VALUEPartnerships
Better Care. Better Outcomes. Better Value.

Blue Cross Blue Shield of Michigan

2018-19 PCMH IG Updates

January 2019

PGIP Field Team, Value Partnerships
Blue Cross Blue Shield of Michigan

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”.

Annually is defined as within the last 12 months.

Capability Demonstration

- All capabilities must be proven
- POs should inform practices that demonstration will be required for certain capabilities. Examples:
  - If the practice is asked to show the field team how patient contacts were tracked in the practice system for abnormal test results, the practice should have patient examples identified ahead of time and be prepared to discuss them with the field team during the site visit.
  - 5.2 – After hours – must have example in EHR or chart
  - Registries – must demonstrate active outreach via worksheets, medical record notes, contact log, tickler file, etc.

NO DOCUMENTATION EXAMPLES CAN BE PROVIDED AFTER THE SITE VISIT

Summary of Changes

- Required Capabilities for PCMH Designation (6)
- Retired Capabilities
  - 6 Retired in 2018
  - 3 Additional Retired Capabilities in 2019 (12.8, 14.3, 14.10)
- New capabilities (11)
  - 1.11, 1.12, 2.22, 2.23, 3.17, 3.18, 4.24, 4.25, 4.26, 4.27, 4.28

Required Capabilities

- In 2018 we began requiring that practices have six core capabilities implemented in order to qualify for PCMH designation.
- These six core capabilities are relevant to all PCP practices and are central to a patient's PCMH experience. Requiring them for designation will enable us to assure customers that every BCBSM PCMH-designated practice in Michigan has the foundational care processes that they and their employees expect from a high-value primary care practice.

PCMH Domain	PCMH Capability #	Description
Patient-Provider Partnership	1.1	Prepared to implement patient-provider partnership with each current patient
Individual Care Management	4.6	Systematic approach in place for appointment tracking and reminders
Extended Access	5.1	24-hour phone access to clinical decision-maker
Test Tracking	6.2	Process in place to ensure patients receive needed tests and practice receives results
Test Tracking	6.5	Systematic approach to ensure patients receive abnormal test results
Linkage to Community Services	10.2	PO maintains community resource database/central repository of community resources

Retired Capabilities

- Starting in 2018, capabilities are retired when they no longer require substantive time and or resources to implement, due to the evolution of practice transformation.

PCMH Domain	PCMH Capability #	Description
Patient-Provider Partnership	1.9	Health care information is shared among care partners as necessary.
Registry	2.5	Registry identifies individual practitioners
Test Tracking	6.3	Process is in place for ensuring patient contact details are kept up to date
Patient Portal	12.1	Available vendor options for purchasing and implementing a patient web portal system have been evaluated
Patient Portal	12.2	PO or Practice Unit has assessed liability and safety issues with portal
Patient Portal	12.8	Patient ability to create personal health record in portal
Specialist Referral	14.3	Specialist directory
Specialist Referral	14.5	Practice Unit or designee ensures patients are scheduled for specialist appointments in timely manner
Specialist Referral	14.10	Physician-to-physician to pre-consultation exchanges

New Capabilities

1.11

Practice has a regularly scheduled in-person new patient orientation that is distinct from a regularly scheduled visit, to set expectations about being a patient within that practice, and provide education about the value of a patient-centered medical home model.

PCP and Specialist Guidelines:

Orientation can be in a group setting and led by a mid-level provider or nurse

Required for PCMH Designation: NO	Predicate Logic: n/a
PCMH Validation Notes for Site Visits	
• Show agendas, patient handouts, meeting schedules for new patient orientation	

1.12

Practice establishes a Patient and Family Advisory Council to better understand patient and caregiver perspectives, and how those perspectives can be used to optimize patient care.

