VALUE Partnerships

Interpretive Guideline 2014-2015

Updates

January , 2015

PGIP Field Team
Value Partnerships
Blue Cross Blue Shield of Michigan

Summary of Changes

- Five new capabilities added for upcoming program year, for a total of 145
  - 141 applicable to adult patients
  - 140 applicable to pediatric patients
- Special focus on enhancing guidelines for specialists
  - PCMH-N Workgroup guided thought process and helped make changes that would be meaningful to specialist community
- Comprised of BCBSM staff, PO leaders and specialist physicians
- Updated info on predicate logic
- Glossary now available on collaborative site
- Clarified language for Specialists
- Added goal statements to domains

Partnerships

Applicable to All Capabilities

Any capability reported to BCBSM as "in place" must be in place and *in use by all appropriate members of the practice unit team on a routine and systematic basis, and, where applicable, patients must be able to use the capability.*

Must be able to demonstrate the capability is currently in use versus "can do".

Partnerships

Introduction

- BCBSM's PCMH program provides the foundation to build Organized Systems of Care (OSCs). These expanded PCMH-N Interpretive Guidelines support implementation of capabilities that will enable specialists and sub-specialists, including behavioral health providers, to partner with primary care physicians engaged in transitioning to the patient-centered medical home model of care and other providers to create highly functioning systems of care.
- The goals of the PCMH-N model are to:
  - Support population health management in collaboration with PCPs
    - Population health management uses a variety of individual, organizational and cultural interventions to help improve the morbidity patterns (i.e., the illness and injury burden) and the health care use behavior of defined populations

Partnerships

Health Literacy

Note regarding health literacy:

It is expected that health literacy will be considered across all relevant domains, and that verbal and written communications with patients will be appropriate to the specific level of understanding and needs of the individual patient.

Partnerships

Domain 1
Patient Provider Partnership

Goal: Build provider care team and patient awareness of and active engagement with the PCMH model, clearly define provider and patient responsibilities, and strengthen the provider-patient relationship.

Capabilities 1.1-1.3 and 1.9 are applicable to specialists

All Capabilities in Domain 1.0 Require Demonstration
All Reports Must Be Current (Within Previous Quarter) At Time of Visit

Partnerships

1.2

c. For those patients who do not come into the practice regularly, outreach must consist of distribution of targeted material that the patient receives personally, either via mail, email, telephone, or patient portal.
   - Postings on websites do not meet the intent of this capability

SCP Guidelines:
   - Examples of outreach include discussion at the time of visit, mailings, emails, telephone outreach, or other electronic means mass mailings do not meet the requirements for 1.3 Outreach materials should explain the PCMH concept and patient-provider partnership, and the roles and responsibilities of the specialist provider, the PCP, and the patient

Partnerships

1.3

Specialist Guidelines:
- Evidence must be provided that patient-provider partnership conversations are occurring with, at a minimum, those patients for whom the specialist has primary responsibility or co-management responsibility with PCP
  - It is not necessary to maintain a list for purposes of quantifying the percentage of patients engaged in patient-provider partnership conversations
- Establishment of patient-provider partnership must include conversation between patient and a member of the practice unit clinical team
- Conversation may be documented in medical record, patient registry, or other type of list

Partnerships

Domain 2
Patient Registry

Goal: Enable providers to manage their patients both at the population level and at point of care through use of a comprehensive patient registry.

Applicable to PCPs; and to specialists for the patients for whom they have primary or co-management responsibility (regardless of insurance coverage and including Medicare patients).

All Capabilities in Domain 2.0 Require Demonstration/Documentation
All Reports Must Be Current At Time of Visit

Partnerships

2.1

PCP Guidelines:
- A patient registry is a database that enables population-level management in addition to generating point of care information, and allows providers to view patterns of care and gaps in care across their patient population.

SCP Guidelines:
- The population can be a co-managed chronic condition or common relevant condition.
- Registry must include data pertinent to key clinical performance measures (e.g., BCBSM-provided data or similar data from other sources).

