03/18/2016
Duration:	3 Months
Electronically signed by:	Melanie S M
Signed on:	3/17/2016 1
Reason:	Refer to Car
	3/18/16 AT 1

We Don't use these very often!

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April 18, 2017
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Progress Note

MRS [redacted]
Female DOB: [redacted] 8002365 Ins: MEDICARE WPS
Home: [redacted]

11/23/2016 - Progress Note: CM visit-comm resources
Provider: Terese Henley LMSW
Location of Care: Internal Medicine of Northern Michigan

Office Visit Note - Extended (test)

Chief complaint Care Management services provided by Terese Henley,LMSW on this date. Patient was referred to Care Managment by Dr. Blanchard for the following concerns: comm. resources

Comments pt. seen after pcp appt.

[Active Medications:
LOXAPINE SUCCINATE 25 MG ORAL CAPS (LOXAPINE SUCCINATE) 1 QHS
PREVNAR 13 IM SUSP (PNEUMOCOCCAL 13-VAL CONJ VACC)
LEVOTHYROXINE SODIUM 150 MCG ORAL TABS (LEVOTHYROXINE SODIUM) 1 daily
FUROSEMIDE 20 MG TABS (FUROSEMIDE) (GEQ for lasix) 2 po q am
FUROSEMIDE 20 MG TABS (FUROSEMIDE) (GEQ for lasix) 2 po q am
KLOR-CON 10 10 MEQ CR-TABS (POTASSIUM CHLORIDE) 2 po qd
DILTIAZEM HCL COATED BEADS 300 MG XR24H-CAP (DILTIAZEM HCL COATED BEADS) 1 po qd
SULFASALAZINE 500 MG TABS (SULFASALAZINE) 3 po q am and 2po q PM
LISINOPRIL 5 MG TABS (LISINOPRIL) 1 po q day

Current Allergies:
BETADINE (Moderate)
NIFEDIPINE (Moderate)

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[redacted]
Female DOB[redacted] 8002365 Ins: MEDICARE WPS Home: [redacted]

History of Present Illness

Referral source: Dr. Blanchard
History from: patient
Reason for visit: comm. resources
Chief Complaint: Care Management services provided by Terese Henley,LMSW on this date. Patient was referred to Care Managment by Dr. Blanchard for the following concerns: comm. resources

HPI:
CM Assessment: Pt recently widowed [redacted].Spouse was at local nursing home [redacted] Not interested in bereavement services. Lives at home alone. Dtr. lives close by in [redacted] son in [redacted]2 lives in [redacted] Neighbor helps with snow.
Medication Management: Walgreen's south, takes pills right out of the bottle.
Risk Factors:dryer is downstairs
Unmet Care Needs:lives alone and independent.
Physical Status:Uses a cane outside to be safe.Has RA challenges at home that she manages on a daily basis (laundry, moving stuff).
Emotional Status:alert and oriented.
Community Resources:none
Readiness to Change:low
Patient verbalizes understanding of treatment plan: continue to f/u with asking family to assist in transitioning things around the house. EX: son in law can move the dryer upstairs.
Short Term Goals:will ask son in law to move dryer upstairs.
Long Term Goals: long term move in with dtr.

Total Time Spent with Patient: 20 min

Terese Henley, LMSW
Adaptive Counseling and Care Management
Under contract with NPO and IMNM
Services provided at IMNM location

Problem Directive Review

Current Problems:
Other long term (current) drug therapy (ICD-V58.69) (ICD10-Z79.899)
Body mass index (BMI) 32.0-32.9, adult (ICD-V85.32) (ICD10-Z68.32)
Encounter for examination of blood pressure without abnormal findings (ICD-V72.85) (ICD10-Z01.30)
MAMMO SCREENING (ICD-V76.12) (ICD10-Z12.31)
Encounter for general adult medical examination without abnormal findings (ICD-V70.0) (ICD10-Z00.00)