PCP and Specialist Guidelines:

- For more information on creating a Patient and Family Advisory Council, review this module from the American Medical Association: https://www.stepsforward.org/modules/pfac
- Cannot be solely hospital-based
- Patients on committee must be current patients of the practice or their family members

Required for PCMH Designation: NO	Predicate Logic: n/a
PCMH Validation Notes for Site Visits	
• Show agendas, meeting schedules, attendee list for PFAC • Show examples of patient feedback collected from PFAC and demonstrate how change was enacted based on feedback	

2.22

Registry is being used to manage all patients with: pediatric autism

PCP and Specialist Guidelines:

- Reference 2.1(a)-(g).
- Information about screening tools for autism is available here: https://www.cdc.gov/ncbddd/autism/hcp-screening.html

Required for PCMH Designation: NO	Predicate Logic: n/a
PCMH Validation Notes for Site Visits	
• Demo the process of using the registry tool to identify the patient population • Registry should contain relevant clinical info such as which screening tool was used to identify condition and related results from screening, along with next steps/treatment plan which may include, but is not limited to, speech therapy, occupational therapy, etc. • How is the info entered in the registry? • What do you do with it when you receive it, how do you address gaps in care?	

2.23

Registry is being used to manage pediatric behavioral health disorders, which may include depression, anxiety, and/or eating disorders

PCP and Specialist Guidelines:

- Reference 2.1(a)-(g).
- If currently using depression for capability 2.13, a different condition other than depression must be used for this capability
- Examples of behavioral health screening tools include the PHQ2/9, Postpartum Depression Screening and GAD (Generalized Anxiety Disorder) scale

Required for PCMH Designation: NO	Predicate Logic: n/a
PCMH Validation Notes for Site Visits	
• Demo the process of using the registry tool to identify the patient population • Registry should contain relevant clinical info such as which screening tool was used to identify condition and related results from screening, along with next steps/treatment plan • How is the info entered in the registry? • What do you do with it when you receive it, how do you address gaps in care?	

3.17

Performance reports are generated for the population of patients with: Pediatric autism

PCP and Specialist Guidelines:

- Reference 3.1

Required for PCMH Designation: NO	Predicate Logic: n/a
PCMH Validation Notes for Site Visits	
• The practice must demo how they are using these performance reports to improve population management. • Steps: 1) For each chronic condition, are the relevant measures included in the performance reports? 2) What sort of review is being done with these reports? 3) What actions are taken?	

3.18

Performance reports are generated for the population of patients with: ***pediatric behavioral health disorders, which may include depression, anxiety, and/or eating disorders***

PCP and Specialist Guidelines:

- Reference 3.1

Required for PCMH Designation: NO	Predicate Logic: n/a
PCMH Validation Notes for Site Visits	
• The practice must demo how they are using these performance reports to improve population management. • Steps: 1) For each chronic condition, are the relevant measures included in the performance reports? 2) What sort of review is being done with these reports? 3) What actions are taken?	

4.24

Physician organization and/or practice unit standardizes, develops and maintains care management processes and workflows, to ensure efficient delivery of care management services in the practices for whom they coordinate/administer care management.

PCP and Specialist Guidelines:

- This capability should be marked as "in-place" only for practices with whom the PO has worked to implement care management. Practice participation in care management may be verified using PDCM claims data.

Required for PCMH Designation: NO	**Predicate Logic: n/a**
PCMH Validation Notes for Site Visits	
• PO or practice provides documentation about general policies related to care management delivery and examples of care management workflows	

4.25

Physician organization ensures that care managers are trained, onboarded, and integrated into their practice(s) effectively. Includes ensuring training requirements are completed, creating process for "warm handoffs" from physician to care manager to facilitate strong uptake of care management services by patients, as well as development of communication materials to promote care manager as integral part of practice staff (i.e., flier about care manager role, business cards for care manager).

PCP and Specialist Guidelines:

- This capability should be marked as "in-place" only for practices with whom the PO has worked to implement care management. Practice participation in care management may be verified using PDCM claims data.