Partnerships

2.2

- The registry is not expected to contain clinical information on all health care services received at any site for 100% of patients in the registry, but is expected to contain a critical mass of information from various relevant sources, including the PO's or practice unit's own practice management system, and electronic or other records from facilities with which the PO or practice unit is affiliated
  - PCP: Substantial majority of healthcare services is 75% of preventive and chronic condition services rendered to patients
  - SCP: Substantial majority of healthcare services is 75% of relevant services rendered to patients.

Partnerships

2.5

Specialist Guideline:
- The individual practitioner responsible for the care of each established patient is identified in the registry.
  - Registry should contain information on both specialist and patient's primary care physician
  - Exceptions may granted when patient does not want to identify provider, e.g., behavioral health providers
  - Occasional gaps in information about some patients' individual attributed practitioner due to changes in medical personnel are acceptable

Partnerships

2.8

PCP and Specialist Guidelines:

- Registry contains basic patient demographics, including name, gender, date of birth.

2.13

Specialist Guidelines:

- Registry is being used to manage all patients with at least 2 other conditions relevant to the specialist's practice for which there are evidence-based guidelines…

2.20 (NEW)

Registry contains advanced patient information that will allow the practice to identify and address disparities in care

PCP and Specialist Guidelines:

- *All or nothing*
- Registry contains advanced patient demographics, including:
  - primary/preferred language
  - race
  - ethnicity
  - measures of level of social support (e.g., disability, family network)
  - disability status
  - health literacy limitations
  - type of payer (e.g., uninsured, Medicaid)
  - relevant behavioral health information

2.21 (NEW)

Registry contains additional advanced patient information that will allow the practice to identify and address disparities in care

PCP and Specialist Guidelines:

- All or nothing
- Registry may be paper or electronic.
  - Registry contains advanced patient demographics, including:
    - gender identity
    - sexual orientation

Domain 3
Performance Reporting

- Goal: Generate reports enabling POs and providers to monitor their population level performance over time, close gaps in care, and improve patient outcomes.
- *Applicable to PCPs and to specialists for the patients for whom they have primary or co-management responsibility* (regardless of insurance coverage and including Medicare patients).

All Capabilities in Domain 3.0 Require Demonstration/Documentation
All Reports Must Be Current At Time of Visit

3.1

- ***Performance reports that allow tracking and comparison of results at a specific point in time across the population of patients are generated for: Diabetes (or for specialists, relevant patient population)***

3.2

Specialist Guidelines:

- Population level optimally consists of PO and/or sub-PO population, but alternatively, as the PO works toward implementing registry capabilities across all practice units, the population level report may be based on a meaningful subset of relevant aggregated practice unit performance
- Performance reports provide information and allow comparison at the population, practice unit, and individual provider level where feasible (i.e., PO has multiple specialist practices of same type) for all patients currently in the registry, regardless of insurance coverage and including Medicare patients
  - "Apples to apples"

Partnerships

3.4

PCP and Specialist Guidelines:

- The practice and PO have process to ensure that data in the registry are representative of the data in the patient's medical record
  - For example, where a test result is needed for management, evidence of the test being ordered should not be used as evidence that test was conducted, absent a test result report being received and entered in the record.

If its in the performance report, it should be in the patient record (think Supplemental Data).

Partnerships

3.5

Specialist Guidelines:

- Trending of 3.2
- Compare apples to apples

Partnerships

3.9

Performance reports include information on services provided by specialists or sub-specialists

PCP and Specialist Guidelines:

Reference 3.1

Information on key preventive or disease specific services provided by specialists or sub-specialists is incorporated into performance reports.

