PCMH User Group Highlights 1/23/18

Slides from presentations are attached to email and on website (slides and highlights under PCMH User Group)

PLEASE REVIEW SLIDES AS THEY ARE NOT REPEATED BELOW – just highlights

2018 PCMH Updates:

- **Capabilities 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**
    - If your practice does not feel a capability is appropriate anymore for your practice, please advise NPO so capability can be accurately reported as reverted. Accurate reporting is the goal.
- **All capabilities must be proven**
    - Changes to the Interpretive Guidelines layout so that there are site visit notes with examples of what would be asked at a site visit.
    - **PLEASE use the guidelines to look at what is required during site visit**
- In 2018 there will be six core capabilities required for PCMH Designation
    - 1.1 – Patient/Provider Partnership (talking about PCMH with patient)
    - 4.6 – Individual Care Management (appointment tracking and reminders)
    - 5.1 – Extended Access (24-hour phone access to clinical decision maker)
    - 6.2 – Test Tracking (ensure patient receive needed tests and practice receives results)
    - 6.5 – Test Tracking (ensure patients receive abnormal test results)
    - 10.2 – Linkage to Community Resources (PO maintains)
- Capability Clarifications noted on slides – please review slides
    - 2.20 – registry contains advanced Patient information, clarified that a minimum of 4 out of 7 of the listed guidelines must be in the registry. *Attendees stated that many practices do ask these but don't have structured fields in EMR to enter these into.*
    - 3.3 – Performance reports include at least 2 other conditions. BCBSM emphasized that these reports must be meaningful and ongoing *which means that during a site visit, BCBSM could ask something like "give an example of how these reports have improved patient care"*
    - 4.6 – ERROR in guidelines – THIS IS REQUIRED for PCMH DESIGNATION.
    - Domain 5 – Extended Access
        - *BCBSM has started a new initiative focusing on those patients with more than 6 ED visits in a year. This is limited to certain employers right now and none of these employers are in this area, but this will be expanding.*
        - *BCBSM also says that large employers are being approached by professional care management companies who offer to share savings achieved through care management of high utilizer patients. BCBSM will be emphasizing PDCM more to help maintain the PCP-patient relationship.*
    - 10.3 - Practice or PO in collaboration with practice is able to provide a list of organizations providing services relevant to their patient population in which collaborative, ongoing relationships are directly established
        - BCBSM expects practices to be able to say, "I know ____ at this organization and have worked with them" *Attendees stated that they don't always receive feedback from organizations but are very comfortable reaching out and have contacts there*

- 10.5 - Systematic team approach is in place for assessing and educating all patients about availability of community resources and assessing and discussing the need for referral
    - *Emphasis on community resources has grown every year.*
    - Site visit validation:
        - Practice to show tools used for patient education on community resources
        - How are a patient's need for resources assessed, what screening tools are utilized? Some tools are:
            - Health Leads Survey – the original tool
            - CHIR Tool – Social Determinants of Health – required for SIM practices
            - Short Screening Tool – a shorter version of the Health Leads tool, developed by NPO, which may work for many practices and references those community resources practices are familiar with
            - TBIM Bubble Survey – a tool developed by Traverse Bay Internal Medicine used at annual exam that includes patient input on wording. Goes into EMR. Either MA or Care Manager (if available) addresses patients with needs.
            - Kids Creek Tool – handed out with Community Resource tool; entered into structured data in EMR. Cathy Carter presented about this process at 11-8-2017 PCMH User Group; highlights and handouts on NPO website
        - Screening tools help ensure that all needs are addressed in a systematic manner
        - Can be done at a set time such as annual physicals
        - If a practice has a Care Manager, patients who screen positive and want assistance can be referred to the Care Manager
        - A practice currently screening all patients says that, in actual practice, very few patients screen positive and want assistance.
        - Screening can be conducted via portal.
- 11.1 - If in place, must have the regular, on-going staff education actively in place. *One practice uses role-playing as a training tool.*
- There is a list of capabilities that were frequently reverted in 2017 (please see slide for list)
    - If your practice has any of these capabilities in place, please be prepared that they will likely be selected for review during site visit

<u>The New Vital Sign and a contract update</u>

- Northern Michigan Health Network has been working with obesity as an initiative to reduce overall BMI in our communities.
    - Diabetes Prevention Programs
    - One on One with the patient
- NMHN was challenged by a member of the community, saying what physicians are doing with their patients is great, but incremental. How can we make big changes to whole communities?
    - This "assignment" was given to the Advisory Committee, which has representation from NMC, a high school student, the Health Dept., Area Agency on Aging and the community.
- The New Vital Sign: 150 minutes of exercise per week (above and beyond normal)
    - The goal is to get this "vital sign" added to the list of vital signs that you perform on each patient.
    - Posters and handouts for offices to promote the new vital sign will be distributed
    - Addition to the EMR/Registry as a structured vital sign field when rolled out
    - Input from group
        - 150 seems to be a big number, easing patients up to that amount of time
        - Kids need an hour a day (recommendation)

- Senior Citizens – cannot always walk etc., so personalized for age groups: IE: Geriatric, Kids, and Adults.

Marie made the announcement that the ASR Contract has been signed, and that they are paying 10% above the Medicare Fee Schedule to PCMH practices who are in NPO to recognize the good PCMH work. Instead of having practices collect quality data for ASR, ASR will be using the Quality Score from the Medicare ACO, to reduce administrative burden on practices.

PLEASE NOTE: If you plan to attend the next meeting either in-person or telephonically, please either email kelliott@npoinc.org or call NPO at 231-421-8505 to RSVP. After we receive your RSVP, we send you an Outlook appointment. Please bring in parking garage tickets for validation.

2018 meetings dates and topics:

- **Thursday, 2/22/18** Lori Boctor from BCBSM will be here to answer your PDCM questions. If you have questions now NPO can send them in advance to her; just send them to NPO, please. Please feel free to have your practice's Care Manager attend the meeting if you like; Sandy Stimson from BCBSM will also be attending the meeting.
- **Wed, 4/25/18** Practice sharing – how is your practice handling the 10.5 capability requirement of a screening tool for community resource needs? Please be prepared to share.
- **Tuesday, 6/19/18**
- **Tuesday, 8/21/18**
- **Wed, 9/26/18**
- **Thursday, 10/25/18**
- **Thursday, 11/29/18**