Required for PCMH Designation: NO	Predicate Logic: n/a
PCMH Validation Notes for Site Visits	
• PO provides documentation on care manager training materials, care management training trackers, processes for ensuring warm handoffs, and/or practice materials used to introduce care manager to patients and caregivers	

4.26

Physician organization supports care management billing process for practices engaged in care management. PO may assist practice billing/coding staff with understanding care management billing process, and ensuring the appropriate training resources are utilized for billing.

PCP and Specialist Guidelines:

- This capability should be marked as "in-place" only for practices with whom the PO has worked to implement care management. Practice participation in care management may be verified using PDCM claims data.

Required for PCMH Designation: NO	Predicate Logic: n/a
PCMH Validation Notes for Site Visits	
• PO or practice provides care management billing training/reference materials/job aids • PO or practice demonstrates billing of care management codes	

4.27

Physician organization assists practices with integrating and analyzing data related to effective care management, including the PDCM monthly member lists, and reports for tracking PDCM Engagement Initiative, to ensure optimal care management engagement and targeting.

PCP and Specialist Guidelines:

- This capability should be marked as "in-place" only for practices with whom the PO has worked to implement care management. Practice participation in care management may be verified using PDCM claims data.

Required for PCMH Designation: NO	Predicate Logic: n/a
PCMH Validation Notes for Site Visits	
• PO demonstrates procedure for processing/disseminating care management data to practices, including monthly patient lists and routine engagement reports and routine claims reports verified through health plan claims data • PO demonstrates how they assist practices in targeting high-risk patients	

4.28

Physician organizations assist practices with seeking waiver for offering Medication Assisted Treatment (MAT) as needed/desired to reduce opioid dependency in the practice's patient population. Practices that seek waiver must be both willing and able to deliver medication assisted treatment to their patients.

PCP and Specialist Guidelines:

- For more information on medication assisted treatment, refer to the following websites: https://www.samhsa.gov/medication-assisted-treatment and https://www.fda.gov/Drugs/DrugSafety/InformationbyDrugClass/ucm600092.htm
- For more information on the waiver process, visit this site: https://www.samhsa.gov/programs-campaigns/medication-assisted-treatment/training-materials-resources/buprenorphine-waiver

Required for PCMH Designation: NO	Predicate Logic: n/a
PCMH Validation Notes for Site Visits	
• Physician can provide evidence that they have successfully received waiver to deliver medication assisted treatment, and can also demonstrate that they have delivered medication assisted treatment to relevant patients through documentation in medical record.	

Capability Clarifications

1.1 and 1.10

1.1 - Required

Practice unit has developed PCMH-related patient communication tools, has trained staff, and is prepared to implement patient-provider partnership with each current patient, which may consist of a signed agreement or other documented patient communication process to establish patient-provider partnership

1.10

Providers have an established process for repeating Patient-Provider Partnership discussion

- Capabilities require active communication between patient and clinical staff member.

2.15

Registry incorporates patients who are assigned by managed care plans once they are established patients in the practice

- Capability updated to clarify that patients are not expected to be added to the registry until they are established patients with the practice.

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

PCP and Specialist Guidelines:

- The integrated team of multi-disciplinary providers must consist of at least 3 non-physician members, including *at least 3 of the following* (composition of team may vary depending on the needs of individual patients): Registered nurse, Certified diabetes educator, nutritionist (RD or Masters-trained nutritionist), respiratory therapist, PharmD or RPH, MSW, certified asthma health educator or other certified health educator specialist (Bachelor's degree or higher in Health Education), licensed professional counselor, licensed mental health counselor, or an NP and/or PA with training/experience in health education who is actively engaged in care coordination/self-management training separate from their office visit E&M duties

- Updated capability to remove requirement of RN

5.9 and 5.10

5.9

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

5.10

Patient education materials and patient forms are available in languages common to practice's established patients

- Removed requirement of 5% of patient population
- This should be relevant to the non-English speaking or hearing impaired patient populations being served

6.4

Mechanism is in place for patients to obtain information about normal tests

- Formalized process for informing patients is required
- “No news is good news” is not acceptable
- Verbally telling patients to call a number without providing written instructions does not meet the intent of this capability
- Grace period for 2019 Site Visits

8.7 and 8.8

8.7

Full e-prescribing system is in place and actively in use by all physicians

8.8

Electronic prescribing system is routinely used to prescribe controlled substances

- Increased required percentage to greater than 75% to be considered actively in use.