Partnerships

3.15

External tracking

PCP Guidelines:

- Practices or POs are tracking and reporting on key clinical indicators, such as rates of patients with HTN who are well controlled, and patients with DM who have an A1C showing reasonable control, in a manner consistent with standardized, generally accepted specifications for such measures

Specialist Guidelines:

- Practices or POs are tracking and reporting on key clinical indicators relevant to their practices, such as those outlined in HEDIS, PQRS and Meaningful Use standards

Partnerships

Domain 4
Individual Care Management

Goal: Patients receive organized, planned care that also empowers them to take greater responsibility for their health

- *Specialist practice must have lead responsibility for care management for at least a subset of patients for a period of time; e.g., oncology care manager has lead responsibility for patients when they are in active chemotherapy).*
- *For patients with an ongoing care relationship with a specialist, PCP and specialist must establish agreement regarding who will have lead responsibility for care management.*
- *To receive credit for an individual care management capability, basic care management delivered in the context of office visits must be available to all patients. Advanced care management, delivered by trained care managers in the context of provider-delivered care management services, is expected to be available only to those members who have the provider-delivered care management benefit.*
- *To facilitate phased implementation of capabilities, providers may select a subset of their patient population for initial focus for capabilities 4.2, 4.5, 4.6, 4.7, 4.8, 4.9*

Partnerships

Demonstration Requirements for Domain 4.0

All capabilities in this domain, except 4.15, 4.20 require demonstration

4.1 – Documentation also required
4.4 – Documentation also required
4.14 – Documentation also required
4.16 – Documentation also required
4.18 – Documentation also required
4.19 – Documentation also required
4.21 – Documentation also required

Partnerships

4.1

PCP and SCP Guideline:

- Process is in place to ensure new staff receive training
- Process is in place to ensure all staff are kept apprised of changes in the PCMH and PCMH-N Interpretive Guidelines, and of the capabilities that have been implemented by the practice
- Training/educational activity is documented in personnel or training records, and content material used for training is available for review

Partnerships

4.2

- ***Practice Unit has developed an integrated team of multi-disciplinary providers and a systematic approach is in place to deliver coordinated care management services that address patients' full range of health care needs for the patient population selected for initial focus***
- The integrated team of multi-disciplinary providers must consist of at least 3 non-physician members, including an RN and at least 2
  - Identify team member structure
  - Discuss communication loop
  - Practice should be able to provide examples
  - Team composition may vary according to patient needs

Partnerships

4.3

Specialist Guidelines:

- Evidence-based care guidelines may be those developed by specialist societies

4.4

Specialist Guidelines:

- Surveys should capture information relevant to all patients managed by the specialist

Partnerships

4.9

The clinician is directly involved and meets with each patient individually

- NP or PA may conduct both the clinical and educational/group activity components of the group visit

For SCPs:

- What was patient population selected for initial focus?

Partnerships

4.10

Medication review and management is provided at every visit for all patients with conditions requiring management

Specialist Guidelines:

At a minimum, medication review and management is provided at every visit for all patients with chronic conditions or when indicated given the patient's health status

- Chronic conditions under 4.10 are defined as any condition requiring maintenance drug therapy.
- During every patient encounter, a list of all medications currently taken by the patient is reviewed and updated, and any concerns regarding medication interactions or side effects are addressed.

Partnerships

4.16

A systematic approach is in place for engaging patients in conversation about advance care planning, executing an advance care plan with each patient who wishes to do so, and including a copy of a signed advance care plan in the patient's medical record

PCP Guidelines:

PCP must have systematic process in place to communicate with specialists and identify who has lead responsibility for discussing and assisting each patient with advance care planning

Specialist Guidelines:

- **Specialist(s) must have systematic process in place to communicate with PCP** and identify who has lead responsibility for discussing and assisting each patient with advance care planning
- Provider with lead responsibility must ensure that all care partners are aware of and have copies of advance care plan

Partnerships

Domain 5
Extended Access

Goal: All patients have timely access to health services that are patient-centered and culturally sensitive and are delivered in the most appropriate and least intensive setting based on the patient's needs

Demonstration Requirements for Domain 5.0

5.1
5.2
5.6
5.7 - Documentation also required (written policy)
5.8 - Documentation also required (written policy)

Partnerships

5.1

For after-hour calls, clinical decision-maker responds to patient inquiry in a timely manner (generally 15-30 minutes, and no later than 60 minutes after initial patient inquiry)

- For calls during office hours, [process for determining urgency, triaging for appropriate response]
  - For urgent calls, clinical decision-maker responds to patient inquiry in a timely manner (generally 15-30 minutes, and no later than 60 minutes after initial patient inquiry
  - For non-urgent calls during office hours, patients may be given response by phone before end of business day, or offered appointments in a timeframe appropriate to their health care needs

Partnerships

5.2

PCP and Specialist Guidelines:

In circumstances where the patient is personally well known to clinician or the condition is non-urgent and easily managed, the clinician may not always need to access the EMR or registry during the call, and may update the record after the call.

Partnerships

5.3

Specialist Guidelines:

- **Feedback from urgent care center is only required when the care provided to the patient is relevant to the condition being managed by the specialist**
  - For patients who do not reside within the specialists geographic vicinity, establishment of a feedback loop may not always be possible

Partnerships

5.4

A systematic approach is in place to ensure that all patients are fully informed about after-hours care availability and location, at the PCMH site as well as other after-hours care sites, including urgent care facilities, if applicable

PCP and Specialist Guidelines:

- Providers should ensure patients know how to contact them during after-hours, and should ensure patients are aware of location of urgent care centers, when applicable
- Specialists are encouraged to work with the PCP community to identify appropriate urgent care sites with whom they share clinical information

Partnerships

5.9

Practice unit has telephonicor other access to interpreter(s) for all languages common to practice's established patients.

PCP and Specialist Guidelines:

- **Languages common to practice aredefined as languagesidentified as primary by at least 5% of the established patient population**

5.10 (NEW)

Patient educationmaterials and patient forms are available in languagescommon to practice's established patients

PCP and Specialist Guidelines:

- Languages common to practiceare defined as languages identified as primary by at least 5% of the established patient population

Partnerships

Domain 6
Test Results Tracking and Follow Up

Goal: Practice uses a standardizedtracking system to ensure neededtests are received, results are communicatedin a timely manner, and follow-up care is received

Applicableto PCPs and specialists.

Provider ordering the test is responsible for following up to clearly communicate information about test orders and test results to partner provider, or to patient when indicated. When specialist recommends tests for co-managed patient, ordering PCP is responsible for all follow-up and for clearly communicating test orders and test results to partner provider.

Partnerships

Demonstration Requirements for Domain 6.0

6.1 - Documentationalso required (written process)
6.4
6.5
6.7
6.8 - Documentationalso required (training)
6.9

Partnerships

6.4

Mechanism is inplace for patients to obtaininformation about normal tests

PCP and Specialist Guidelines:

Patients are informed about how to access normal test results

Process may use any of the following mechanisms:

- **Direct conversation with patient**
- Telling patients that ***"No news is good news"*** does not meet the intent of this capability. Patients must have clear understandingof how to obtain information about normal test results.

Partnerships

6.6

Systematicapproach is used to communicatewith patients withabnormal results regarding receivingthe recommendedfollow-up care within definedtimeframes

PCP and Specialist Guidelines:

Patient requiring follow-up are flagged and follow-up timeframes are specified

- Provider makes at least 2 attempts to contact patient; for serious conditions, third attempt is made by certified mail
  - Communicationattempts are documentedin patient's medical record

Partnerships

Domain 9
Preventive Services

Goal: Actively screen, educate, and counsel patients on preventive care and health behaviors

- Typically, primary preventionrelates to PCPs, secondaryrelates to SCPs.
- Primary preventionis all or nothing
- **Applies to full range ofprimary preventive services (for example, an ob-gyn ensuring patients receivemammograms and pap tests, but not flu shots, would not meet the intent of this capability).**
- *When patient is co-managedby PCP and specialist, roles must be clearly definedregarding who is responsible for ensuring patients receive needed preventive services.*

Partnerships

Demonstration Requirements for Domain 9.0

9.3
9.5
9.6 - Documentationalso required (written standing order protocols)
9.7
9.8
9.9 - Documentationalso required (planned visit template

9.8

Staff receives regular training and/or communications and updates regarding health promotion and disease prevention and incorporates preventive-focused practices into ongoing administrative operations

PCP and Specialist Guidelines:
Applicable to either primary or secondary preventive services

Domain 10
Linkage to Community Services

Goal: Expand the PCMH-Neighborhood to include community resources. incorporate use of community resources into patients' care plans and assist patients in accessing community services

All Capabilities in Domain 10.0 Require Demonstration

No Changes

Domain 11
Self Management Support

Goal: Systematic approach to empowering patients to understand their central role in effectively managing their illness, making informed decisions about care, and engaging in healthy behaviors.