9.1

Primary prevention program is in place that focuses on identifying and educating patients about personal health behaviors to reduce their risk of disease and injury

- Counseling on isolated elements of prevention, such as tobacco cessation, does not meet the intent of this capability; only comprehensive primary prevention meets the intent.
- If this capability is being reported as in place for a specialist practice, the specialist must be addressing **all** primary prevention measures including colorectal screenings, mammograms, immunizations, etc.
- Update to PCMH Validation Notes for Site Visits

12.12

Patients actively view visit summaries online that contain patient personal health information that has been reviewed and released by the provider and/or practice

- Elements must include, at a minimum: active diagnoses, current medications, allergies, treatment plan, next steps/follow-up
- Update to PCMH Validation Notes for Site Visits

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 who are eligible receive individualized transition of care phone call or face-to-face visit within 24-48 hours

- Who at the PU contacts the patient for the Transition of Care (TOC) visit?
- What is the time frame for patient contact (e.g. 24-48 hours?)
- Are same day appointments held for TOC visits?
- Update to PCMH Validation Notes for Site Visits

13.11

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

- Who at the PU has access to the ADT information and how is the information used?
- How often do you access the ADT?
- What is your patient outreach process after an ED visit or IP visit (include timeframe)?
- Update to PCMH Validation Notes for Site Visits

Capabilities frequently reverted in 2018

Capability	NIP	FIP	% REV
11.4	4	5	80%
5.10	11	14	79%
8.11	3	4	75%
14.9	14	25	56%
12.4	3	6	50%
2.12	8	16	50%
2.15	4	8	50%
4.18	3	6	50%
4.22	1	2	50%
4.16	8	18	44%
10.5	16	38	42%
2.13	8	19	42%
12.6	2	5	40%
8.8	6	17	35%
2.10	6	19	32%
2.11	5	16	31%

Capability	Description	Reason
11.4	Satisfaction survey for care management	Survey results unavailable. Must be aggregated, quanitifed and tracked over time
5.10	Pat. Education materials in multiple languages	Required 5% of population speaking other languages; capability changed for 2019
8.11	Sharing of controlled substance agreement	Contract was not flagged for other providers (in common EHR) and/or not shared with other providers of care
14.9	Satisfaction survey for specialists	Survey results unavailable. Must be aggregated, quantified and tracked over time
12.4	Web portal graphing of self admin. tests	No examples or usage logs available
2.12	Registry for CHF	Registry unavailable; no documented examples of patient outreach
2.15	Registry incorportates patients assigned by mgd care	Practice unable to demonstrate outreach to assigned patients
4.18	Palliative care planning	Practice unable to define process for identifying patients and enaging/referring eligible patients
4.22	Sharing of advanced care plans	Providers not sharing/unable to identify common location in shared EHR
4.16	Advanced care planning	Practice unable to define process for identifying and counseling patients and/or practice does not have process for ensuring follow-up at subseqent visit
10.5	Assessment of all patients for community resource needs	Capability requires either a document handed to patient or a systematic screening tool used by staff; this was not available
2.13	Registries for two other conditions	Registry unavailable; no documented examples of patient outreach for conditions of focus
12.6	E-Visits	No recent example e-visits in EHR
8.8	eRX of controlled substances	Practices unable to electronically prescribe or did not meet percentage
2.10	Registry for Asthma	Registry unavailable; no documented examples of patient outreach for conditions of focus
2.11	Registry for CAD	Registry unavailable; no documented examples of patient outreach for conditions of focus