All Capabilities in Domain 11.0 Require Demonstration
All Reports Must Be Current At Time of Visit

11.4 – Documentation of aggregated results

11.1

PCP and Specialist Guidelines:
Regular intervals are defined as a minimum of once per year
- New staff must be trained at time of entry to practice

11.2, 11.3, 11.5, 11.6

Self-Management Support:
- Updated 11.2, 11.3, 11.5 and 11.6 to make language clearer

Self-management support is offered to all patients <u>in the patient population</u> selected for initial focus (based on need, suitability and patient interest)

11.7

Support and guidance in establishing and working towards a self-management goal is offered to every patient, including well patients

PCP and Specialist Guidelines:

Self-management goal is developed collaboratively with the patient and is specific and reflective of the patient's interests and motivation

Domain 12
Patient Web Portal

Goal: Patients have access to a web portal enabling patients to access medical information and to have electronic communication with providers

All Capabilities in Domain 12.0 Require Demonstration
Or Current Usage Logs Required

12.3

Ability for patients to request appointments electronically is activated and available to all patients

PCP and Specialist Guidelines:

Practice will schedule patients and notify them of their appointment time

12.7

Providers are using patient portal to send automated care reminders, health education materials, links to community resources, educational websites and self-management materials to patients electronically

PCP and Specialist Guidelines:

- **At least 4 out of the 5 types of communications must be occurring**
- Information must be actively transmitted to patients (not merely available on website)

12.13

Ability for patients to schedule appointments electronically through an interactive calendar is activated and available to all patients

PCP and Specialist Guidelines:

- Patients should have the ability to see currently available appointments and insert themselves in to the schedule of the practice. Time slot is then reserved for patient.
  - May be subject to final confirmation by practice

Domain 13
Coordination of Care

Goal: Patient transitions are well-managed and patient care is coordinated across health care settings through a process of active communication and collaboration among providers, patients and their caregivers

Applicable to PCPs. When patient is co-managed by PCP and specialist, roles must be clearly defined regarding which provider is responsible for leading care coordination activities.

Applicable to specialists for patients for whom the specialist has lead care management responsibility or when the admission is relevant to the condition being managed by specialist

(All Capabilities in Domain 13.0 Require Demonstration)
(13.10 – Documentation Required)

13.1-13.7

13.1-13.7 Apply to ***patient population selected for initial focus***

Partnerships

13.8

Care coordination capabilities as defined in 13.1-13.7 are extended to multiple patient populations that need care coordination assistance

PCP Guidelines:

- Applicable to all patients with chronic conditions
- Written procedures and/or guidelines on care coordination processes may be developed by the PO or practice

Specialist Guidelines:

- Applicable to multiple patient populations relevant to the practice
- Written procedures and/or guidelines on care coordination processes may be developed by the PO or practice

Partnerships

13.9

Coordination capabilities as defined in 13.1-13.7 are extended to all patients that need care coordination assistance

PCP and Specialist Guidelines:

Written procedures and/or guidelines on care coordination processes may be developed by the PO or practice

Partnerships

13.10

Following hospital discharge, a tracking method is in place to apply the practice's defined hospital discharge follow-up criteria, and those patients eligible receive individualized transition of care phone call or face-to-face visit within 24-48 hours

PCP and Specialist Guidelines:

- PCP and specialists should coordinate to determine which physician(s) is/are most appropriate for follow-up
- Hospital discharge follow-up criteria is defined by the practice

Partnerships

13.11 (NEW)

13.11-Practice is actively participating in the Michigan Admission, Discharge, Transfer (ADT) Initiative

PCP and Specialist Guidelines:

- Practice maintains an all-patient list that has been sent to MiHIN's Active Care Relationship File in accordance with all MiHIN's specifications
- The practice maintains an **active** and compliant status with the statewide health information exchange (HIE) system.
- The practice has a process for managing protected health information in compliance with applicable standards for privacy and security.
- **The practice connects information received through the HIE process with clinical processes, such as transition of care management following hospitalization.**

Partnerships

Domain 14
Specialist Pre-Consultation and Referral Process

Goal: Process of referring patients from PCPs to specialists, and from specialists to sub-specialists, is well coordinated and patient-centered, and all providers have timely access to information needed to provide optimal care

Applicable to PCPs and specialists.

Partnerships

Demonstration Requirements for Domain 14.0

14.1 – Requires additional documentation (documented process)
14.2 - Requires additional documentation (documented process)
14.3
14.4
14.6
14.7
14.9 - Requires additional documentation (aggregated survey results)
14.10 – Requires documentation (documented process)

Partnerships

14.1

Documented procedures are in place to guide each phase of the specialist referral process – including desired timeframes for appointment and information exchange - for preferred or high volume providers

PCP Guidelines:
Practice unit has defined parameters for specialist referral process, including timeframes, scheduling process, transfer of patient information to specialist, and reporting of results from specialist(s), for preferred and high-volume providers

- Parameters include procedures to ensure that specialists are being given the information they need prior to appointments, including but not limited to:
  - Care manager (if one assigned)
  - Names of other specialists seen for same condition
  - Requested service (e.g., single consult, co-management, assumption of care)
    - Please reference Introduction, p. 2-3

Specialist Guidelines:

- Parameters include procedures to ensure that PCPs are aware of what information is needed by specialist prior to appointments
- Parameters include procedures to ensure that when specialist is referring to a different specialist, the referring physician provides information needed prior to appointments

Partnerships

14.10

Physician-to-physician pre-consultation exchanges are used to clarify need for referral and enable PCP to obtain guidance from specialists and subspecialists, ensuring optimal and efficient patient care

PCP Guidelines:
Documented procedures are in place outlining processes to be followed for pre-consultation exchanges, when appropriate, and related documentation

Specialist Guidelines:
Specialist practice has mechanism in place to ensure PCP access to timely pre-consultation exchanges

Partnerships

14.11(NEW)

When patient has self-referred to specialist, specialist obtains information from patient about PCP and informs PCP of patient's visit so PCP follow-up can be conducted

PCP Guidelines:
PCP conducts follow-up with patients who have self-referred to specialist

Specialist Guidelines:
Specialist routinely notifies PCP of visits when patients have self-referred

Partnerships

Predicate Logic

- 1.0 Patient Provider Partnership
  - 1.3 prior to 1.4-1.8
- 2.0 Patient Registry
  - 2.2 prior to 2.9
- 4.0 Individual Care Management
  - 4.5 prior to 4.11
  - 4.6 prior to 4.12
  - 4.7 prior to 4.13
  - 4.8 prior to 4.14
  - 4.9 prior to 4.15
  - 4.2 prior to 4.21

Partnerships

Predicate Logic Continued

- 5.0 Extended Access
  - 5.1 prior to 5.2
  - 5.3 prior to 5.5
  - 5.7 prior to 5.8
- 6.0 Test Tracking
  - 6.5 prior to 6.6
- 10.0 Linkage to Community Resources
  - 10.7 prior to 10.8

Partnerships

Predicate Logic Continued

- 11.0 Self Management
  - 11.1 prior to 11.2, 11.3,
  - 11.1, 11.2 prior to 11.4 and 11.5
  - 11.1, 11.3 prior to 11.6
- 12.0 Patient Web Portal
  - 12.1, 12.2 prior to 12.3-12.13
- 13.0 Coordination of Care
  - 13.1-13.7 prior to 13.8
  - 13.1-13.8 prior to 13.9